NEW HAMPSHIRE
Insurance Department

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

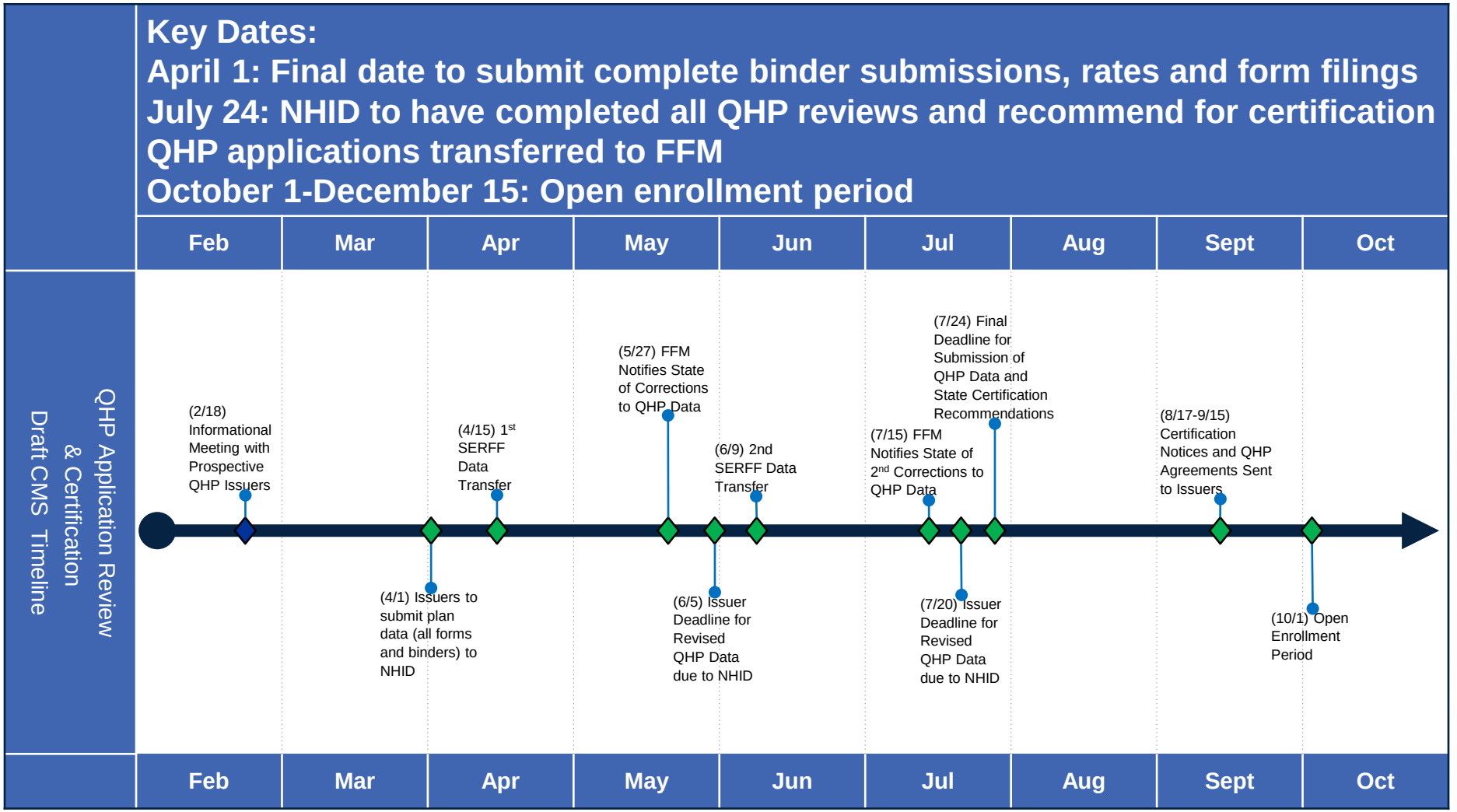
In order to receive any follow-up documents, please send a list of attendees and their email addresses to Marlene Sawicki at Marlene.Sawicki@ins.nh.gov

