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BULLETIN
Docket No.: INS-17-017-AB

TO: All New Hampshire Licensed Health Carriers and Dental Insurers
FROM: Roger A. Sevigny
Insurance Commissioner
DATE: March 27, 2017
RE: 2018 Plan Year QHP 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 2018 as well as the standards that apply to QHPs offered on and off the Marketplace. Issuers should note that the Bulletin reflects the federal Market Stabilization Proposed Rule. The following guidance will be updated as necessary if changes are made in finalizing those rules.

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.

Open enrollment for 2018 plans will run from November 1, 2017 to December 15, 2017.

Individual and small group plans to be offered off the Marketplace must also meet certain QHP standards for benefit and rate approval and are subject to filing deadlines set forth in this Bulletin.

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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 federal 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 final 2018 Letter to Issuers in the Federally-facilitated Marketplaces as amended on February 17, 2017. Issuers are reminded that changes to the applicable regulations have been proposed via the Market Stabilization Proposed Rule. Issuers should consult and ensure compliance with the final rule when issued. 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 addressing legal requirements that are applicable to individual and small group coverage in New Hampshire, and interpreting the interplay between state law and ACA requirements. These bulletins include, but are not limited to, the following:

- Guidance on Application of Extended Transition to Individual and Small Group Policies
- Network Adequacy Procedure for 2018 Plans
- Guidance on Newborn Coverage
- Coverage of Preventive Health Services under the Patient Protection and Affordable Care Act
- 2017 Plan Year QHP Issuer Bulletin
- Large and Small Group Coverage for 2016
- Guidance on Federal Group Size Amendment, Including REVISED Guidance on Application of Extended Transition to Individual and Group Policies and Employee Counting
- Guidance on Administration of Autism Benefits
- Continuity of Care Issuer Bulletin
- Transparency in Provider Network Directory and Formulary
- 2015 QHP Certification: Guidance on the Filing of Advertising Materials
- Auto Enrollment for Pediatric Dental

- Market Rules Guidance
- Network Based Hospital Services

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

III. Procedures and Timelines

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 templates, submissions, and form filings, with rate filings and binder submissions due no later than April 24, 2017. Petition to the Centers for Medicare & Medicaid Services (CMS) is required for changes to service area after initial submission. Rate submissions must be finalized by July 3, 2017. The NHID will link to the CMS website where proposed rate increases subject to state review will be posted on August 1, 2017. The NHID will complete all reviews and make recommendations for certification by September 27, 2017. Specific timelines for the QHP certification process are attached hereto as Appendices I and II. Any plan that is not certified under this timeline will be ineligible to be offered in the Marketplace during plan year 2018.

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 product - one individual binder and one SHOP binder, 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, including cost-sharing reduction plan variations, 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 2018, 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, and submissions will not be reviewed until such time as attestations are received noting satisfactory results. If issuers receive an "unmet" when running a tool but believe they are still compliant, they must submit the Excel tool's results tab and add an "explanations" column for their justification. Both the attestation form and Excel spreadsheet must be uploaded to the Supporting Documents tab in the binder.

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 them for review. Updated Checklists (individual major medical/small group major medical) for 2018 can be found at http://www.nh.gov/insurance/lah/lah_checklists.htm.

B. Recertification/Guaranteed Renewability of 2017 QHPs

QHPs currently offered on the New Hampshire Marketplace that are applying for renewal must be recertified – i.e., are not 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 2018, a QHP or stand-alone dental plan (SADP) certified by a federally-facilitated Marketplace (FFM) must be the same "plan," as defined in 45 CFR 144.103, as the plan that was certified for plan years beginning in 2017. 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.[1] Allowed changes are summarized below:

- Changes made solely pursuant to applicable federal or state requirements; or
- All of the following:
    - Changes in cost sharing are solely related to changes in cost and utilization of medical care, or to maintain the same metal tier 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;
    - The plan covers a majority of the same counties in its service area; and
    - The plan covers a majority of the same provider network.

Additionally, for 2018, as outlined in the Department's bulletin INS-15-051-AB issued on August 25, 2015, the Department will require that issuers alert consumers to the addition or removal of a benefit from a plan, even if the plan is within the above-outlined parameters for renewal and fall within the regulatory parameters for uniform modification. An example of a benefit addition that would require consumer notification is adding pediatric dental benefits.

