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BULLETIN
Docket No.: INS-15-012-AB

TO: All New Hampshire Licensed Health Carriers and Dental Insurers

FROM: Roger A. Sevigny
Insurance Commissioner
DATE: April 9, 2015
RE: 2016 Plan Year QHP/Continuity of Care Issuer Bulletin

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 2016. Open enrollment for these plans will run from November 1, 2015-January 31, 2016.

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.

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II. Legal Authority

The New Hampshire Insurance Commissioner "is charged with the rights, powers, and duties pertaining to the enforcement and execution of the insurance laws" of New Hampshire. 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 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 2016 Letter to Issuers in the Federally-facilitated Marketplaces. Federal regulatory and guidance materials are available at http://www.cms.gov/cciio/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
- Auto Enrollment for Pediatric Dental
- 2015 QHP Certification Supplemental Bulletin Guaranteed Availability of Coverage on and off Marketplace
- 2015 QHP Certification: Guidance on the Filing of Advertising Materials
- Transparency in Provider Network Directory and Formulary

Issuers are responsible for reviewing and complying with all standards laid out in Department bulletins.

III. Procedures and Timelines

New Hampshire requested that issuers notify the Department by January 30, 2015 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 state required network templates and form

filings, with rate filings and binder submissions due no later than by April 15, 2015. Petition to CMS is required for changes to service area after initial submission. The NHID will complete all reviews and make recommendations for certification by August 25, 2015. 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 2016.

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. Each issuer should submit no more than one binder per market - one individual and one SHOP, inclusive of both on and off Marketplace plans. It is important for issuers to be aware that additional plans cannot be added to a QHP binder after it is submitted in SERFF. Additional plans 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.

For 2016, the NHID will require an attestation from issuers that all CMS QHP tools have been run and errors resolved prior to submission of data templates. NHID will require the state-generated attestation form at the time of filing found here, and submissions will not be reviewed until such time as attestations are received noting satisfactory results. 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 Supporting Documents tab in SERFF.

Issuers are urged to follow the guidelines and requirements for filing set forth in the applicable NHID filing checklists, and to consult the NHID filing checklist as they complete binders, prior to submitting for review. Updated Checklists (individual major medical/small group major medical) for 2016 can be found at: http://www.nh.gov/insurance/lah/lah_checklists.htm

B. Recertification/Guaranteed Renewability of 2015 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. To be eligible for recertification for plan years beginning in 2016, a QHP or SADP certified by an FFM must be the same "plan," as defined in 45 C.F.R. 144.103, as the plan that was certified for plan years beginning in 2015. CMS will use the amended definition of "plan" from §144.103 of the 2016 Payment Notice Final Rule. Such plans are also guaranteed renewable. Change in plan marketing name itself does not constitute a new plan. 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.[2] Allowed changes are summarized below;

- Changes made solely pursuant to applicable Federal or State requirements or;
- 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.

C. Participation in the New Hampshire Health Protection Program

In addition to the guidance pertaining to QHP certification, issuers are reminded to consult guidance from NHID and New Hampshire Department of Health & Human Services (DHHS) on the New Hampshire Health Protection Program (NHHPP), in particular the marketplace Premium Assistance Program. RSA 126-A:5, XXV(g) maintains the existing and traditional regulatory authority of the New Hampshire Insurance Department under Title XXXVII with respect to private health insurance coverage, including with respect to insurance coverage in which persons are enrolled under the NHHPP. However, DHHS may institute provisions specific to this program via guidance or agreement with carriers.

RSA 126-A:5, XXV(a) provides that adults eligible for the NHHPP who are ineligible for the Health Insurance Premium Payment program shall choose from any qualified health plans offered on the New Hampshire Marketplace if cost-effective. As such, carriers offering QHPs on the NH Marketplace in 2016 must accept NHHPP participants as enrollees. Additionally, pursuant to RSA 126-A:5, XXV(e), a determination for eligibility for the NHHPP marketplace Premium Assistance Program shall be a qualifying event under the Health Insurance Portability and Accountability Act of 1996. New NHHPP enrollees may enroll in QHPs via special enrollment periods throughout the year.

