Health Insurance Marketplace Plan Management
2016 QHP/Continuity of Care Application Process

February 18, 2015
9:00AM – 12:00PM

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

WebEx: 2016 QHP Application Process
Password: nhid2016
Phone: 1-877-668-4493
Access code: 760 527 136

In order to receive any follow-up documents, please send a list of attendees and their email addresses to Marlene Sawicki at Marlene.Sawicki@ins.nh.gov
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Part 1: Policy Discussion

QHP Review Timeline

Key Dates:
April 1: Final date to submit complete binder submissions, rates and form filings
July 24: NHID to have completed all QHP reviews and recommend for certification
QHP applications transferred to FFM
October 1-December 15: Open enrollment period

Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct
---|---|---|---|---|---|---|---|---
(2/18) Informational Meeting with Prospective QHP Issuers | (4/1) Issuers to submit plan data (all forms and binders) to NHID | (4/15) 1st SERFF Data Transfer | (5/27) FFM Notifies State of Corrections to QHP Data | (6/9) 2nd SERFF Data Transfer | (6/5) Issuer Deadline for Revised QHP Data due to NHID | (7/20) Issuer Deadline for Revised QHP Data due to NHID | (7/24) Final Deadline for Submission of QHP Data and State Certification Recommendations | (8/17-9/15) Certification Notices and QHP Agreements Sent to Issuers | (10/1) Open Enrollment Period
QHP Certification

The Department understands the complexity of the QHP Certification process and as such, the Department has guidance and tools to assist issuers during the QHP submission and review process.

CMS Tools/Guidance include:

- **SERFF Industry User Manual**
- **Instructions for QHP Applications and PY 2016 templates**: The instructions cover general QHP application instructions, including issuer module, benefits and service area module, rating module and justifications
- **2016 Draft Letter to Issuers** (Final out by 2/23/15)
- **2016 Draft Benefit and Payment Parameters** (Final out by 2/23/15)
- **QHP Review Tools** (2016 tools are forthcoming)

NHID Tools/Guidance include:

- 2016 Plan Year Continuity of Care/QHP Certification Issuer Bulletin;
- Network Adequacy Package;
- Master list of SERFF form and binder documents needed for QHP submission
- **Premium Assistance Program (PAP) required cost sharing**

All NHID tools & guidance will be available on the Department website
QHP Certification

Much like the 2015 review period, Issuers will have weekly calls with the compliance team and other members of the QHP review team. These calls will be at a set time and day.

New for 2016

- Issuers must submit questions in writing 24 hours in advance of their scheduled weekly conference call. NHID will do their best to have responses prepared in advance of the weekly call.

- Issuers will have an assigned review team much like 2015, and all questions or concerns will be triaged through their review team.

- The Department will post significant updates that arise from questions and responses that pertain to all issuers*

*The Department will not distribute questions/responses containing carrier specific information, product design, rate or other propriety information.
Network Adequacy

NHID will prospectively review adequacy of issuer networks for 2016 plan year based on distance measures from providers.

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

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

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

Network Adequacy Package to include 3 documents

1. Network Adequacy Attestations
   - Network Attestations
   - Proposed service area (Counties)
   - List key provider types:
     - Hospitals
     - FQHCs
     - SUD treatment centers and Methadone Clinics

2. NH Network Data Template (Excel)
   - Standardized format for issuers to input PCP and OB/GYN provider networks
   - Additional data fields requested in document:
     - Hospital Admitting Privileges
     - Accepting New Patients

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

Issuer attests that:

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

- Network data submitted represents signed contracts in place

- Identify the counties covered in the proposed service area as well as identification of leased network if being used

- Lists the key provider types—for each county, issuer lists:
  - Hospitals
  - FQHCs
  - SUD treatment centers and Methadone Clinics
Network Adequacy Package

2 Network Data Template

- Standardized excel-based template for listing issuer PCP and OB/GYN provider networks
- Key data fields
  - Hospital admitting privileges;
  - Admitting new patients;
- NOTE: CMS Network Adequacy Template still a separate requirement for entire provider list

## New Hampshire Insurance Department

New Hampshire Network Data Template (Provider Network Data)