Agenda (Contents)

Agenda (Contents)

Part 1: Policy Discussion

QHP Review Timeline



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;
- QHP Filing Checklists (Individual, Small Group Medical Plans & Individual/Small Group Stand-Alone Dental Plans).
- 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

3. Network Adequacy Summary Page

2. Network Data Template (Excel)

1. Network Adequacy Attestations

Health Insurance Marketplace

Network Adequacy Application Package

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

Key Provider Contracts Form – Hospitals

[Issuer] is currently contracted with the following Hospitals for its QHP product:

County	Hospitals
Belknap	
Carroll	
Cheshire	
Coos	
Grafton	
Hillsborough	
Merrimack	
Rockingham	
Strafford	
Sullivan	

Key Provider Contracts Form – FQHC’s

[Issuer] is currently contracted with the following FQHC's for its QHP product:

County	FQHC
Belknap	
Carroll	
Cheshire	
Coos	
Grafton	
Hillsborough	
Merrimack	
Rockingham	
Strafford	
Sullivan	

Key Provider Contracts Form – SUD treatment centers and Methadone Clinics

[Issuer] is currently contracted with the following providers for its QHP product:

County	SUD Treatment Center	Methadone Clinic
Belknap		
Carroll		
Cheshire		
Coos		
Grafton		
Hillsborough		
Merrimack		
Rockingham		
Strafford		
Sullivan		

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

Version 6.0 - Updated 2/18/2015 New Hampshire Insurance Department

New Hampshire Insurance Department

New Hampshire Network Data Template (Provider Network Data)

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

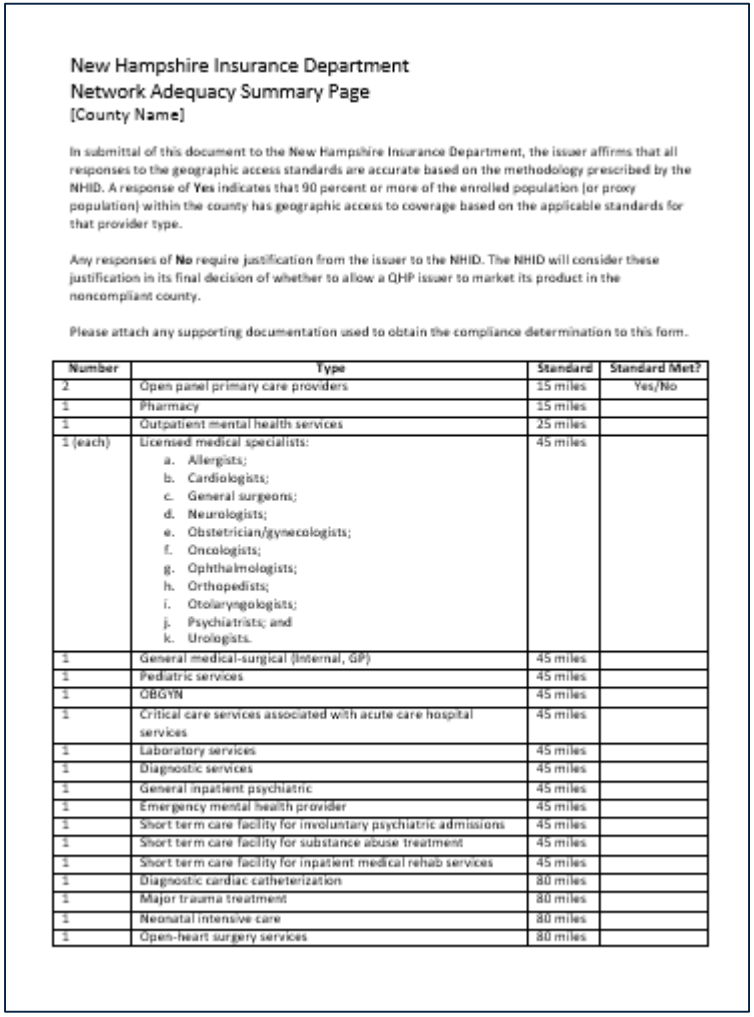
HIOS Issuer ID	
Company Legal Name	

Service Area Name	Network ID	Provider Name	Provider Type	County	Hospital Admit Privileges	Accepting New Patients?
Required: Enter the Service Area Identification as delineated from the SERFF Service Area Template	**Required:** Enter the Network Identification as delineated from the SERFF Network Template	**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.	**Required:** Input the Provider Type	**Required:** Enter the provider county location	**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.)	**Required only for PCP Provider Type:** Indicate whether the Primary Care Provider is accepting new patients