This information must be provided in a consumer notice to be issued on the first allowable date prior to open enrollment for 2018 and is in addition to all federally-required notice language outlined in 45 CFR 146.152, 147.106, and 148.122. The disclosure must appear on the first page in bold type, and include sufficient information for the average consumer to understand the nature of the change and make an informed plan selection decision for 2018.

The recertification process for QHPs and SADPs will continue to mirror the certification process of a new plan. Issuers must submit all of the same information for recertification of plans that are on the Marketplace in 2017.

QHPs and SADPs being recertified for plan year 2018 must use the same HIOS plan identification number as used for plan year 2017.

C. Plan Terminations and Mapping

If an issuer chooses to not recertify a plan in the Marketplace, it is subject to the standards outlined in 45 CFR 156.290.

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

The definition of the same "plan" from 45 CFR 144.103 will also apply to reenrollment. Issuers offering plans on the individual market FFM and SHOP in plan year 2017 should submit Plan ID Crosswalk data for their QHPs and SADPs to CMS via email. The revised hierarchy set forth at 45 CFR 155.335(j) will apply to both QHPs and SADPs. CMS only requires the Plan ID Crosswalk for the individual market, but New Hampshire is requiring it for the SHOP as well for informational purposes.

For purposes of identifying to CMS significant rate increases, new plans that map 2017 members from terminating plans will be considered the same "plan."

D. Participation in the New Hampshire Health Protection Program

Issuers offering individual health insurance in the Marketplace are required to accept New Hampshire Health Protection Program (NHHPP) members as enrollees, including offering plan variations associated with this population, consistent with the terms of state law creating the NHHPP and federal waiver requirements. The New Hampshire Department of Health & Human Services (DHHS) will communicate any changes to the benefit design requirements for such plan variations.

The guidelines relative to the NHHPP are set forth in the Continuity of Care Issuer Bulletin (INS-15-013-AB) as well as guidance provided by the DHHS.

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 plan offerings are compliant. In subsequent pages, issuers will find guidance regarding those issues the NHID seeks to clarify for the plan year 2018 certification process.

In order to ensure adequate and timely review under both state and federal standards, we ask that issuers 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 that began in 2015 for its review process for plan year 2018. 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. However, with regard to the reporting requirements of Ins 2701.09 for plan year 2018, issuers are responsible for complying with Bulletin INS-17-011-AB "Network Adequacy Procedures for 2018 Plans." 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.

For plan year 2018, the NHID will accept a simplified filing in lieu of the full New Hampshire specific Network Adequacy Template required in past years. The simplified filing must include a product-specific listing of all in-network providers in the states of New England, including

dentists, pharmacies, and institutional providers. As outlined in the Excel Provider File Template, the network provider file shall include the provider name, national provider identifier (NPI), issuer-specific identifier,[2] and provider address. If the provider has multiple addresses where services are available, the provider identifier information should show up on separate rows, each row with the same provider name and identifier, but with a different address. The file should also indicate for what counties the issuer is seeking approval. Issuers should not change the file column names or add notes to the data worksheet. This change shall apply to both medical and dental insurance issuers.

The NHID will do a geo-access review of submissions in accordance with existing rules and based on 2010 census data (under 65 population by zip code)[3]. The NHID will work with issuers to resolve any issues identified during that review.

Issuers must also submit the simplified New Hampshire Network Adequacy Summary Template to identify and provide a justification for known network deficiencies and regarding network hospitals and Substance Use Disorder providers.

It is the Department's intention to make issuers' network adequacy information available to the public during the QHP review process. RSA 420-N:5-a requires that NHID hold public information sessions about the proposed network for each issuer by mid-June of each year. In addition to holding these sessions in June, NHID updates the initial network adequacy public information session presentations as networks change. It is the intention of the Department to continue this process for the 2017 QHP review process. In order to facilitate this public information, issuers will be required to submit via the New Hampshire Network Adequacy Summary Template which of the New Hampshire 26 acute care hospitals are covered for each network with their initial filings and indicate whether their contracts with such hospitals are full-scope contracts. Issuers are also asked to identify any out-of-state hospitals that are contracted with in order to meet network adequacy standards as the Department is considering how to include information about out-of-state network hospitals in the future. In addition, issuers are required to inform the Department of changes to their New Hampshire hospital submission so that the information made public by the NHID can be updated. The information will be made public initially in June 2017. Updates will be made on August 1st and October 15th as needed. Network providers will only be listed based on signed contracts and after issuers have submitted updates in writing and have updated all applicable state and federal templates via SERFF. Issuers are urged to consult RSA 420-N:5-a and the 2017 Network Adequacy presentation made available to the public by the Department in 2016 for additional information.

