

**The State of New Hampshire  
Insurance Department**

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**Roger A. Sevigny  
Commissioner**

**Alexander K. Feldvebel  
Deputy Commissioner**

**BULLETIN**

**Docket No.: INS-14-010-AB**

**TO:** All New Hampshire Licensed Health Carriers and Dental Insurers  
**FROM:** Roger A. Sevigny   
Insurance Commissioner  
**DATE:** April 4, 2014  
**RE:** 2015 QHP Certification

**I. Introduction**

The purpose of this Bulletin is to detail the process issuers must follow in New Hampshire to have their non-grandfathered individual and small group health plans certified as Qualified Health Plans (QHPs) to be offered on the federally-operated New Hampshire Health Insurance Marketplace (Marketplace) for calendar year 2015. Open enrollment for these plans will run from November 15, 2014-February 15, 2015.

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) will review and recommend certification of QHPs to the HHS Center for Consumer Information and Insurance Oversight (CCIIO), which will have the opportunity to ratify the certification recommendations.

**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. NH RSA 400-A:3. The Commissioner has general rulemaking and enforcement authority with respect to regulation of the business of insurance in New Hampshire. NH RSA 400-A:15 and 16. Under New Hampshire law, the Insurance Department regulates health insurance carrier licensing (NH RSA chapter 400-A; NH RSA chapter 402; NH RSA chapter 420-A and NH RSA

chapter 420-B) and solvency (NH RSA 400-A:36-37), reviews health insurance policy forms and benefit design (NH RSA chapter 415, NH RSA chapter 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 chapter 420-J), and has authority to take enforcement action with respect to violations of health insurance regulatory standards (NH RSA 415:20, NH RSA 420-G:16, NH RSA 420-J:14) and unfair trade practices (NH RSA chapter 417).

The 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 2015 Letter to Issuers in the Federally-facilitated Marketplaces.<sup>1</sup> Federal regulatory and guidance materials are available at <http://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html>.

The Department has issued several bulletins interpreting the interplay between state law and ACA requirements, including but not limited to the following:

- Market Rules Guidance:  
[http://www.nh.gov/insurance/media/bulletins/2013/documents/ins\\_13-017-ab-mktrules.pdf](http://www.nh.gov/insurance/media/bulletins/2013/documents/ins_13-017-ab-mktrules.pdf)
- Auto Enrollment for Pediatric Dental:  
[http://www.nh.gov/insurance/media/bulletins/2013/documents/ins\\_13-039-ab.pdf](http://www.nh.gov/insurance/media/bulletins/2013/documents/ins_13-039-ab.pdf)
- New Hampshire Qualified Health Plan Bulletin to Issuers Planning to Offer Insurance on the NH Health Insurance Marketplace – 2015 Plan Year:  
[http://www.nh.gov/insurance/media/bulletins/2014/documents/ins\\_14\\_004\\_ab.pdf](http://www.nh.gov/insurance/media/bulletins/2014/documents/ins_14_004_ab.pdf)

Issuers are responsible for reviewing and complying with any standards laid out in Department bulletins.<sup>2</sup>

### III. Procedures and Timelines

New Hampshire requested that issuers notify the Department by March 3, 2014 of their intent to participate in the Marketplace certification process. Plans will be reviewed in the order received, with priority given to plans submitted by carriers who filed letters of intent. Health insurance issuers, as well as stand-alone dental issuers wishing to offer plans in the Marketplace, must submit their initial applications, including all form filings, by May 1, 2014, with rate filings and binder submissions due no later than June 1, 2014. Specific timelines for the QHP certification process are attached hereto as Appendices II and III. Any plan that is not certified under this timeline will be ineligible to be offered in the federally-operated New Hampshire Health Insurance Marketplace during plan year 2015.

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<sup>1</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

<sup>2</sup> QHP issuers in the Marketplace may also be subject to other requirements for the 2015 certification year, as made in future rulemaking or agency guidance.