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



New Hampshire Insurance Department
Network Adequacy Summary Page
[County Name]

In submittal of this document to the New Hampshire Insurance Department, the issuer affirms that all responses to the geographic access standards are accurate based on the methodology prescribed by the NHID. A response of **Yes** indicates that 90 percent or more of the enrolled population (or proxy population) within the county has geographic access to coverage based on the applicable standards for that provider type.

Any responses of **No** require justification from the issuer to the NHID. The NHID will consider these justification in its final decision of whether to allow a QHP issuer to market its product in the noncompliant county.

Please attach any supporting documentation used to obtain the compliance determination to this form.

Number	Type	Standard	Standard Met?
2	Open panel primary care providers	15 miles	Yes/No
1	Pharmacy	15 miles	
1	Outpatient mental health services	25 miles	
1 (each)	Licensed medical specialists: a. Allergists; b. Cardiologists; c. General surgeons; d. Neurologists; e. Obstetrician/gynecologists; f. Oncologists; g. Ophthalmologists; h. Orthopedists; i. Otolaryngologists; j. Psychiatrists; and k. Urologists.	45 miles	
1	General medical-surgical (Internal, GP)	45 miles	
1	Pediatric services	45 miles	
1	OBGYN	45 miles	
1	Critical care services associated with acute care hospital services	45 miles	
1	Laboratory services	45 miles	
1	Diagnostic services	45 miles	
1	General inpatient psychiatric	45 miles	
1	Emergency mental health provider	45 miles	
1	Short term care facility for involuntary psychiatric admissions	45 miles	
1	Short term care facility for substance abuse treatment	45 miles	
1	Short term care facility for inpatient medical rehab services	45 miles	
1	Diagnostic cardiac catheterization	80 miles	
1	Major trauma treatment	80 miles	
1	Neonatal intensive care	80 miles	
1	Open-heart surgery services	80 miles	

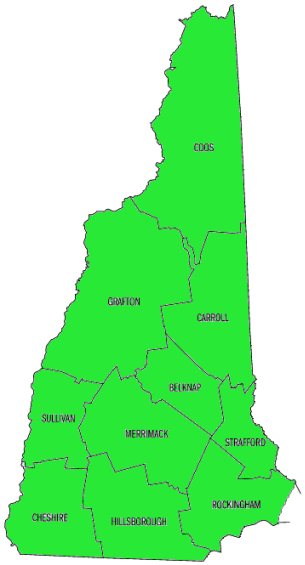
For issuers offering dental coverage (including stand-alone dental plans), access to coverage will be deemed adequate in cases where the issuer offers two open-panel general practice dental providers for each county within the proposed service area.

Network Adequacy Package - Summary Page Methodology

NHID will prospectively review adequacy of issuer networks for 2016 plan year based on distance measures from providers. Three scenarios exist for issuers proposing a network:

1

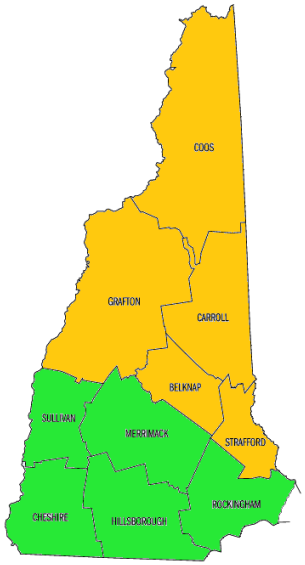
Issuer submits network and has existing QHP membership within the entire proposed service area.