As in prior years, 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' plans will not be certified if they do not meet this standard for 2018.

[2] The issuer-specific identifier should match the MC024 "Service Provider Number" as submitted under Ins 4000.
[3] Available at https://www.nh.gov/insurance/lah/index.htm

The Department requires that provider information submitted and / or 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.

To the extent that a change made to the issuer network after submission of the filing impacts compliance with network adequacy standards or results in the loss of a major inpatient or outpatient facility or large provider group, that change must be reported to the Department in writing immediately, and issuers shall update all applicable state and federal templates via SERFF at the same time.

B. Essential Community Provider Requirements

The Department will review the plan's compliance with 2018 Essential Community Provider (ECP) Standards as set forth by CMS, and outlined in the 2018 Benefit and Payment Parameter regulations, the final 2018 Letter to Issuers in the FFM, and the Market Stabilization Proposed Rule.

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.

For 2018, ECP compliance requires the issuer to demonstrate that it has:

- Achieved at least 20% ECP participation in network in the service area;
- Offered contracts in good faith 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 in good faith 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 and is due at the time of filing.

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

- Number of contracts offered to ECPs for the 2018 benefit year;
- Number of additional contracts issuer expects to offer for the 2018 benefit year and the timeframe of those planned negotiations;
- Evidence of efforts of contracting including, but not limited to: emails; date/time of contract attempts made and to whom those communications were made to in an effort to contract; or other evidence as requested by the Department if needed;
- 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 issuer must explain how its target populations will be served.

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. Issuers can also write-in ECP providers, as long as those providers submit an ECP petition to CMS by August 16th. This non-exhaustive list is updated annually near the beginning of the calendar year and is available at: https://www.qhpcertification.cms.gov/s/Home.

In addition, CMS included the following list of ECP Categories and Types in the final 2018 Letter to Issuers in the FFM:

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

We reiterate the importance of issuers complying with 45 CFR. 156.235(e), which requires that QHP issuers must pay an amount to FQHCs 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 item or service, as specified in section 1302(g) of the Affordable Care Act.[4]

Issuers of individual market QHPs, including SADPs, are required under 45 CFR. 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;

[4] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf

and state or federal government programs, as well as applicable downstream entities.[5] 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.

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.[6]

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.

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:

"*Prescribed FDA approved contraceptives are not subject to cost-shares.*"

D. Mental Health Parity and Addiction Equity

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires that treatment limitations for mental health and substance use disorder (SUD) benefits be no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.[8] The law specifically expands parity requirements to include substance use disorder benefits.[9] As a result, all parity requirements that apply to coverage of services for mental health conditions also apply to coverage of services for substance use disorders. Under the MHPAEA, plans must define mental health conditions and substance use disorders in accordance with

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[5] 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 CFR 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.

[6] "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.

[7] http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf.

[8] 42 U.S.C. 300gg-26; 78 FR 68240.

[9] 75 FR 5412

applicable federal and state law and consistent with generally recognized independent standards of current medial practice (including the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version of the International Classification of Diseases (ICD), or State guidelines).

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) Mental Health and SUD services may be no more restrictive than requirements and limitations for inpatient (in-network) medical and surgical benefits.

The MHPAEA refers to annual and lifetime aggregate limits, quantitative treatment limitations and financial requirements, such as cost sharing, in establishing parity between mental health and substance use disorder services and medical/surgical services. As noted above, these requirements and limitations must be offered at parity with medical and surgical services in each of the six classifications. Non-quantitative treatment limitations (NQTLs) are also regulated under the MHPAEA, and must be offered at parity with medical and surgical services. NQTL requirements include geographic limits, facility-type limits, and network adequacy, and, as such, issuers will need to demonstrate that members will have the necessary access to mental health and substance use disorder providers. Issuers must submit to the Department their attestations to CMS that their plans filed for offering on the Marketplace comply with the requirements of 45 CFR 146.136.

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 and the NHID bulletin regarding Guidance on Administration of Autism Benefits (INS 15-046-AB) which clarifies that in New Hampshire pervasive development disorders and autism are defined as biologically-based mental illnesses.