The 1115 Premium Assistance Waiver includes the utilization of existing high-level silver plans with standard cost-sharing as the most cost-effective way to incorporate personal responsibility as required by RSA 126-A:5, XXV(b). As such, issuers must offer at least one 94% AV high silver plan that conforms with the standard cost-sharing design for each unique combination of product type and network used in a silver level QHP. Issuers shall use a unique identifier in SERFF to distinguish the plan from issuers' other cost sharing variation plan filings. To promote continuity of care, as also required by RSA 126-A:5, XXV(b), and pursuant to federal guaranteed issue requirements (see 42 U.S.C. 300gg-1), these standard cost-sharing plans must also be available to those individuals who purchase QHPs on the New Hampshire Marketplace and are eligible for 94% silver plan variations via cost-sharing reductions. The zero cost sharing plan will also be used by NHHPP for those eligible.

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

The 94% plan and zero cost sharing plan for eligible NHHPP enrollees will have the same HIOS ID as the standard plan but with the variant of -36 and -32 respectively; these variants are for form filings identification and should not be included in the binder templates.

Furthermore, issuers must create a separate schedule of benefits (SOB) for the 94% standard cost sharing plan for the NHHPP enrollees. This SOB will be identical to the corresponding 94% marketplace plan except in deductible and maximum out of pocket (MOOP), since the state is responsible for the deductible for these enrollees. The -36 variant SOB will show a $0 deductible and a $600 MOOP; whereas the corresponding -06 variant will show a $325 deductible and a $925 MOOP. Please see Appendix IV for a visual explanation.

IV. Guidance to Issuers on Select QHP Requirements

As the certification and open enrollment process proceeded in past years, certain areas surfaced as needing additional clarity in order to ensure that all 2016 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 2016 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.

A. Network Adequacy

Because of substantial public interest in the issue of network adequacy, the Department plans to continue the additional transparency efforts underway from 2015 for its review process for 2016 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 NHCAR Part 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 at: http://www.nh.gov/insurance/lah/index.htm#pm

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. For the 2015 review process, SB 340, now RSA 420-N:5-a, required that NHID hold public information sessions about the proposed network for each carrier. NHID updated the initial Network Adequacy public information session presentations throughout the summer and fall as networks changed. It is the

intention of the Department to continue this process for the 2016 QHP review process. Issuers are urged to consult RSA 420-N:5-a and the 2015 Network Adequacy presentations made available in 2014-2015 to the public by the Department for additional information.

For issuers offering dental coverage (including stand-alone dental plans), the Department will require that issuers offer two open-panel full time general practice dental providers for each county within the proposed service area in order to be deemed adequate coverage. Issuers will not be certified if they do not meet this standard for 2016 plans.

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 immediately, and issuers shall update all applicable state and federal templates at the time they report a network change. The Department will only process changes that are received through SERFF and after such time as an issuer has updated all applicable documents to reflect a change to a network.

For issuers entering their second or third year of Marketplace operation, the NHID will be looking for issuers to highlight changes in their filings from the final approved networks in 2015 to the proposed network for 2016. This will assist in the review process, and ensure new additions and changes to the currently operating networks are reviewed first.

B. Essential Community Provider Requirements

The Department will review the plan's compliance with 2016 Essential Community Provider (ECP) Standards as set forth by CMS, and outlined in the 2016 Benefit and Payment Parameter regulations.[1]

QHP issuers must ensure that the provider network of each of its QHPs includes ECPs in sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service areas. Additionally, issuers must ensure that filings are in compliance with RSA 415:25, which relates to contracting with federally-qualified health centers (FQHCs).

For 2016, ECP compliance requires the issuer to demonstrate that it has:

- 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

[1] https://www.federalregister.gov/articles/2015/02/27/2015-03751/benefit-and-payment-parameters-patient-protection-and-affordable-care-act

currently designed, provides an adequate level of service for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network in future years, as necessary. The justification is subject to approval by the Department and is due at time of filing.

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

- Number of contracts offered to ECPs for the 2016 benefit year;
- Number of additional contracts issuer expects to offer for the 2016 benefit year and the timeframe of those planned negotiations;
- Names of the ECP hospitals, Federally Qualified Health Centers (FQHCs), Ryan White providers, family planning providers, and providers in the other ECP categories to which the issuer has offered contracts, but with which an agreement has not yet been reached; and
- Contingency plans for how the issuer's provider network, as currently designed, will provide adequate care to enrollees who might otherwise be cared for by relevant ECPs. For example, if available FQHCs, Indian health care providers, Ryan White HIV/AIDS Program providers, or family planning providers are missing from the network(s), the Application must explain how its target populations will be served.