#### 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: <http://www.regtap.info>.

In order to allow adequate time for review of QHP submissions, the NHID requires that all SERFF Binders containing Marketplace plans and final templates be submitted by June 1, 2014. Submission after this date will be handled on a case-by-case basis, time permitting. The NHID will complete all reviews and make certification decisions by July 31, 2014.

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 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.

#### B. Recertification/Guaranteed Renewability of 2014 QHPs

QHPs currently offered on the New Hampshire Marketplace that are applying for renewal must be recertified – i.e., 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.<sup>3</sup> Such plans are also guaranteed renewable. Issuers should consult *The Exchange and Insurance Market Standards for 2015 and Beyond*, which outlines the standards for determining whether a plan has undergone a uniform modification and would be found guaranteed renewable.<sup>4</sup>

#### IV. Guidance to Issuers on Select QHP Requirements

In 2013, QHP review and Marketplace operations were constrained by time pressures and the ongoing issuance of guidance even after plans had been submitted. As the certification and open enrollment process proceeded, certain areas surfaced as needing additional clarity in order to ensure that all 2015 plan offerings are compliant. In subsequent pages and attached Appendices I-IV, issuers will find guidance regarding those issues the NHID seeks to clarify for the 2015 certification process.

In order to ensure adequate and timely review under both state and federal standards, we ask that carriers explicitly highlight any deviations from these standards, especially in terms of benefit administration, meaningful difference, and network adequacy.

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<sup>3</sup> Page 13; <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

<sup>4</sup> Page 37, et seq.; <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf>.

### A. Network Adequacy

Because of substantial public interest in the issue of network adequacy, the Department plans to introduce additional transparency into its review process for 2015 plans. During its prospective review of proposed QHPs, the Department will measure the adequacy of issuer networks based on the geographic accessibility standards contained in New Hampshire's Network Adequacy rules, New Hampshire Code of Admin. Rules PART Ins 2701. Issuers are responsible for complying with Ins 2701 in its entirety. However, because many of these standards are designed for after-the-fact market conduct review, the Department's QHP review process will focus on the key distance standards for availability of coverage found in Ins 2701.06 – Standards for Geographic Accessibility. Compliance with these standards will be determined through an issuer's submission of a Network Adequacy Packet containing the following documents:

1. Network Adequacy Attestations;
2. Network Adequacy Summary Page; and
3. Network Data Template.

Instructions for submittal of this package and the components of each of the pieces are found in Appendix IV and will be posted to the Department's website.

It is the Department's intention to make issuers' Network Adequacy Packets available to the public during the QHP review process, most likely in mid-June. A bill to require additional transparency during the network review process, SB 340, has been passed by the New Hampshire Senate and is currently pending in the New Hampshire House. If enacted, its requirements may be applicable to 2015 plans, so issuers may wish to track its status.<sup>5</sup>

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 full time general practice dental providers for each county within the proposed service area.

The Department requires that provider information used to analyze the network's adequacy be representative of signed contracts in place, and that all data submitted be accurate and current as of the date of filing. Any changes in the issuer network made after submission of the filing must be reported to the Department.

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<sup>5</sup>[http://www.gencourt.state.nh.us/bill\\_status/bill\\_docket.aspx?lsr=2778&sy=2014&sortoption=&txtsessionyear=2014&txtbillnumber=sb340&q=1](http://www.gencourt.state.nh.us/bill_status/bill_docket.aspx?lsr=2778&sy=2014&sortoption=&txtsessionyear=2014&txtbillnumber=sb340&q=1).

### *B. Essential Community Provider requirements*

The Department will review the plan's compliance with 2015 Essential Community Provider (ECP) Standards as set forth by CMS. For 2015, CMS has proposed changes to the ECP standards at 45 CFR 156.235, as articulated in the 2015 Letter to Issuers in the Federally-Facilitated Marketplace; *see specifically* pages 20-27.<sup>6</sup>

For 2015 plans, a QHP issuer 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. During the second year of Marketplace operation, this must be done by demonstrating that the issuer:

- Achieved at least 30% ECP participation in network in the service area;
- Offered contracts 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 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, which may request additional information or require changes as necessary to ensure adequate access.