Parity includes access to services for mental health and substance use disorders that is equivalent to access to any other medical/surgical service. Issuers will need to demonstrate using the New Hampshire Network Adequacy Summary Template that members will have the necessary access to providers for these services.

E. Benefit Design

Essential Health Benefits

The Essential Health Benefit (EHB) benchmark plan for plan year 2018 is Matthew Thornton Blue; plan materials can be found at: https://www.cms.gov/cciio/resources/data-resources/ehb.html. Pediatric dental is supplemented by the FEDVIP dental plan.

Clarity in Describing Benefit Design

For 2018 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.

Issuers must make benefit coverage and cost sharing limitations clear in their Plan and Benefit Template submissions by utilizing the exclusions and benefit explanations section of the template. If, for example, there is a copay for the first three visits and then a coinsurance after deductible for the subsequent visits, issuers must put in the benefit explanations that the copay is only for the first three visits. Issuers must strictly follow the QHP Application Instructions which give explicit instruction for the templates and supporting documentation and can be found at https://www.qhpcertification.cms.gov/s/Home.

For 2018, 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 2016 plans, the NHID found significant discrepancies between the benefit and cost sharing wording on forms and the way plans were input into 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 2016 caused both the state and CMS serious concern and issuers must ensure both the filings and templates are accurate going forward.

For plan year 2018 the maximum annual limitation on cost sharing is $7,350 for self only coverage and $14,700 for family coverage. The 2016 Benefit and Payment Parameters clarified that even for family coverage (with an overall limit of $14,700), no individual enrollee in the coverage can be required to spend more than $7,350 in cost sharing for care attributable to that individual enrollee.

Standardized Options

Starting for plan year 2018, issuers will have the option of offering standardized plans (also known as "Simple Choice Plans"). These plans will receive differential display on HealthCare.gov. New Hampshire will not require issuers to offer standardized plans. Issuers will have the option to offer one or more of the standardized options. Issuers that offer a silver standardized option must also offer the silver cost-sharing reduction plan variations of the standardized option. Issuers may choose to offer more than one standardized option at each coverage level as long as the plans meet the requirements for meaningful difference as outlined below.

Plans will be considered, and displayed as, standardized plans if they align with the copays and coinsurance for a key set of essential health benefits set forth at Appendix III. These plans must also have:

- A single provider tier;
- A fixed deductible (plans at the silver, silver cost-sharing reduction and gold levels must have separate medical and drug deductibles; 87% and 94% silver cost-sharing reduction plans must have a $0 deductible for drugs); and
- A fixed annual limitation on cost sharing.

Issuers are reminded that standardized plans must continue to comply with all applicable state laws, including but not limited to RSA 415:6-t. Specific to RSA 415:6-t, CMS clarified that plans that only deviate from the standardized plan design to comply with a state law that requires cost sharing for chemotherapy different from the cost sharing specified in the standardized

options' drug tiers will be considered to be a standardized plan. In such cases, issuers must clearly indicate the required adjustments in plan formularies.

F. Meaningful Difference

For 2018, CMS will first group an issuer's QHPs into subgroups based on plan type, metal level, child-only plan status, and overlapping counties/service areas, and then will review for meaningful difference based on the presence of at least one material difference in the following:

- Cost Sharing:
  - Integrated medical and drug maximum out-of-pocket (MOOP)
  - Integrated medical and drug deductible
  - $500 difference in MOOP
  - $250 difference in deductible
  - Multiple in-network tiers
- Provider Networks:
  - Different provider network IDs
- Covered Benefits:
  - Variance in coverage of one or more benefits displayed on healthcare.gov
  - Different drug list ID

G. Provider Directory

The final 2018 Letter to Issuers in the FFM states:

> Under 45 CFR 156.230(b), a QHP issuer, including issuers of SADPs, 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 FFMs, CMS, and OPM. CMS will consider a provider directory to be up-to-date if the issuer updates it at least monthly. CMS considers a provider directory to be 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 plans and provider networks. Further, if the health plan issuer maintains multiple provider networks, the plans 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 also requires QHP issuers in the FFMs, including issuers of SADPs, to make this provider directory information publicly available on their websites in a machine-readable file and format specified by CMS, 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 read and ensure compliance with the New Hampshire Insurance Department September 25, 2014 bulletin INS-14-025-AB. The Department will be actively and continually checking for compliance with provider directory standards. If non-compliant, the Department will refer the issuer to its Market Conduct Division for action as needed.