Issuer may use existing QHP enrollment data as population sample

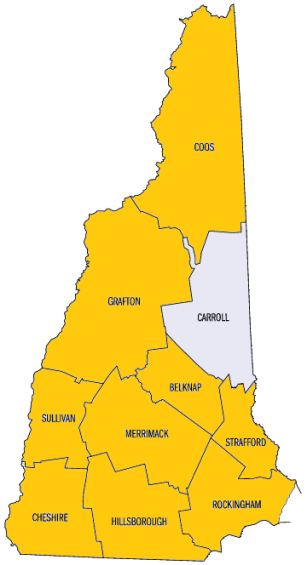
2

Issuer submits network and has existing QHP membership within the state, but not in the entire proposed service area.



3

Issuer submits network without any existing QHP membership within proposed service areas.



Current

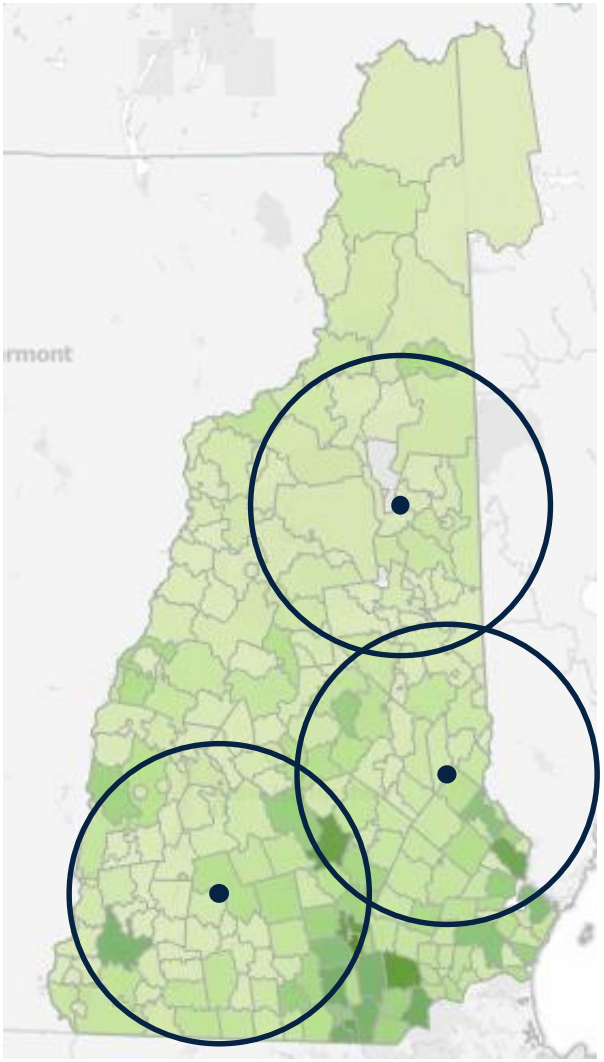
Proposed

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)

Network Adequacy - Distance Measurement Process

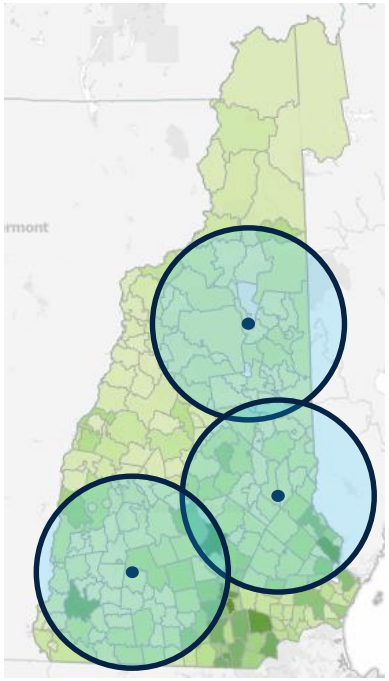
Issuers will be responsible for performing time and distance measures and reporting results to the NHID through Network Adequacy Summary Page

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.