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

- Number of contracts offered to ECPs for the 2015 benefit year;
- Number of additional contracts issuer expects to offer for the 2015 benefit year and the timeframe of those planned negotiations;
- Names of the ECP hospitals and FQHCs to which the issuer has offered contracts, but with which an agreement has not yet been reached;
- Attestation that the issuer has satisfied the "good faith" contracting requirement with respect to offering contracts to all available Indian health providers and one ECP in each major ECP category per county, where an ECP in that category is available; and
- Contingency plans for how, absent participation of the available ECP and Indian health providers, the plan will be able to provide adequate care to enrollees who might otherwise be cared for by relevant ECP providers.

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<sup>6</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

In addition, CMS requires reimbursement in accordance with 45 CFR 156.235(e), and as such QHP issuers must pay an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such amount.<sup>7</sup>

The final benefit and payment parameter rule released by HHS on March 14, 2014 requires QHPs and SADPs to accept premium and cost-sharing payments from Ryan White HIV/AIDS Programs; Indian tribes, tribal organizations, or urban Indian organizations; and state or federal government programs. This rule clarifies HHS’s position on Ryan White HIV/AIDS programs, stating that qualified health plans must accept third-party premium payments from Ryan White HIV/AIDS programs.

Please note that CMS has provided a non-exhaustive list of ECPs that can be sorted by state, category and provider type.<sup>8</sup> In addition, CMS included the following list of ECP Categories and Types in the 2015 Letter to Issuers:

<b>Major ECP Category</b>	<b>ECP Provider Types</b>
Federally Qualified Health Centers (FQHC)	FQHC and FQHC “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Family Planning Provider	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Indian Health Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

### *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

<sup>7</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

<sup>8</sup> <https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Providers/ibqy-mswg>.

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.<sup>9</sup>

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.<sup>10</sup>

Additionally, the HRSA guidelines and federal regulations require issuers to cover at least one type of contraceptive in each classification of contraceptive, requiring specifically that at least one intrauterine device and one implant contraceptive method be covered without the imposition of cost-sharing requirements.<sup>11</sup>

The NHID will only certify 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:

*"Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements."*

#### *D. Clarity in Describing Benefit Design*

For 2015 QHP Certification, the NHID 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.

For example, in a plan where copays are in effect only for the first three office visits, consumers may not understand that *any* office visit, regardless of specific provider or provider type, is included in the total office visits calculation. Thus, a consumer could be misled by language such as the following: *"\$XX copay for first 3 visits, and then XX% coinsurance. Copay applies to the first three office visits, then deductible and coinsurance apply."* In order to assist consumers and accurately disclose potential out of pocket costs, in this example the issuer should explain in clear language that the copay is in effect *only* for the first three visits, of any type and to any provider, and that coinsurance, rather than a copay, applies to any subsequent visits.

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<sup>9</sup> "Women's Preventive Services: Required Health Plan Coverage Guidelines" (HRSA Guidelines) were adopted and released on August 1, 2012, based on recommendations developed by the Institute of Medicine (IOM) at the request of HHS. These recommended women's preventive services are required to be covered without cost-sharing, for plan years (or, in the individual market, policy years) beginning on or after August 1, 2012.

<sup>10</sup> [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs12.html#fn6](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html#fn6).

<sup>11</sup> <http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf>.

### E. *Meaningful Difference*

For 2015, CMS defined “meaningfully different” in order to help consumers better identify the differences between QHPs.<sup>12</sup> CMS states that “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 plan and other plan offerings:

- Cost sharing;
- Provider networks;
- Covered benefits;
- Plan type;
- Health Savings Account eligibility; or
- Self-only, non-self-only, or child only plan offerings.”

For 2014-2015 certification purposes, the NHID will be seeking an attestation or inclusion in the actuarial certification that plans at the same metal, or service area meet the federally defined definition of “meaningfully different.” The Department expects issuers to include explicit language in the actuarial certification that explains which characteristics a plan meets, and how those characteristics make a plan “meaningfully different.” Explicit language will ensure a smooth, on-time certification process.