<table>
<thead>
<tr>
<th>HIOS Issuer ID</th>
<th>Company Legal Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Area Name</th>
<th>Network ID</th>
<th>Provider Name</th>
<th>Provider Type</th>
<th>County</th>
<th>Hospital Admit Privileges</th>
<th>Accepting New Patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required: Enter the Service Area Identification as delineated from the SERFF Service Area Template</td>
<td>Required: Enter the Network Identification as delineated from the SERFF Network Template</td>
<td>Required: Enter the last and first name (in that order) of each contracted physician provider. If the provider is not a physician, enter the name of the hospital, facility, pharmacy, etc.</td>
<td>Required: Input the Provider Type</td>
<td>Required: Enter the provider county location</td>
<td>Required only for OB/GYN Provider Type: List the hospital(s) for which OB/GYN providers have admitting privileges. In cases where providers have admitting privileges to more than one hospital, separate hospital names with commas (e.g., Hospital 1, Hospital 2, etc.).</td>
<td>Required only for PCP Provider Type: Indicate whether the Primary Care Provider is accepting new patients</td>
</tr>
</tbody>
</table>

Instructions:
Complete the fields below to detail the PCP and OB/GYN Provider Networks you are submitting for approval.
Network Adequacy Package

3 Network Adequacy Summary Page

Issuer attests that the network meets geographic access standards

Access standards based on distance from provider, reflective of standards found in INS 2701 Network Adequacy

Issuers must provide an access summary page for each county included in the proposed service area

Process for determining adequacy found in following slides

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

For issuers offering dental coverage (including stand-alone dental plans), access to coverage will be deemed adequate in cases where the issuer offers two open-panel general practice dental providers for each county within the proposed service area.
NHID will prospectively review adequacy of issuer networks for 2016 plan year based on distance measures from providers. Three scenarios exist for issuers proposing a network:

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

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

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

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

1. Provider location(s) mapped across the State

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

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

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

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

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

<table>
<thead>
<tr>
<th>Zip</th>
<th>Pop.</th>
<th>County</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>03218</td>
<td>960</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03220</td>
<td>7,430</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03225</td>
<td>3,660</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03226</td>
<td>1,117</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03237</td>
<td>2,254</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03246</td>
<td>15,963</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03249</td>
<td>7,113</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03253</td>
<td>6,219</td>
<td>Belknap</td>
<td>Yes</td>
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<tr>
<td>03256</td>
<td>2,169</td>
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<td>Yes</td>
</tr>
<tr>
<td>03269</td>
<td>2,966</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03276</td>
<td>8,324</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03809</td>
<td>3,716</td>
<td>Belknap</td>
<td>Yes</td>
</tr>
<tr>
<td>03810</td>
<td>1,538</td>
<td>Belknap</td>
<td>No</td>
</tr>
<tr>
<td>03837</td>
<td>1,519</td>
<td>Belknap</td>
<td>No</td>
</tr>
</tbody>
</table>

Numerator = Under 65 Population of covered zip codes within county

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

\[
\frac{61,891}{63,429} = 95.3\%
\]

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

If the covered population is less than 90 percent, the issuer must either expand its network or reduce the proposed service area to exclude counties in which the threshold is not met.
In order to satisfy the requirements set out in 45 C.F.R 156.235, Issuers must:

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

### ECP Categories

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

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

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

- $50 Deductible difference
- $100 MOOP difference
- Provider Network
- Formulary
- Covered Benefits
- Plan Type (HMO, PPO)
- HSA Eligibility
- Self/Non-Self/Family Offering

Cost Sharing

### Maximum Cost Sharing for Medical Plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>$6,850</td>
<td>$13,700</td>
</tr>
<tr>
<td>73%</td>
<td>$5,450</td>
<td>$10,900</td>
</tr>
<tr>
<td>87%</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
<tr>
<td>94%</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

### Maximum Cost Sharing for Pediatric Dental Plans

<table>
<thead>
<tr>
<th>1 Child</th>
<th>2 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>$350</td>
<td>$700</td>
</tr>
</tbody>
</table>

The above-listed annual limits on cost sharing apply only to essential health benefits received in-network.


Current provider information must be accessible to plan enrollees, prospective enrollees, the state, the FFM, HHS, and OPM.