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

Numerator = Under 65 Population of covered zip codes within county

$$\frac{61{,}891}{63{,}429} = \mathbf{95.3\%}$$

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

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

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

Essential Community Provider Standards

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 faith[2] 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

Federally Qualified Health Centers	Family Planning Providers
Ryan White Providers	Indian Health Providers
Hospitals	Other ECP Providers

[1]A 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

[2]Definition of "good faith" and allowable justifications found on pages 24-26 of http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf

Meaningful Difference

2016

Review Standards[1]

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

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

[1]2015 Final Letter to Issuers http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

Cost Sharing

Maximum Cost Sharing for Medical Plans[1]

Plan Type	Individual	Family
Standard	$6,850	$13,700
73%	$5,450	$10,900
87%	$2,250	$4,500
94%	$2,250	$4,500

Maximum Cost Sharing for Pediatric Dental Plans[2]

1 Child	2 or more
$350	$700

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

[1]Proposed Rule: Notice of Benefit and Payment Parameters for 2016 https://www.federalregister.gov/articles/2014/11/26/2014-27858/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016

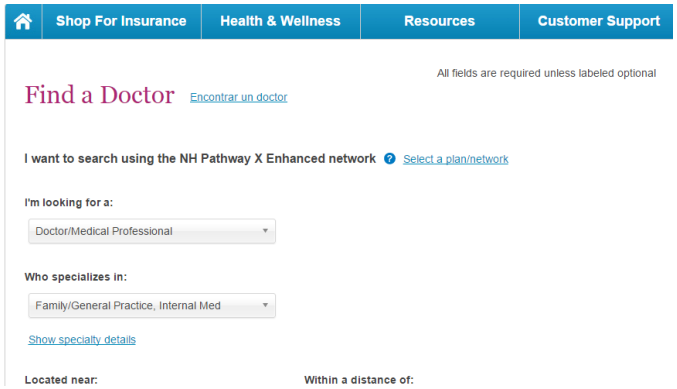
[2]Final Rule: Notice of Benefit and Payment Parameters for 2015 https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015

Provider Directories

- 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

Healthcare.gov

Provider Directory Link



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

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[1]:
  - 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 redlined on all forms

Plan ID Crosswalk

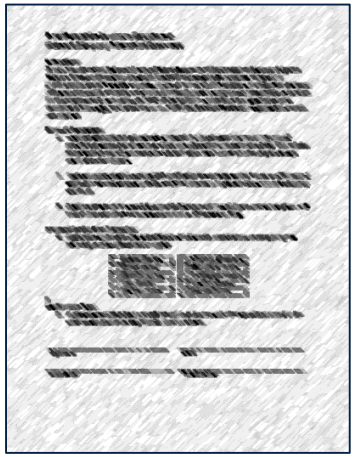
- Issuers who recertify or discontinue a plan for some enrollees must fill out the federal crosswalk template showing what plan they intend to enroll those consumers in for this year. This template can be found in SERFF and must be part of the 4/1/2015 QHP submission.

[1]http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf

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



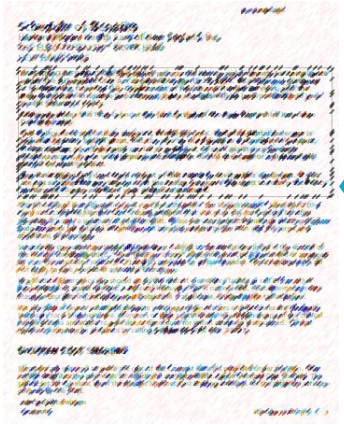
Screenshot of Cost Sharing Tool that shows the MOOP requirements were Met