In addition to the Department’s review of issuer attestations, CMS will be examining plans recommended for certification for “meaningful difference.”<sup>13</sup> As indicated in the 2015 Letter to Issuers, if “CMS finds that two or more plans within a subgroup do not differ based on at least one of the above criteria (that is, the two or more QHPs are of the same plan type, and metal level; have overlapping service areas; have the same provider network, formulary, covered benefits; HSA eligibility, and child-only coverage, and have less than a \$50 difference in the deductibles and less than a \$100 difference in maximum out of pocket), then those QHPs would be flagged for additional review and follow-up.”<sup>14</sup>

In line with federal guidance, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one or more of the flagged health plans. The 2015 Letter to Issuers states that “the issuer may submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP. For example, an issuer may make the case that one QHP is an Accountable Care Organization. This additional

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<sup>12</sup> HHS Notice of Benefit and Payment Parameters for 2015, 78 FR 72321, <http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf>.

<sup>13</sup> HHS Notice of Benefit and Payment Parameters for 2015, 78 FR 72321, <http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf>.

<sup>14</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

information will factor into the determination of whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP (see 45 CFR § 155.1000)."<sup>15</sup>

Stand-alone dental, given the unique nature of the market, will not be reviewed for meaningful difference during the plan certification process.

#### *F. Segregation of Funds under ACA Section 1303*

Each QHP issuer offering Marketplace coverage must submit to the Department an annual assurance statement attesting that the issuer has complied with ACA section 1303 and applicable regulations. In addition, each QHP issuer offering Marketplace coverage that includes services described under section 1303(b)(1)(B)(i) of the ACA must submit a plan for approval by the Department that details its process and methodology for complying with the segregation of funds requirements laid out in ACA section 1303 and 45 CFR section 156.280. For purposes of approval by the Department, the segregation of premium may occur solely as an accounting transaction, and does not require an issuer to conduct two separate premium transactions with enrollees.

#### *G. Mental Health Parity*

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires that treatment limitations for Mental Health Services Act (MHSA) benefits be no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.<sup>1617</sup> 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) MHSA services may be no more restrictive than requirements and limitations for inpatient (in-network) medical and surgical benefits.

The MHPAEA refers to quantitative treatment limitations and financial requirements in establishing parity between MHSA and medical/surgical services. As noted above, these requirements and limitations for MHSA must be offered at parity with medical and surgical services in each of the six classifications. Non-quantitative treatment limitations are limitations (NQTLs) that are also regulated in the MHPAEA, and must be offered at parity with medical and surgical services. The NHID will be requiring attestation that all plans filed for offering on the federally-operated New Hampshire Health Insurance Marketplace are in compliance with MHPAEA and will be administered in accordance with said regulations.

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<sup>15</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

<sup>16</sup> <http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169>.

<sup>17</sup> [http://www.mhsoac.ca.gov/docs/MHSA\\_AsAmendedIn2012\\_AB1467AndOthers\\_010813.pdf](http://www.mhsoac.ca.gov/docs/MHSA_AsAmendedIn2012_AB1467AndOthers_010813.pdf).

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 chapter 417-E, NH RSA 415:6-n and NH RSA 415:18-s.

#### *H. Stand-Alone Dental/Pediatric Dental Disclosure*

It is the position of the NHID that all stand-alone dental plans offered for purchase on the federally-operated New Hampshire Health Insurance 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 Appendix II. Stand-Alone Dental plan issuers are urged to reference the 2015 Letter to Issuers in the Federally-Facilitated Marketplace for any additional guidance.<sup>18</sup> We have included the chart put forth by CMS in the 2015 Letter to Issuers in the Federally-Facilitated Marketplace as reference for stand-alone dental issuers as Appendix I.