“Current” is defined as updated at least monthly.

The general public must be able to view all of the current providers for a plan in a provider directory on the plan’s public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number.
Drug Lists

Formulary Drug List

- Drug lists must be easily accessible to plan enrollees, prospective enrollees, the state, the FFM, HHS, and OPM
- Issuers must publish an up-to-date, accurate, and complete list of all covered drugs, including any tiering structure and any restrictions on the manner in which a drug can be obtained

Prescription Drug Exception Process

- Proposed provisions establish more detailed procedures for the standard review process, and require an external review if the health plan denies an initial request made on a standard or expedited basis. CMS also clarifies that cost sharing for drugs obtained through the exceptions process must count towards the annual limitation on cost sharing

CMS encourages issuers to temporarily cover non-formulary drugs as if they were on the formulary during the first 30 days of coverage when an enrollee is transitioning to a new plan
Recertification of 2015 Plans

Uniform Modification

- QHPs currently offered on the FFM must be recertified (will keep the same HIOS ID and will not be required to be withdrawn and filed as new plans) so long as any plan modifications fall within regulatory parameters for uniform modifications of coverage:\footnote{http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf}
  - Changes made solely pursuant to applicable Federal or State requirements.
  - Changes in cost sharing are solely related to changes in cost and utilization of medical care, or to maintain the same 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; and
  - The plan covers a majority of the same counties in its service area.

Any changes from last year must be \textcolor{red}{redlined} on all forms

Plan ID Crosswalk

- Issuers who recertify or discontinue a plan for some enrollees must fill out the federal crosswalk template showing what plan they intend to enroll those consumers in for this year. This template can be found in SERFF and must be part of the 4/1/2015 QHP submission.
Issuer Evaluation of QHP Application

Review Tools Requirement

- NHID will require attestations from issuers that all CMS QHP tools have been run and errors resolved prior to submission of data templates (tools are available through SERFF)
- Additionally, issuers must submit screen shots of the result received after running the tools. Both the attestation form, and screen shots should be uploaded to the Binder side Supporting Documents tab in SERFF

Attestation that tools were run with no errors

Screenshot of Cost Sharing Tool that shows the MOOP requirements were Met
Issuer Evaluation of QHP Application

Matching Policy Forms and Plan and Benefit Templates

- Last year NHID and CMS found significant discrepancies between the benefit and cost sharing wording on forms, and the way plans were categorized in the plan and benefit templates.
- Issuers must input data into the plan and benefits template accurately and that data must match the policy forms.
  - Functionality in the plan and benefits template must be used to show whether a benefit has any limits, and any applicable exclusions or benefit explanations.
- When plan and benefit templates are updated through the certification process, the plans forms must be updated as well.
- Discrepancies will significantly slow down the review process and possibly cause issuers to not be certified in 2016.
Rate Filing Requirements

Rate Review Considerations for 2016 Plan Year

Changes in rates between plan years¹:
- Issuers seeking rate increases greater than or equal to 10% must publicly disclose and provide justification for proposed increases;
- States will determine whether these increases are reasonable.

Same rates for On- and Off-Marketplace²:
- A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent.

Additional Resource: Notice of Benefit and Payment Parameters Draft Rule³

²http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=162e6716ea28bf56f3bd02636800d296&ty=HTML&h=L&r=PART&n=45y1.0.1.2.71#45:1.0.1.2.71.3.27.10
Stand-Alone Dental

All Stand-Alone Dental Plan (SADP) issuers are bound by the same timeline as QHP issuers, included on Slide 4

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

- 2016 Letter to Issuers in the Federally-Facilitated Marketplace;
- NHID 2016 Issuer Bulletin; and
- SADP Small Group and Individual Filing Checklists

SADP Network Adequacy: Access to coverage will be deemed adequate in cases where the issuer offers two open-panel general practice dental providers for each county within the proposed service area.

<table>
<thead>
<tr>
<th>2015 SADP A/V and MOOP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Type</strong></td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Low</td>
</tr>
</tbody>
</table>
Stand-Alone Dental

Stand-alone dental plans are not subject to many of the requirements that are applicable to all QHP issuers.