We reiterate the importance of issuers complying with 45 C.F.R. 156.235(e) regarding payment of FQHCs. For covered services provided by an FQHC, 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 SSA for such item or service, as specified in section 1302(g) of the Affordable Care Act.[2]

Issuers of individual market QHPs, including SADPs, are required under 45 C.F.R. 156.1250 to accept third party premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Programs; Indian tribes, tribal organizations, or urban Indian organizations; and state or federal government programs.[3] 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.

To assist issuers in identifying these providers, CMS has published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, which issuers may use to assess their satisfaction of the ECP standard. This non-exhaustive list is updated annually near the beginning of the calendar year and is available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

[2] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf#page=25.

[3] This standard was effective on March 14, 2014; see Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums; Interim Final Rule; 79 Federal Register 15240 (March 19, 2014); codified at 45 C.F.R. part 156. The standard applies to all individual market QHPs and SADPs, regardless of whether they are offered through the FFM, an SBM, or outside of the Marketplace.

In addition, CMS included the following list of ECP Categories and Types in the 2016 Letter to Issuers:

Major ECP Category	ECP Provider Types
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, Community **Mental Health Centers, Rural Health Clinics,** and other entities that serve predominantly low-income, medically underserved individuals.

RSA 415:25 requires that each QHP on the New Hampshire Marketplace: "(1) offer to each federally-qualified health center, as defined in section 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(l)(2)(B), providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services[4] that are covered by the plan that the center offers to provide; and (2) reimburse each such center for such services as provided in section 1302(g) of the Patient Protection and Affordable Care Act, Public Law 111-148, as added by section 10104(b)(2) of such Act."

Issuers as part of their network adequacy attestation submission will indicate which FQHCs they are contracted with or offered contracts to in order to prove compliance with RSA 415:25.

C. Contraceptive Coverage

Public Health Service Act section 2713 and federal regulations require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for and prohibit the imposition of cost-sharing requirements, with respect to women, for evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), to the extent not already included in certain recommendations of the US Preventative Services Task Force.[5]

[4] For the purposes of this provision, "ambulatory services" are defined as health care services provided on an outpatient basis.

[5] "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.

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.[6]

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.[7]

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

"*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. 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.[8,9] 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.

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.

[6] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.
[7] http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf.
[8] http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169.
[9] http://www.mhsoac.ca.gov/docs/MHSA_AsAmendedIn2012_AB1467AndOthers_010813.pdf.

E. Clarity in Describing Benefit Design

For 2016 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. Issuers must also make this clear by utilizing functionality in the plan and benefit template to explain the cost sharing in the "explanation of benefits" section of the template. Issuers must strictly follow the QHP Application Instructions which give explicit instruction for the templates and supporting documentation and can be found here.

For 2016, issuers will be required to update form filings if they make changes to their plan and benefit templates and vice versa. After initial certification, and during our process of assembling our "plan compare" document of the approved 2015 plans, the NHID 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. The discrepancies found in plan year 2015 caused both the state and CMS serious concern and issuers must ensure both the filings and templates are accurate for this plan year.

For Plan Year 2016 the maximum annual limitation on cost sharing is $6,850 for self only coverage and $13,700 for family coverage. The 2016 Benefit and Payment Parameters clarified that even when family coverage is purchased (and therefore the overall limit is $13,700), no individual enrollee in the coverage can be required to spend more than $6,850 in cost sharing for care attributable to that individual enrollee.[10]

F. Meaningful Difference

For 2015, CMS defined "meaningfully different" in order to help consumers better identify the differences between QHPs.[11] CMS stated 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:

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[10] https://www.federalregister.gov/articles/2015/02/27/2015-03751/benefit-and-payment-parameters-patient-protection-and-affordable-care-act

[11] HHS 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#h-103

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

For 2015-2016 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.

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

G. Provider Directory

The 2016 Letter to Issuers in the FFM states:

"Pursuant to the 45 C.F.R. 156.230(b), CMS, as administrator of the FFMs, will require QHPs to make their provider directories available to the FFMs for publication online by providing the URL link to their network directory. As stated in the 2016 Payment Notice Final Rule, CMS is strengthening the provider directory requirement. **Specifically, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the FFM, HHS, and OPM. A provider directory will be considered up-to-date if it is updated at least monthly and easily accessible when the general public is able to view all of the current providers for a plan in the provider directory on the issuer's public website through a clearly identifiable link or tab without having to create or access an account or enter a policy number**. The general public should be able to easily discern which providers participate in which plan(s) and provider network(s). Further, if the health plan issuer maintains multiple provider networks, the plan(s) and provider network(s) associated with each provider, including the tier in which the provider is included, should be clearly identified on the website and in the provider directory. **CMS is also requiring issuers to make this information publicly available on their websites in a machine-readable file and format specified by HHS, to allow the creation of user-friendly aggregated information sources.**"

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

Additionally, please re-read the New Hampshire Insurance Department September 25, 2014 Bulletin INS-14-025-AB and ensure compliance. The Department will be actively and continually checking for compliance with provider directory standards, and will refer to market conduct division for action as needed.