The NHID strongly encourages issuers of stand-alone dental plans seeking certification to thoroughly check all federal guidance and Department bulletins prior to submission, in particular the recently released federal guidance applicable to stand-alone dental carriers.<sup>19</sup>

All issuers offering individual or small group health insurance plans for purchase on the New Hampshire 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:

Required disclosure language:

*"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](http://Healthcare.gov), if you wish to purchase pediatric dental coverage or a stand-alone dental services product."*

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<sup>18</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

<sup>19</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

### *I. Composite Billing*

The 2015 Notice of Benefit and Payment Parameters final regulation includes composite billing as a permissible billing methodology. New Hampshire law does not dictate permissible billing methodologies, and thus Department permits either composite bill or list bill methodologies.

A change in billing methodology has no impact on the total premium charged an employer. However, alternate billing methodologies do impact the allocation of premium among participating employee members and can cause impact cost sharing requirements in cases where employees must contribute towards plan costs.

The Insurance Department will approve composite billing methodologies consistent with the CMS Final Rule. In cases where an employer group is billed using a methodology different from the methodology applied in a prior policy period, the carrier shall provide, for illustrative purposes, a derivation using the billing method from both the prior and current period.

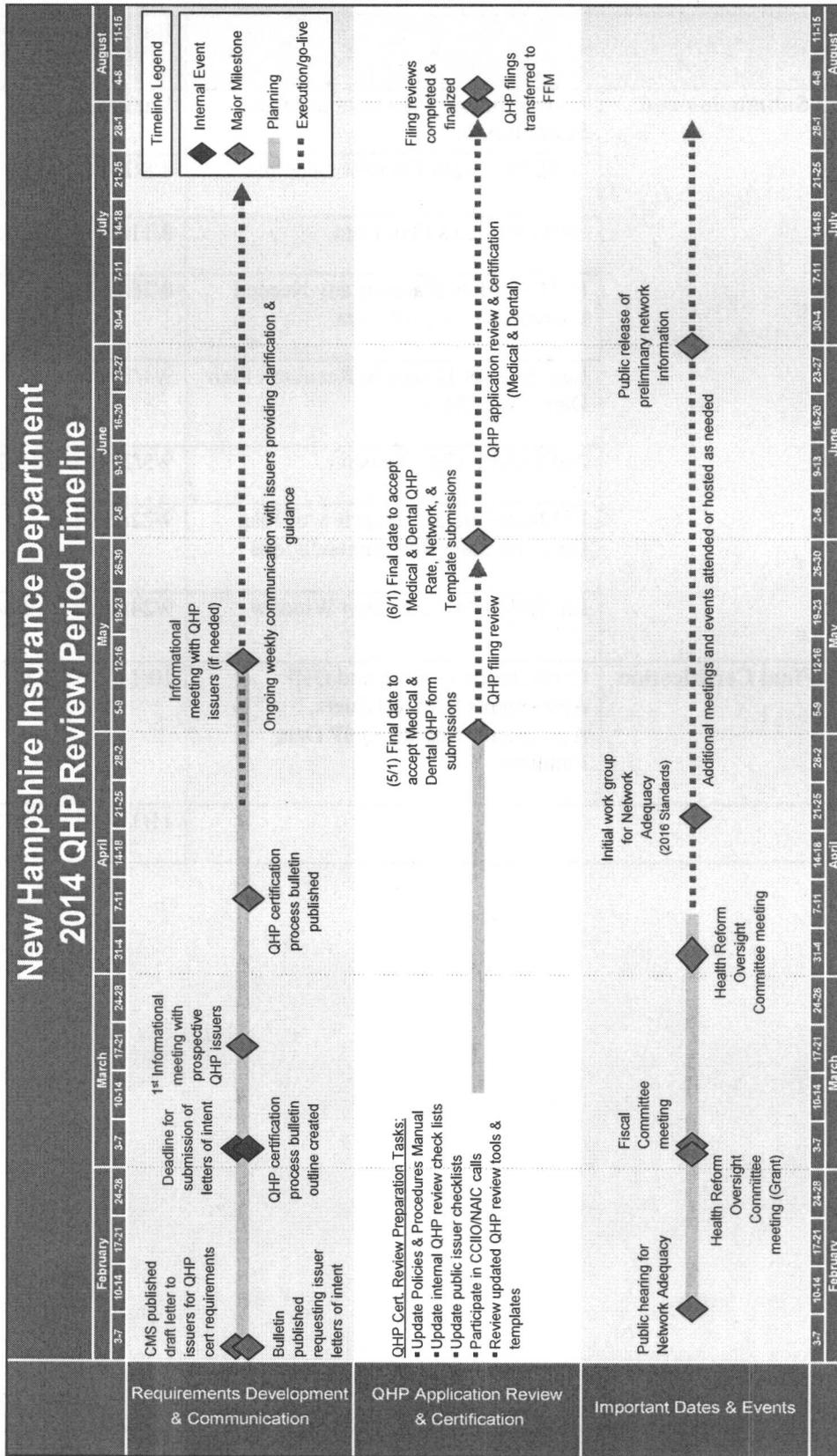
### **V. Contact Information**

Questions related to this bulletin should be directed to Michael Wilkey, Director of Compliance and Consumer Services at the New Hampshire Insurance Department, at [michael.wilkey@ins.nh.gov](mailto:michael.wilkey@ins.nh.gov) or by phone at (603) 271-2261 ext. 330.

**Appendix I: Certification Standards Applicable to Stand-alone Dental Plans**

<b>Certification Standard Applies (* denotes modified standard)</b>		<b>Certification Standard Does Not Apply</b>
Essential Health Benefits*	Actuarial Value*	Accreditation