H. Formulary Information

45 CFR 156.122(c) requires health plans to have a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan. The process must include:

- An internal review (federal regulations require the issuer to make a determination and notify the enrollee no later than 72 hours following receipt of the request, however, RSA 420-J:7-b requires that the process not exceed 48 hours);
- An external review; and
- The ability to expedite the reviews (must make determination and notify the enrollee no later than 24 hours following receipt of the request).

In the event that an exception request is granted, the excepted drug(s) are treated as an EHB including counting any cost sharing towards the plan's annual limitation on cost sharing.

Information on Prescription Drugs from the final 2018 Letter to Issuers in the FFM:

> The formulary drug list must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Marketplace, CMS, OPM, and the general public. A formulary drug list is easily accessible when it can be viewed on the plan's public website 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. Under §156.122(d)(2), CMS requires QHP issuers in the FFMs, including SHOP issuers but excluding SADP issuers, to make this formulary drug list information publicly available on their websites in a machine-readable file and format specified by CMS, to allow the creation of user-friendly aggregated information sources.

Issuers are reminded that non-discrimination provisions apply to issuer formularies and will be reviewed by the Department.

Please also note that the final 2018 Letter to Issuers in the FFM states that more stringent reviews will be done on prescription drugs to help ensure that QHPs are in compliance with applicable regulations. CMS will conduct the following prescription drug reviews:

Formulary Category/Class Count: Issuers do not provide EHB unless they cover the greater of: one drug in every USP category and class; or the same number of drugs in each category and class as the EHB benchmark plan. All issuers will be reviewed to ensure compliance with this provision, and we note that there is only one drug (Naloxone) in the Anti-Addiction/ Substance

Abuse Treatment Agents (Opioid Reversal Agent) class. Therefore, Naloxone must be covered to be compliant with this rule.

Formulary Outlier Review: All formularies will be compared, and formularies with an unusually high number of drugs that are subject to prior authorization or step therapy requirements in a particular USP category and class will be flagged and identified as outliers. The outlier calculation includes both state and national level outlier threshold values. Issuers will not know if they pass this review as they will not have market-wide data. In addition to the USP categories/classes reviewed for plan year 2017, the following USP categories/classes will also be reviewed for plan year 2018: Antivirals/Anti-cytomegalovirus (CMV) Agents, Antivirals/Anti-hepatitis B (HBV) Agents, Antivirals/Anti-hepatitis C (HCV) Agents, Antivirals/Antiherpetic Agents, and Antiemetics/Emetogenic Therapy Adjuncts.

Clinical Guideline-Based Review of Prescription Drug Coverage: The availability of drugs recommended by nationally recognized clinical guidelines will be analyzed. In some cases, the review will also evaluate whether certain first-line therapies are available without step therapy or prior authorization. Drugs included in this review are not limited to those included on the EHB-Rx Crosswalk. The medical conditions included in the review for 2018 include: bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia.

I. Prohibition on Mid-Year Withdrawals

Issuers are reminded that QHPs must be made available for enrollment through the Marketplace for the full plan year for which the plan was certified, unless a basis for suppression under 45 CFR 156.815 applies.

J. Summary of Benefits and Coverage

Issuers are reminded that CMS released the Summary of Benefits and Coverage and Uniform Glossary final rule on June 16, 2015 and it includes the following provisions:

- Summaries of Benefits and Coverage (SBCs) must include a web address that links directly to a copy of the individual coverage policy or group certificate of coverage.
- All URL links included on the SBC must link directly to the referenced information, such as the specific formulary for that SBC benefit package.
- QHP SBCs must disclose whether or not the QHP pays for abortions for which federal funding is not available.
- QHP insurers are required to make SBCs available that accurately reflect each cost-sharing plan variation, and must include a separate URL linking to the SBC created for each plan variation as part of the QHP data submission.

CMS SBC instructions and templates can be found here.

In order to streamline the submission and review of SBCs, NHID is providing the following guidance:

- For each plan, issuers should submit the standard plan variation on the forms schedule tab with the HIOS ID; the plan variation suffix and cost sharing can be variable. A "master" SBC demonstrating the plan variation suffix and corresponding cost sharing should be attached to the supporting documentation tab.
- Please keep in mind that CMS requires each plan variation to be published separately with no variation, so it is the issuer's responsibility to assure accuracy and consistency with the schedules of benefits. The URL in the Plan and Benefits Template must link to the unique SBC.