<table>
<thead>
<tr>
<th>Standard Applies</th>
<th>Standard does not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Essential Health Benefit (Pediatric Dental Only);</td>
<td>- Accreditation;</td>
</tr>
<tr>
<td>- Actuarial Value (High/Low);</td>
<td>- Cost-sharing Reduction Plan Variations;</td>
</tr>
<tr>
<td>- Annual Limits on Cost-sharing;</td>
<td>- Unified Rate Review Template;</td>
</tr>
<tr>
<td>- Licensure;</td>
<td>- Meaningful Difference;</td>
</tr>
<tr>
<td>- Network Adequacy;</td>
<td>- Patient Safety;</td>
</tr>
<tr>
<td>- Inclusion of ECPs;</td>
<td>- Quality Reporting;</td>
</tr>
<tr>
<td>- Marketing;</td>
<td>- Prescription Drugs.</td>
</tr>
<tr>
<td>- Service Area;</td>
<td></td>
</tr>
<tr>
<td>- Non-discrimination;</td>
<td></td>
</tr>
<tr>
<td>- Third Party Premium &amp; Cost-Sharing Payments;</td>
<td></td>
</tr>
<tr>
<td>- Data Integrity Tool.</td>
<td></td>
</tr>
</tbody>
</table>

SADP issuers applying for “Off-Exchange Certified” designations must comply with all standards applicable to on-Marketplace plans.
What is the latest information on the SHOP?

Issuers are reminded that effective January 1, 2016, the definition of “Small Group” will be standardized to 100 or fewer full-time employees (FTE’s) using the CMS methodology for counting FTE’s.

Plans filed in 2015 for offering on the small group marketplace in 2016 must be in compliance with federal guidance related to group size.


The following link organizes all SHOP regulations, including all recently filed proposed regulations relating to SHOP functions, and should serve as a resource to issuers (45 CFR 155 subpart H)
Part 2: SERFF and Filing Submittal

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

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

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

Online Portal

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

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

**Components of a Form/Rate Filing**

**Form Schedule Documents**
- Policy
- Certificate
- ID Cards
- Schedule of Benefits
- Outline of Coverage
- Application Form
- Enrollment Form

**Supporting Documentation**
- Compliance Certification
- (Applicable) NHID Filing Checklist
- Certificate of Readability
- Patient Bill of Rights
- Summary Notice of Continuation of Coverage rights
- Managed Care Consumers Guide to External Appeal

**Forms**

**Rates**

**Complete Filings Due: April 1, 2015**
QHP Filing Submission - SERFF

Binder

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

Components of a QHP Binder

Associate Schedule Items
- Issuer links documents from form/rate filing
- Forms queried from filings by the SERFF tracking number
- Forms assigned to specific plans within the binder

QHP Templates
- Administrative Data
- Plan and Benefits
- Prescription Drug
- Network
- Service Area
- Essential Community Providers
- Rate Data
- Rating Business Rules

Supporting Documentation
- Network Adequacy Package
- Compliance Plan/Org Chart
- Program Attestations
- Unified Rate Review
- Actuarial Memorandum
- Accreditation
- Plan ID Crosswalk
- Fed Network Adequacy
- Licensure
- Cert. of Good Standing

Complete Binders Due: April 1, 2015
Premium Assistance Program (PAP) Filing Submission - SERFF

Forms for 94% and zero cost sharing plans that are used for the new PAP population should be filed in SERFF with the same HIOS ID, but a different variant. The normal 94% plan has a variant of -06, and the PAP plan should have a variant of -36. The normal zero cost sharing plan has a variant of -02, and the PAP plan should have a variant of -32. This is just for the forms side, and this variant should NOT be included on the plan and benefits template.