Annual Limits on Cost Sharing*	Licensure	Cost-sharing Reduction Plan Variations
Network Adequacy	Inclusion of ECPs	Unified Rate Review Template
Marketing	Service Area	Meaningful Difference
Non-discrimination		

# Appendix II: NHID Plan Management Timeline



### Appendix III: CCIIO Plan Management Timeline

Activity		Dates (Approximate)
<b>QHP Application Submission and Review Process</b>	Issuers Submit Plan Data to States, States Review	Varied
	1 <sup>st</sup> SERFF Data Transfer Deadline	8/8/2014
	FFM Reviews Plan Data	8/11/2014 – 8/25/2014 8/11/2014-8/25/2014
	FFM Notifies States of any Needed Corrections to QHP Data	8/26/2014
	Last date for Issuers to Resubmit Plan Data into SERFF	9/4/2014
	2 <sup>nd</sup> SERFF Data Transfer	9/5/2014 – 9/10/2014
	FFM Completes Re-review of Plan Data and State Recommendations	9/22/2014
	Limited Data Correction Window	9/24/2014 – 10/6/2014
<b>QHP Agreement/Final Certification</b>	Certification Notices and QHP Agreements Sent to Issuers, Agreements Signed, QHP Data Finalized	10/14/2014 – 11/3/2014
<b>Open Enrollment</b>		11/15/2014 – 2/15/2015

**Appendix IV: New Hampshire Insurance Department  
Network Adequacy Attestation Document (Part 1 of 3)**

**Instructions:**

Respond **Yes** or **No** to each of the attestations below and provide a signature the Network Adequacy Attestation Document. Responses of **No** to any of the below attestations must be addressed through a justification provided in the attached Supplemental Response Form. Justifications will be reviewed by the NHID on a case-y-case basis in review of this form. If the applicant provides **Yes** responses to all attestations, the Supplemental Response Form is not required.

**Network Attestations**

1. Applicant attests that it will maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. This includes providers that specialize in mental health and substance abuse services for all plans except stand-alone dental plans.

Yes       No

2. Applicant attests that it is seeking QHP certification in a state determined to have sufficient and applicable network access standards, and that the applicant shall comply with all applicable State network adequacy standards.

Yes       No

3. Applicant attests that network data provided is representative of signed contracts in place, and that all data submitted is accurate and current as of the date of filing.