HIOS Plan ID* (Standard Component + Variant)	Compliant?	Family MOOP Values Missing	Dental Only Plan	Medical & Drug Maximum Out of Pocket Integrated?	Multiple In Network	Maximum Out of Pocket for Medical EHB Benefits						
						In Network		In Network (Tier 2)		Combined In/Out		
						Individual	Family	Individual	Family	Individual	Family	Indivi
57601NH0370003-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0390003-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0390003-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0390004-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0390004-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0400003-00	Met		Yes		No	Not Applic	Not Applicable			350	700	
57601NH0400003-01	Met		Yes		No	Not Applic	Not Applicable			350	700	
57601NH0420003-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0420003-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0420004-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
57601NH0420004-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0110001-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0120001-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0110002-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0120002-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0070001-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0070001-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0080001-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0080001-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0090001-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
87701NH0100001-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
24847NH0090002-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
24847NH0100002-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
24847NH0060002-00	Met		Yes		No	350	700			Not Applic	Not Applicable	
24847NH0060002-01	Met		Yes		No	350	700			Not Applic	Not Applicable	
24847NH0080002-00	Met		Yes		No	350	700			Not Applic	Not Applicable	

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

FORMS



TEMPLATES

Rate Filing Requirements

Rate Review Considerations for 2016 Plan Year

Changes in rates between plan years[1]:

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

Same rates for On- and Off-Marketplace[2]:

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

Additional Resource: Notice of Benefit and Payment Parameters Draft Rule[3]

[1]Final Rule: Rate Insurance Disclosure and Review http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf
[2]http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=162e6716ea28bf56fdbd02636800d296&ty=HTML&h=L&r=PART&n=45y1.0.1.2.71#45:1.0.1.2.71.3.27.10
[3]Draft Rule: Notice of Benefit and Payment Parameters for 2016 https://www.federalregister.gov/articles/2014/11/26/2014-27858/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016

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.

2015 SADP A/V and MOOP

Plan Type	A/V Level
High	85%
Low	70%

Number of Children	MOOP
1 Child	$350
2 or more	$700

Stand-Alone Dental

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

Standard Applies

- Essential Health Benefit (Pediatric Dental Only);
- Actuarial Value (High/Low);
- Annual Limits on Cost-sharing;
- Licensure;
- Network Adequacy;
- Inclusion of ECPs;
- Marketing;
- Service Area;
- Non-discrimination;
- Third Party Premium & Cost-Sharing Payments;
- Data Integrity Tool.

Standard does not Apply

- Accreditation;
- Cost-sharing Reduction Plan Variations;
- Unified Rate Review Template;
- Meaningful Difference;
- Patient Safety;
- Quality Reporting;
- Prescription Drugs.

SADP issuers applying for “Off-Exchange Certified” designations must comply with all standards applicable to on-Marketplace plans.

Small Business Health Options (SHOP) Marketplace

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.

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf

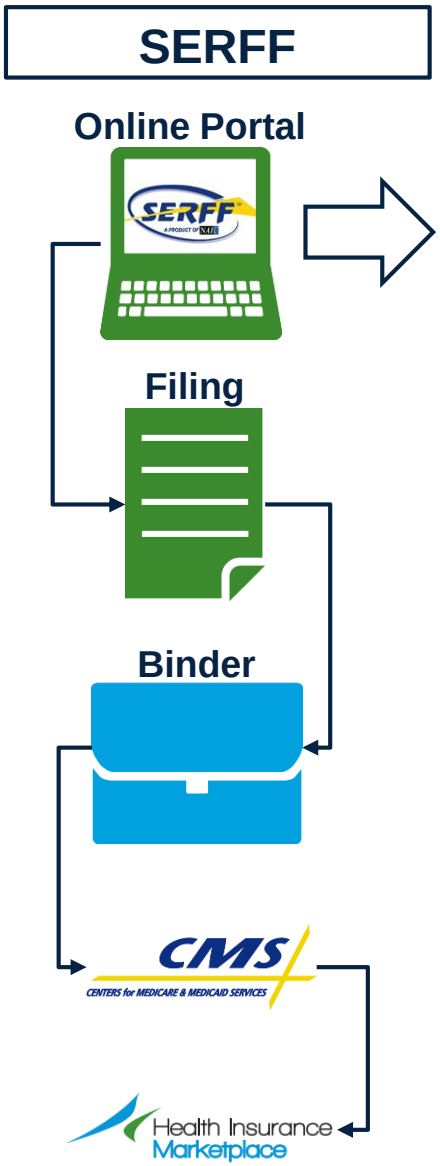
The following link organizes all SHOP regulations, including all recently filed proposed regulations relating to SHOP functions, and should serve as a resource to issuers (45 CFR 155 subpart H)