H. Formulary Information

In accordance with RSA 420-J:7-b issuers must provide prescription drug information, including drugs and medications that are covered and those not included in the drug formulary to prospective enrollees and enrollees. As outlined in RSA 420-J-7-b, the specific items that shall be included in the description provided to prospective enrollees and enrollees include:

"(1) The procedure a covered person must follow to obtain drugs and medications that are subject to a plan list or plan formulary.

(2) A description of the drug formulary and the plan's exception process.

(3) A description of the extent to which a covered person will be reimbursed for the cost of a drug that is not on a plan list or formulary. "

Information from 2016 Letter to Issuers on Prescription Drugs:

The formulary drug list URL link required in the prescription drug template should be the same direct formulary drug list link for obtaining information on prescription drug coverage in the Summary of Benefits and Coverage, in accordance with 45 C.F.R. 147.200(a)(2)(i)(K).

In the 2016 Payment Notice Final Rule, CMS finalized a number of changes to the EHB prescription drug benefit. These changes include a requirement that issuers' formulary drug lists be up-to-date, accurate, and include a complete list of all covered drugs. The formulary drug list must include any tiering structure that the plan has adopted and any restrictions on the manner in which a drug can be obtained, including prior authorization, step therapy, quantity limits, and any access restrictions related to obtaining the drug from a brick and mortar retail pharmacy.

The formulary drug list must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Marketplace, HHS, OPM, and the general public. A formulary drug list is easily accessible when it can be viewed on the plan's public web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and if an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan. CMS is also requiring issuers to make this information publicly available on their websites in a machine-readable file and format specified by HHS.

The 2016 Payment Notice Final Rule includes new requirements for the prescription drug exception process. An issuer must notify the enrollee and the prescribing physician of its coverage decision no more than 72 hours (NH law requires 48 hours RSA 420-J:7-b II) following the receipt of a standard exception request, and the issuer must have a process for the enrollee or the prescribing physician to request that the denied exception request be reviewed by an independent review organization. In the event that an exception request is granted, the plan must treat the excepted drug as an EHB, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing, and they must provide coverage of the excepted non-

formulary drug for the duration of the prescription. Issuers must update their policies and procedures to reflect the new requirements for plan year 2016.

In addition to the above standards, CMS continues to encourage issuers to temporarily cover non-formulary drugs, as well as drugs that are on an issuer's formulary but require prior authorization or step therapy, during the first 30 days of coverage when an enrollee is transitioning to a new plan.

Additionally, please re-read the New Hampshire Insurance Department September 25, 2014 Bulletin INS-14-025-AB and ensure compliance. This bulletin does not preclude issuers from complying with all procedures and timelines outlines in RSA 420-J-7-b.

I. Advertisements

For 2016 QHP certification purposes, the NHID will require issuers to file advertisements "prior to use," in accordance with RSA 420-B:8, VI. The Department interprets "review and approval prior to use" in RSA 420-B:8 Forms of Evidence of Coverage to mean:

> Before an HMO uses any materials meeting the definition of advertising in RSA 420-B:1 I, the HMO shall file materials with the Department for review. Issuers must submit all such advertisements in SERFF in the filing mode of "information only" with the filing type marked as "Advertising." Per NHCAR Part Ins 401.03, all forms must have a form number in the lower left hand corner.
>
> In addition to the informational filing, issuers shall submit an attestation in the supporting documentation tab in SERFF stating that all advertising materials are in compliance with applicable state and federal regulations, including the standards set forth in RSA 420-B:12,I. Attestation can be found here.

The issuer may commence using the advertising materials once the filing requirements above have been completed. The Department reserves the right to disapprove any and all filed advertisements, to the extent that they do not conform with the substantive requirements under RSA 420-B:12, or other applicable laws. All issuers should be prepared to participate in a full review of all filed materials, and are reminded that advertisements are subject to a market conduct review if issues arise after use. Issuers are urged to consult the NHID guidance entitled 2015 QHP Certification: Guidance on the Filing of Advertising Materials for additional information.