Yes       No

**Proposed Service Area Attestations**

4. Applicant is applying to offer a Qualified Health Plan with a service area encompassing the following counties (Check all that apply):

<input type="checkbox"/>	Belknap County	<input type="checkbox"/>	Hillsborough County
<input type="checkbox"/>	Carroll County	<input type="checkbox"/>	Merrimack County
<input type="checkbox"/>	Cheshire County	<input type="checkbox"/>	Rockingham County
<input type="checkbox"/>	Coos County	<input type="checkbox"/>	Strafford County
<input type="checkbox"/>	Grafton County	<input type="checkbox"/>	Sullivan County

**Key Provider Types**

5. Applicant attests that the proposed network includes the each of the providers named in the counties as stated in the Key Provider Contracts Form.

Yes       No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title/Position

New Hampshire Insurance Department

Key Provider Contracts Form – Hospitals & ECPs

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

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

New Hampshire Insurance Department

Key Provider Contracts Form – Inpatient & Outpatient Mental Health

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

County	Inpatient Mental Health	Outpatient Mental Health
Belknap		
Carroll		
Cheshire		
Coos		
Grafton		
Hillsborough		
Merrimack		
Rockingham		
Strafford		
Sullivan		

# New Hampshire Insurance Department

## Attestation Justification Supplemental Response Form

[Issuer] is providing this supplemental response to the New Hampshire Insurance Department in order to offer justification for providing a response of **No** to an attestation listed in the Network Adequacy Attestation Document. In submitting this Supplemental Response Form, the Applicant notes that the Insurance Department maintains discretion to accept this justification as adequate and may ask for additional documentation if necessary.

Attestation #	Response (Yes/No)	Justification / Clarification

**Appendix IV: New Hampshire Insurance Department  
Network Adequacy Summary Page & Supplemental Response Form (Part 2 of 3)**

**Instructions:**

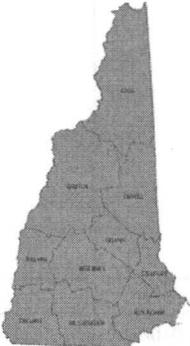
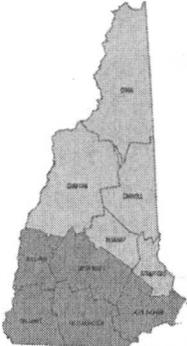
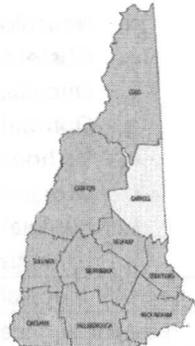
Review the standards that follow and provide a response indicating whether the issuer meets (Yes) or does not meet (No) the compliance threshold New Hampshire's Network Adequacy Standards.

In completion of this form, issuers must provide evidence of maintaining a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay, as measured by standards put in place by New Hampshire INS 2701 Network Adequacy.

The standards to be measured for compliance during the 2014 QHP review period are listed in the Network Adequacy Summary Page. A separate copy of the Network Adequacy Summary Page must be included for each of the counties in which the issuer is applying to market its health plan.

**Network Adequacy Review - Enrollment Data Requirements**

There exist three scenarios for which the Insurance Department will determine network adequacy:

<b>1</b>	<b>2</b>	<b>3</b>
Issuer submits network and has existing QHP membership within the entire proposed service area.	Issuer submits network and has existing QHP membership within the state, but not in the entire proposed service area.	Issuer submits network without any existing QHP membership within proposed service areas.
		

In Case 1, the issuer maintains a network for an existing QHP product that encompasses the entire proposed service area, and may use its existing enrollment from the previous plan year's enrollment period as its underlying data set to determine adequacy.

In Cases 2 and 3, the issuer must use a proxy population to demonstrate the adequacy of its network. The proxy population to be used is the state population by Zip code as measured by the 2010 Census. The underlying data set containing this information can be found on the Insurance Department's website.

The standards for access are considered met in cases where the percentage of individuals with geographic access meets or exceeds 90 percent of the population within the county (please note that population may refer to either total individuals enrolled in QHP products or the total proxy population). Additional information on the required process by which to measure these standards may be found in the Appendix to this document.

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 justifications on a case-by-case basis in its evaluation of an issuer's ability to offer adequate geographic access to providers.