<table>
<thead>
<tr>
<th>HIOS Issuer ID</th>
<th>HIOS Plan ID* (Standard Component)</th>
<th>HIOS Product ID*</th>
<th>HIOS Plan ID* (Standard Component + Variant)</th>
<th>CSR Variation Type*</th>
</tr>
</thead>
<tbody>
<tr>
<td>59025</td>
<td>59025NH0260005</td>
<td>59025NH026</td>
<td>59025NH0260005-01</td>
<td>Standard Silver On Exchange Plan</td>
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<tr>
<td>59025</td>
<td>59025NH0260005</td>
<td>59025NH026</td>
<td>59025NH0260005-03</td>
<td>Limited Cost Sharing Plan Variation</td>
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<tr>
<td>59025</td>
<td>59025NH0260005</td>
<td>59025NH026</td>
<td>59025NH0260005-04</td>
<td>73% AV Level Silver Plan</td>
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<tr>
<td>59025</td>
<td>59025NH0260005</td>
<td>59025NH026</td>
<td>59025NH0260005-05</td>
<td>87% AV Level Silver Plan</td>
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<td>59025NH0260005</td>
<td>59025NH026</td>
<td>59025NH0260005-06</td>
<td>94% AV Level Silver Plan</td>
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<td>59025</td>
<td>59025NH0260005</td>
<td>59025NH026</td>
<td>59025NH0260005-02</td>
<td>Zero Cost Sharing Plan Variation</td>
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</tbody>
</table>

Special Schedule of Benefits with the variant -36 must be created for the PAP population that is identical to the -06 variant 94% plan except in Deductible and MOOP amounts, since the state will be paying the deductible for the PAP population:

<table>
<thead>
<tr>
<th>SOB Consumer Cost Sharing</th>
<th>-06 Variant Marketplace Plan</th>
<th>-36 Variant PAP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$325</td>
<td>$0</td>
</tr>
<tr>
<td>MOOP</td>
<td>$925</td>
<td>$600</td>
</tr>
</tbody>
</table>

Special Schedule of Benefits with the variant -36 must be created for the PAP population that is identical to the -06 variant 94% plan except in Deductible and MOOP amounts, since the state will be paying the deductible for the PAP population:

Special Schedule of Benefits with the variant -36 must be created for the PAP population that is identical to the -06 variant 94% plan except in Deductible and MOOP amounts, since the state will be paying the deductible for the PAP population:

PAP cost sharing requirements can be found here
Helpful Filing Tips

State licensure:
- Issuer licenses are renewed on June 15 of each year currently during the QHP review period. In order to receive a recommendation for certification, the issuer must re-apply for a license in the State for the next year and provide proof of this application to the Department.
- State license must be provided for the correct company for the filing (HMO product must have HMO license, etc.)
- Issuers are reminded that they must submit to the Department proof of licensure for all subcontractors or third party entities performing services on their behalf.

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

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

Summaries of Benefits and Coverage
- Issuers offering group or individual health insurance coverage must compile and provide a Summary of Benefits and Coverage (SBC) that accurately describes the benefits and coverage under the applicable plan or coverage for each plan variation. Separate SBCs for each variation is a new requirement this year.
**CMS QHP Conference**

We urge all NH issuers to attend this conference either remotely or in person.

**Annual Qualified Health Plan Certification Conference**

**February 23-24, 2015**

**CMS Headquarters**

**Baltimore, Maryland**

The intended audience for this event includes issuers obtaining certification and/or certification of Qualified Health Plans in the Federally-facilitated Marketplace (FFM). Topics will include, but are not limited to:

- System for Electronic Rate and Form Filing (SERFF)
- Certification Process
- Market-wide Reforms
- FFM Issuer Compliance
- Health Insurance Oversight System (HIOS)
- Rate Review and Business Rules
- Essential Health Benefits/Actuarial Value
- CSR Advance Payment Calculation

Registration required and only allowed for either in-person or remote participation. For in-person attendance, registration is limited to four participants, per organization, per state.

**Registration Deadlines:**
- In-person - February 18th at 12:00 p.m. ET
- Remote - February 20th at 5:00 p.m. ET

Register Today at [https://www.REGTAP.info](https://www.REGTAP.info)
# New Hampshire Insurance Department Contacts

<table>
<thead>
<tr>
<th>NHID Division</th>
<th>Contact</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Office</td>
<td>Roger Sevigny</td>
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<td>Consumer Services</td>
<td>Keith Nyhan</td>
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<tr>
<td>PCG</td>
<td>Margot Thistle</td>
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<tr>
<td>PCG</td>
<td>Blair Kennedy</td>
<td><a href="mailto:Bkennedy@pcgus.com">Bkennedy@pcgus.com</a></td>
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Additional Resources

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

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