J. 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.

K. 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 2016 Letter to Issuers in the Federally-Facilitated Marketplace for any additional guidance.[12] We have included the chart put forth by CMS in the 2016 Letter to Issuers in the Federally-Facilitated Marketplace for reference to 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.

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, if you wish to purchase pediatric dental coverage or a stand-alone dental services product."

L. Composite Billing

The 2016 Notice of Benefit and Payment Parameters final regulation includes composite billing as a permissible billing methodology for small group plans. 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 to an employer. However, alternate billing methodologies do impact the allocation of premium among participating employee members and can 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.

[12] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf_

M. Balance Billing

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

N. SHOP Guidance

Group Size: Per Section 1304(b)(2) of the ACA, a small employer is defined as an employer having at least one but no more than 100 employees. However, Section 1304(b)(3) provides states the option of defining small employers as having at least one but not more than 50 employees in plan years beginning before January 1, 2016. Issuers are reminded that effective January 1, 2016, the definition of "Small Group" will be standardized to 100 or fewer full-time employees. Plans filed in 2015 for offering on the small group marketplace in 2016 must be in compliance with federal guidance related to group size. [13]

Employee Choice: For 2016, CMS has not extended the transitional policy allowing states to request a waiver of employer choice in the FF-SHOP. This transitional policy allowed the FF-SHOP in New Hampshire to limit employers to offering a single plan, rather than allowing employers to offer employee choice in 2015. Issuers are reminded that for 2016, all qualified employers will have a choice of two methods to make QHPs available to qualified employees through the FF-SHOP; (1) a choice of all QHPs at a single level of coverage or (2) a single QHP. Employers will also have the option to make available either (1) all SADPs at a single level of coverage (high or low), or (2) a single SADP.

Transition to Small Group Coverage for Groups of 51-100: In Bulletin AB 14-009, issued March 11, 2014, the Department adopted the federal policy of allowing renewal of non-grandfathered health insurance coverage under certain circumstances. For groups of 51-100, this means that large group coverage may be renewed (if allowed by the carrier) for a policy year starting no later than October 1, 2016, so long as the conditions outlined in the bulletin and in the underlying federal guidance are met. This transition coverage is not considered small group coverage, even if it is issued to a group that falls under the definition of small group starting January 1, 2016.

