NHID Issuer FAQ
Certification Process 2016
April 6, 2015

FAQ 1 Topic: Schedule of Benefits

Question: What are the form submission requirements surrounding Schedule of Benefits (SOB) for NH Marketplace (On Exchange) plans as well as Off Marketplace only plans? What are the SOB form submission requirements concerning the Premium Assistance Program (PAP) plan when it comes to SOB's?

Answer:

The Schedule of Benefits (SOB) is a document that identifies the cost sharing an individual and or family is required to pay ("out-of- pocket" amounts) by category of coverage under the plan covered under an insurance policy. The SOB will reflect copays, deductibles and co-insurance cost sharing and the Maximum Out-of-Pocket amount that must be paid before benefits are paid at 100%.

For each plan variation, an SOB must be submitted in PDF form in SERFF by April 15, 2015. Variable fields are not allowed. Please name the document submitted in SERFF with the corresponding HIOS ID and variant, and associate the schedule item so it links to the correct plan within the binder. Use the variant -36 for the 94% Premium Assistance Program (PAP) plan and -32 for the 100% PAP plan (separate -32 SOBs are only required for PPO plans). The PAP plan requires separate SOBs but not unique policies.

Example of how to name a Schedule of Benefit: [SOB for *Plan Marketing Name_HIOSID+variant]*

SOB's must be submitted for each of the following, and the cost sharing on the forms MUST match the cost sharing in the plan and benefits template:

Standard/Limited variation (variant 00/01/03)

Zero cost sharing variation (variant 02) *NOTE: must be no cost sharing on EHBs in or out of network except for closed-panel HMO's, which would not cover out of network cost sharing.*[1]

Zero cost sharing variation for PAP (variant 32) *NOTE: Only create this SOB if the plan has out of network cost sharing. There must be no cost sharing on EHBs in network. Out of network cost sharing would follow the corresponding 70% standard plan out of network cost sharing.*

73% AV Level Silver Plan (variant 04)

87% AV Level Silver Plan (variant 05)

94% AV Level Silver Plan (variant 06)

94% AV Level Silver Plan (variant 36) *NOTE: This SOB should be identical to the corresponding 06 variation except in deductible and MOOP. The Deductible should be $0 and the MOOP will therefore be $600.*[2]

[1] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf#page=43
[2] http://www.dhhs.nh.gov/pap-1115-waiver/documents/planbenefittemplate.pdf#page=3

FAQ 2 Topic: Summary of Benefits and Coverage

Question: What are the submission requirements surrounding Summary of Benefits and Coverage (SBC) NH Marketplace (On Exchange) plans as well as Off Marketplace only plans? What are the submission requirements concerning the Premium Assistance Program (PAP) when it comes to SBC's?

Answer:

Summary of Benefits and Coverage (SBC**)** is a document that summarizes important health coverage information in a standard format to help consumers compare their choices.

Please see Section 4 Summary of Benefits and Coverage on page 65-66 of the 2016 Letter to Issuers. Separate URL's for each plan variation must be included in the plan and benefits template and the links must be active by open enrollment (November 1, 2015). Issuers will need to create a URL for PAP plan SBC's and submit those to the Department by June 1, 2015. The URL's can be submitted outside of the PBT for PAP.

Proposed Summary of Benefits and Coverage and Uniform Glossary was released December 30, 2014, and the SBC template, Uniform Glossary, and instructions can be found here. For the 2016 plan year, use the currently applicable templates, not the proposed templates which will not be finalized in time for this plan year.[3]

For each plan variation, an SBC must be submitted in PDF form in SERFF by April 15, 2015. Variable fields are not allowed. Please name the document submitted in SERFF with the corresponding HIOS ID and variant, and associate the schedule item so it links to the correct plan within the binder. Use the variant -36 for the 94 Premium Assistance Program (PAP) plan and -32 for the 100% PAP plan (separate -32 SBCs are only required for PPO plans).