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	

Network Adequacy Supplemental Response Form

[County Name]

[Issuer] is providing this supplemental response to the New Hampshire Insurance Department in order to offer clarification or justification for failing to meet a network access standard named in the Network Adequacy Summary Page. In submitting this Supplemental Response Form, the Applicant notes that the Insurance Department maintains discretion to accept this justification as adequate and may ask for additional documentation if necessary.

Number	Type	Standard	Standard Met?
X		XX miles	No
Reason:			
Reason:			
Reason:			
Reason:			
Reason:			

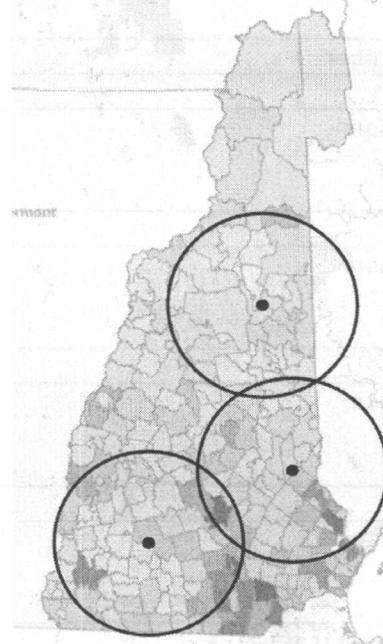
<Issuer may add rows as needed>

# Network Adequacy Compliance Measurement Process

## Network Adequacy - Distance Measurement Process

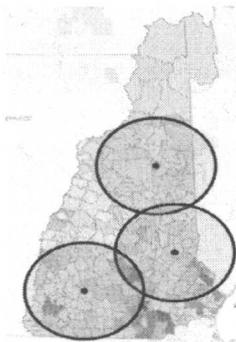
Issuers will be responsible for performing time and distance measures and reporting results to the NHID through Network Adequacy Summary Sheet

- 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 meet 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

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



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

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

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.

**Appendix IV: New Hampshire Insurance Department  
Network Adequacy Summary Page & Supplemental Response Form – Dental (Part 3 of 3)**

**Instructions:**

Review the standards that follow and provide a response indicating whether the issuer meets (**Yes**) or does not meet (**No**) New Hampshire’s Network Adequacy Standards for dental providers.

In completion of this form, issuers of stand-alone dental plans must provide evidence of maintaining a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay.

In submittal of this document to the New Hampshire Insurance Department, the issuer affirms that all responses to the geographic access standards are accurate and representative of signed contracts in place. A response of **Yes** indicates that the issuer contains within its network at least 2 open-panel general dentists within the applicable county.

Any responses of **No** require justification from the issuer to the NHID. The NHID will consider these justifications on a case-by-case basis in its evaluation of an issuer’s ability to offer adequate geographic access to providers.

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

<b>County</b>	<b>Number</b>	<b>Type</b>	<b>Standard Met?</b>
Belknap County	2	Open panel general dental care providers	Yes/No
Carroll County	2	Open panel general dental care providers	
Cheshire County	2	Open panel general dental care providers	
Coos County	2	Open panel general dental care providers	
Grafton County	2	Open panel general dental care providers	
Hillsborough County	2	Open panel general dental care providers	
Merrimack County	2	Open panel general dental care providers	
Rockingham County	2	Open panel general dental care providers	
Strafford County	2	Open panel general dental care providers	
Sullivan County	2	Open panel general dental care providers	

# Network Adequacy Supplemental Response Form

[County Name]

[Issuer] is providing this supplemental response to the New Hampshire Insurance Department in order to offer clarification or justification for failing to meet a network access standard named in the Network Adequacy Summary Page. In submitting this Supplemental Response Form, the Applicant notes that the Insurance Department maintains discretion to accept this justification as adequate and may ask for additional documentation if necessary.

Number	Type	Standard	Standard Met?
X		XX miles	No
Reason:			
Reason:			
Reason:			
Reason:			
Reason:			

<Issuer may add rows as needed>