V. Contact Information

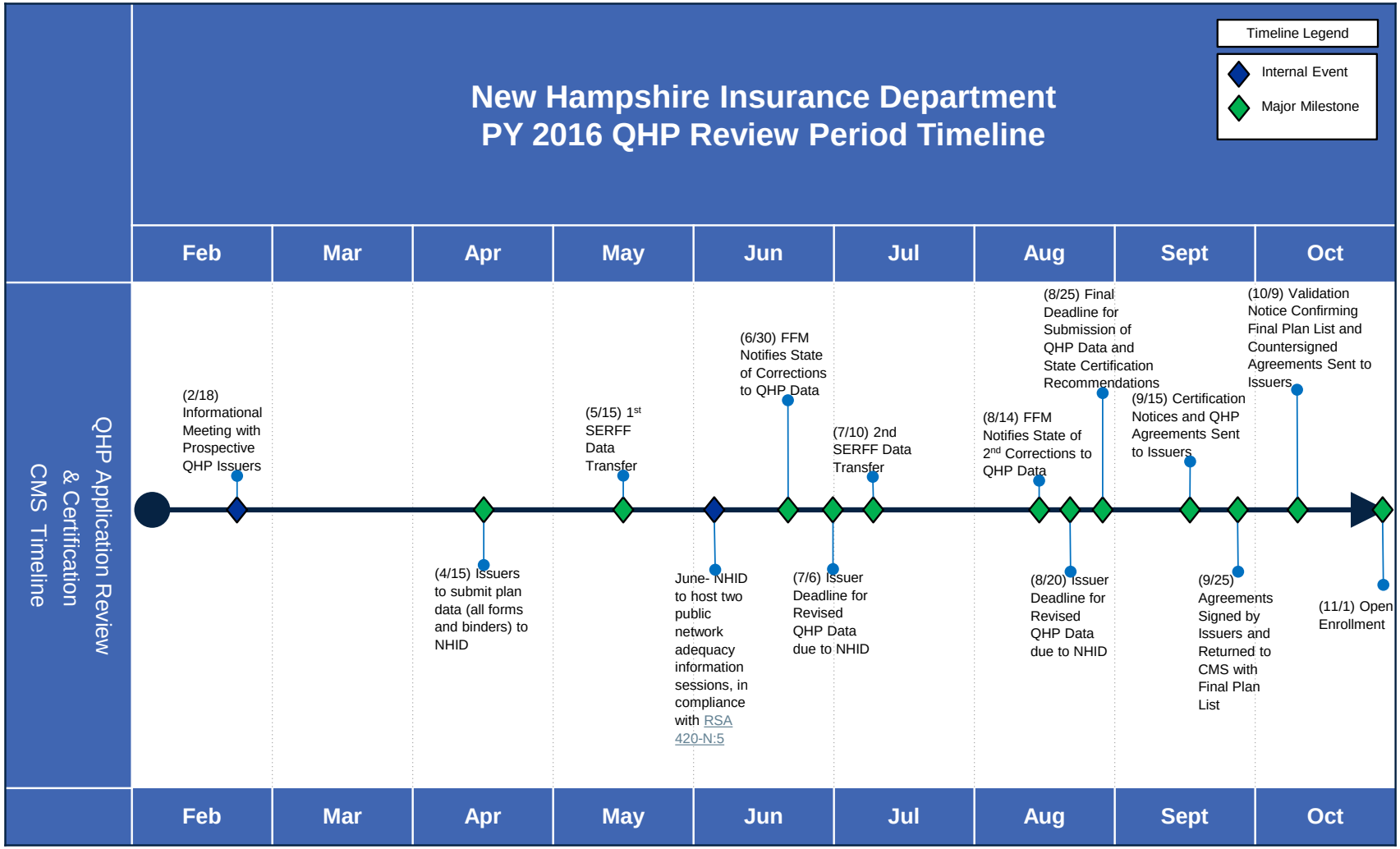
Questions related to this bulletin should be directed to Michael Wilkey, Director of Compliance and Consumer Services at the New Hampshire Insurance Department, at michael.wilkey@ins.nh.gov or by phone at (603)-271-2261 ext. 330. NHID will set up weekly conference calls with all carriers intending to submit plans to the marketplace.

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

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

Certification Standard Applies (* denotes modified standard)	**Certification Standard Does Not Apply**
Essential Health Benefits*	Accreditation
Annual Limits on Cost Sharing*	Cost-sharing Reduction Plan Variations
Network Adequacy	Unified Rate Review Template
Marketing	Meaningful Difference
Acceptance of Third Party Premium and Cost-sharing Payments	Patient Safety
Actuarial Value*	Quality Reporting
Licensure	Prescription Drugs
Inclusion of ECPs	Cost Sharing Reductions
Service Area	
Data Integrity Tool	
Non-discrimination	

Appendix II: NHID QHP Review Timeline



Appendix III: CCIIO QHP Timeline

Activity		Dates (Approximate)
QHP Application Submission and Review Process	Issuers Submit Plan Data to States, States Review	4/15/2015
	1st SERFF Data Transfer Deadline	5/15/2015
	FFM Reviews Plan Data	5/18/2015 – 6/26/2015 8/11/2014-8/25/2014
	FFM Notifies States of any Needed Corrections to QHP Data	6/29/2015 – 6/30/2015
	Issuers to Resubmit Plan Data into SERFF	7/6/2015
	2nd SERFF Data Transfer	7/10/2015
	FFM Completes Re-review of Plan Data	7/13/2015 – 8/12/2015
	FFMs Notify States of any Needed Corrections to QHP Data	8/13/2015 – 8/14/2015
	Issuers Resubmit Plan Data into SERFF	8/20/2015
	Final Deadline for Submission of QHP Data and Certification Recommendations; Deadline for All Risk Pools with QHPs to Be in "Final" Status in the URR System; Data Locked Down	8/25/2015
	FFMs Conduct Final Review of QHP Application Data	8/26/2015 – 9/16/2015
QHP Agreement/Final Certification	Certification Notices and QHP Agreements Sent to Issuers	9/17/2015 – 9/18/2015
	Agreements Signed by Issuers and Returned to CMS with Final Plan List	9/21/2015 – 9/25/2015
	Validation Notice Confirming Final Plan List and Countersigned Agreements Sent to Issuers	10/8/2015 – 10/9/2015
Open Enrollment		11/1/2015 – 1/31/2016

Appendix IV: Premium Assistance Program Filing Submission

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

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