K. Advertisements

Advertising materials for all plans, including indemnity licensed products, must be submitted to the Department for review and approval in accordance with the requirements under this Bulletin.

The Affordable Care Act and subsequent regulations grant the Department authority to review marketing materials, including advertisements, and ensure that materials are not false, misleading or discriminatory. This authority is in addition to existing authority under state law, discussed further below. The Department will review marketing materials to ensure that that marketing practices or benefit designs will not have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[10] Advertising must also comply with NHCAR Part Ins 2600.

For 2018 QHP certification purposes, the NHID requires issuers to file advertisements "prior to use," in accordance with RSA 420-B:8, VI. In 2015 QHP Certification: Guidance on the Filing of Advertising Materials (INS-14-015), NHID interpreted "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, including webpages, must have a form number in the lower left hand corner.

Issuers must submit advertising in accordance with the following guidelines:

- Advertisements that contain plan-specific benefit descriptions and / or cost sharing must be filed for Review and Approval.
- Advertisements that are institutional, and do not contain specific benefit descriptions or cost sharing should be submitted as Informational. The Department reserves the right to have the file changed to Review and Approval should there be a need.
- Webpages should be submitted as Informational.

[10] 45 CFR 156.225; final 2018 Letter to Issuers in the Federally-facilitated Marketplaces

Issuers shall also 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.

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 INS-14-015 for additional information.

Further, the Department reserves the right to review all advertisements, whether submitted or not, in order to protect consumers in the event such advertising is determined to be misleading or inaccurate. In the event there is information presented that would lead a reasonable consumer to believe that a policy confers a greater benefit than stated in the approved policy or certificate, the issuer will be held accountable, as set forth in INS-14-015. As a reminder, insurance issuers are responsible for the advertisements utilized by their appointed producers.

L. Segregation of Funds under ACA Section 1303

Each QHP issuer offering Marketplace coverage must submit to the Department its annual attestation to CMS that it will adhere to the requirements related to segregation of funds consistent with 45 CFR 156.280 and all applicable guidance.

M. Stand-Alone Dental/Pediatric Dental Disclosure

All stand-alone dental plans offered on the 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 Appendices I and II. Stand-alone dental plan issuers are urged to reference the final 2018 Letter to Issuers in the FFM for any additional guidance. As a reference for stand-alone dental plan issuers, we have included as Appendix IV to this Bulletin the chart put forth by CMS in the final 2018 Letter to Issuers in the FFM detailing which standards and tools apply to stand-alone dental coverage and which do not.

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 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:

"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."

N. Out-of-Network Services and Balance Billing

Pursuant to 45 CFR 156.230(e), starting in 2018, issuers are required to count cost sharing paid for an essential health benefit provided by an out-of-network, ancillary provider at an in-network setting towards the in-network annual cost-sharing limitation unless the issuer provides written notice to the enrollee by the longer of: when the issuer would typically respond to a prior authorization request; or 48 hours prior to the provision of the benefit. Each issuer must provide a statement to the Department outlining how it intends to comply with this requirement.

Further, the Department is looking carefully at the costs consumers face when they receive care from out-of-network providers at in-network facilities. The Department may provide future guidance regarding further transparency and notice requirements.

Issuers must continue to comply with state law regarding 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 issuer 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. Issuers that offer HMO products for the 2018 plan year are reminded they are subject to bulletin issued by the Department in 2006, entitled Network Based Hospital Services.

O. SHOP Guidance

Group Size

The PACE Act, signed into law on October 7, 2015, amended the ACA to keep the definition of small employer at groups of 1-50.[11] This definition is consistent with New Hampshire law.[12] As such, and as communicated in the Department's bulletin INS-15-065-AB issued on October 27, 2015, issuers should offer and write small group coverage only to groups of 1-50. Any group of 51 or more may be offered and written only as large group coverage. In addition, as outlined in bulletin INS 15-061-AB, as a result of this federal policy change, transition policies with respect to groups of 51-100 are no longer necessary in New Hampshire and language in 2015 bulletins applicable to groups of this size has been rescinded.

Employee Counting

As outlined in NHID bulletin INS-15-014-AB issued on April 20, 2015, federal counting rules for determining whether a purchaser falls into the definition of a small group or a large group are different from the method traditionally used in New Hampshire and should be used in all cases for policies issued on or after July 1, 2015. Issuers should consult 45 CFR 155.20 for a detailed explanation of the counting methodology to be followed.