Example of how to name a Summary of Benefits and Coverage: [SBC for *Plan Marketing Name_HIOSID+variant]*

SBC's must be submitted for each of the following, and the cost sharing on the forms MUST match the cost sharing in the plan and benefits template:

Standard/Limited variation (variant 00/01/03)

Zero cost sharing variation (variant 02) *NOTE: must be no cost sharing on EHBs in or out of network except for closed-panel HMO's, which would not cover out of network cost sharing.*[4]

Zero cost sharing variation for PAP (variant 32) *NOTE: Only create this SOB if the plan has out of network cost sharing. There must be no cost sharing on EHBs in network. Out of network cost sharing would follow the corresponding 70% standard plan out of network cost sharing.*

73% AV Level Silver Plan (variant 04)

87% AV Level Silver Plan (variant 05)

[3] http://www.dol.gov/ebsa/faqs/faq-aca24.html
[4] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf#page=43

94% AV Level Silver Plan (variant 06)

94% AV Level Silver Plan (variant 36) *NOTE: This SOB and SBC should be identical to the corresponding 06 variation except in deductible and MOOP. The Deductible should be $0 and the MOOP will therefore be $600.*[5]

FAQ 3 Topic: Network Adequacy

Question: What are the requirements for Network Adequacy? What are the requirements for off Marketplace only plans? What are the requirements for medical plans with embedded dental? What are the requirements for Stand Alone Dental Plans (SADPs)?

Answer:

Please see page 6 of the QHP Bulletin on Network Adequacy found here. Please see slide 7-14 from the NHID Carrier meeting on February 18, 2015 here.

Medical off Marketplace only plans have the same submission requirements for Network Adequacy as on exchange plans. They must submit the NH 2016 Network Data Template, the NHID Network Adequacy Attestation Document, the NHID Medical Network Adequacy Summary Page, as well as the federal Network Adequacy Template (includes full list of all providers) in SERFF by April 15, 2015.

Medical plans with embedded dental must also submit the NHID Dental Network Adequacy Summary Page.

SADP's do not need to submit the NH 2016 Network Data Template.

The NHID Network Adequacy Attestation Document includes a section for Key Provider Contracts Form – Substance Use Disorder (SUD) treatment centers and methadone clinics. Issuers should use the following guidance when completing the attestation document. The NHID is looking for outpatient treatment facilities contracted through carriers, excluding acute-care hospitals. These may be inclusive of ECPs.

SUD treatment centers and methadone clinics should include both public and private centers, provider or provider group that an issuer is contracted with to provide the following types of care:

Outpatient Treatment:

Outpatient Treatment Services which are provided in individual and group counseling sessions in a non-residential setting with an average duration of services of approximately 90 days or less.

Intensive Outpatient Treatment Services, which are conducted in an outpatient setting for a minimum of 3 hours of direct client treatment services per day, and could include both group and individual formats for a minimum of three days a week, with an average treatment plan of 4-6 weeks, with less intense services following.

Short Term Residential Treatment:

Short-term residential treatment, also referred to as Clinically Managed Medium Intensity Residential Treatment (CMMIRT), is designed to assist individuals who require a more intensive level of service in a

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[5] http://www.dhhs.nh.gov/pap-1115-waiver/documents/planbenefittemplate.pdf#page=3

structured setting and/or individuals that may be homeless, with a length of stay determined by clinical indicators. The average length of stay is expected to be approximately 28 days or less.

Long Term Residential Treatment:

Long-term, extended care residential treatment services, also referred to as Clinically Managed High Intensity Residential Treatment (CMHIRT.)

FAQ 4 Topic: Non-Discrimination Tools

Question: Which federal Non-discrimination tools must the carriers use? What are the thresholds?

Answer:

The only tools that the carriers do not use are the Non-Discrimination Benefit tool and Non-Discrimination Formulary Outlier tool.

NH will be using the default and recommended threshold values, so when using the Non-Discrimination Formulary Clinical Appropriateness tool please use these default threshold values.

FAQ 5 Topic: Plan and Benefits Template EHB Add-in

Question: The Essential Health Benefits (EHB) Add-in file includes items that are not included in the benchmark plan, such as routine footcare. How do we complete the template?

Answer:

Routine footcare is not an EHB in NH. We are working with CMS to revise the add-in file to correct it for this and other benefits. In the meantime, please follow the procedure below:

> The plan and benefits template instructions state: "If a benefit auto-populated as "Yes" in the EHB column, but you have received guidance from CMS or the state indicating that it should not be considered an EHB (e.g., non-emergency care outside the United States), set the EHB Variance Reason to "Above EHB." This benefit is not considered an EHB." Link: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter10PlanBenefitTemplate-Ver2-031315.pdf#page=22