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
- SERFF Plan Management Industry Manual found at https://login.serff.com/Appendix%20II.pdf
- NHID has “retaliatory” fee requirements, meaning that issuer’s state of domicile determines whether the issuer submits a filing fee

QHP Filing Submission - SERFF

SERFF

Online Portal

Filing

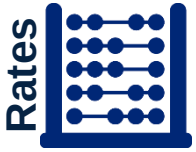
Binder

Filing

- Filings are submitted through SERFF
- Instructions to create a filing: https://login.serff.com/Complete%20Industry%20Manual.pdf
- 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

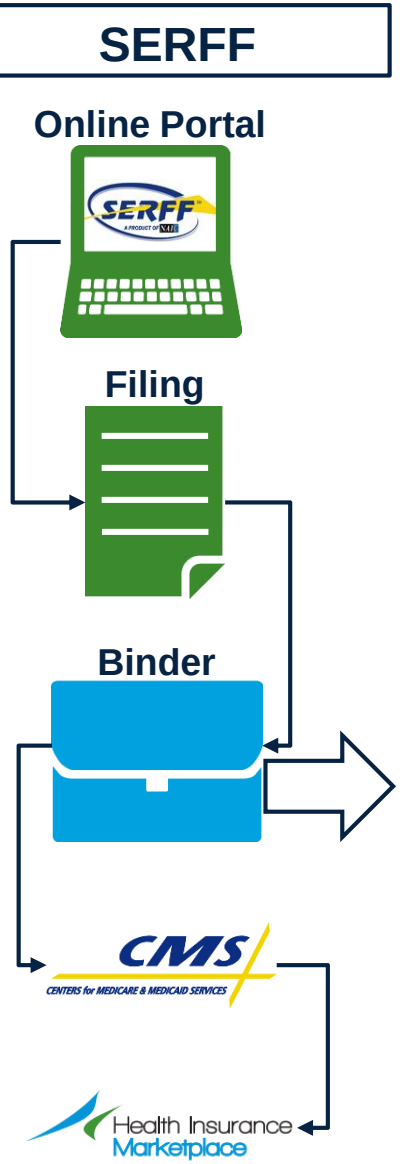


Supporting Documentation
- Rate Submissions
- Actuarial Memorandum
- Actuarial Value Calculator

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

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.

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

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

SOB Consumer Cost Sharing	-06 Variant Marketplace Plan	-36 Variant PAP Plan
Deductible	$325	$0
MOOP	$925	$600

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/lah/

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

New Hampshire Insurance Department Contacts

NHID Division	Contact	Email
Executive Office	Roger Sevigny	Roger.Sevigny@ins.nh.gov
Executive Office	Alexander Feldvebel	Alexander.Feldvebel@ins.nh.gov
Operations/Health Reform	Alain Couture	Alain.Couture@ins.nh.gov
Legal & Enforcement	Jennifer Patterson	Jennifer.Patterson@ins.nh.gov
Compliance	Michael Wilkey	Michael.Wilkey@ins.nh.gov
Compliance	Sonja Barker	Sonja.Barker@ins.nh.gov
Compliance	Diana Lavoie	Diana.Lavoie@ins.nh.gov
Compliance	Tom Weston	Thomas.Weston@ins.nh.gov
Compliance	Ingrid Marsh	Ingrid.Marsh@ins.nh.gov
Compliance	Marlene Sawicki	Marlene.Sawicki@ins.nh.gov
Market Conduct	Karen McCallister	Karen.McCallister@ins.nh.gov
LAH Actuarial	David Sky	David.Sky@ins.nh.gov
Consumer Services	Keith Nyhan	Keith.Nyhan@ins.nh.gov
PCG	Margot Thistle	Mthistle@pcgus.com
PCG	Blair Kennedy	Bkennedy@pcgus.com

Additional Resources

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

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