Employee Choice

All qualified employers will continue to have the option of offering their employees choice among multiple QHPs and SADPs on the FF-SHOP. In New Hampshire, employers may offer

[11] 42 USC 18024(b)(3)
[12] RSA 420-G:2, XVI

employees a single QHP / SADP or, in the alternative, may provide qualified employees a choice of: (1) all QHPs / SADPs at a single level of coverage;[13] or (2) all plans across all metal levels from a single insurer.[14]

Prohibition on Mid-Year Withdrawals

The prohibition on mid-year withdrawals applies in FF-SHOPs. QHPs offered through the SHOP must be made available for enrollment for the full plan year for which the plan was certified, unless a basis for suppression under 45 CFR 156.815 applies.

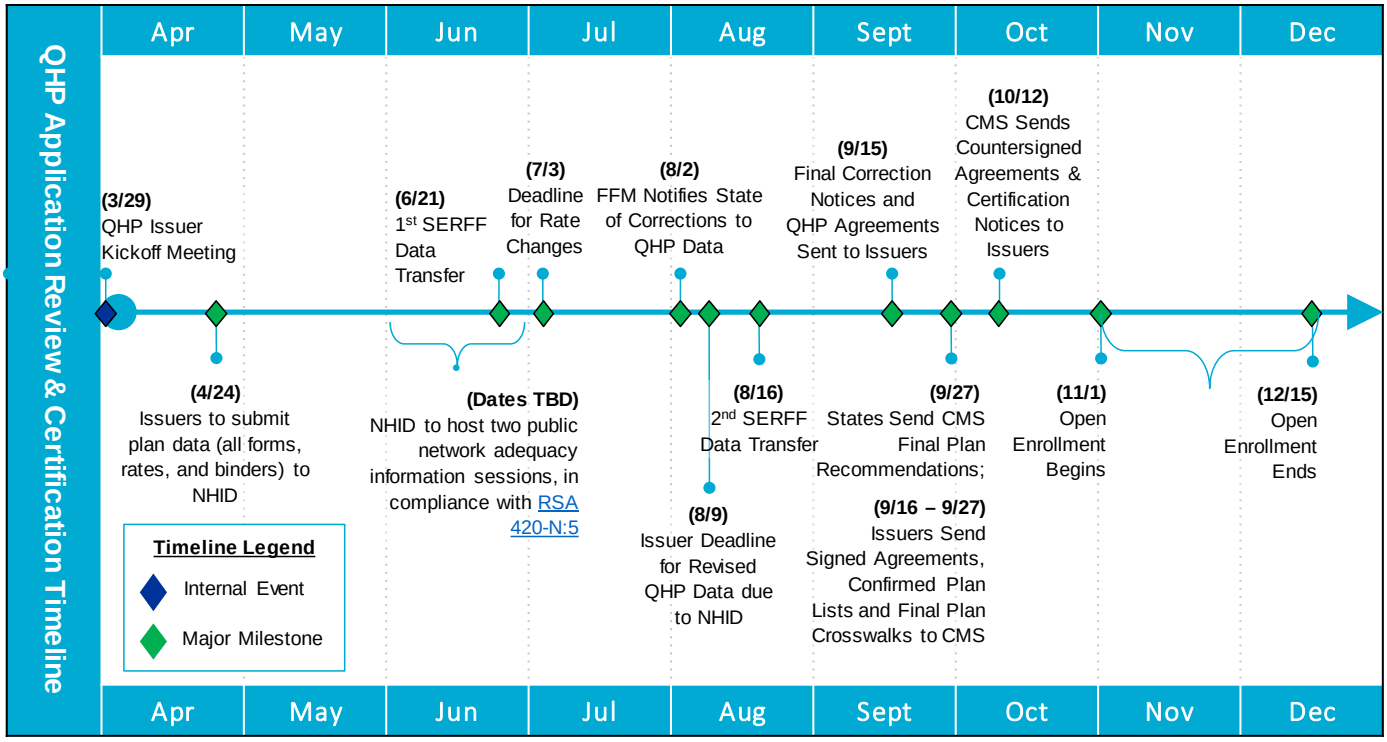
Contact Information

Questions related to this Bulletin should be directed to Michael Wilkey, Director of Life, Accident and Health at the New Hampshire Insurance Department, at michael.wilkey@ins.nh.gov or by phone at (603) 271-3218. NHID staff will be available on a weekly basis for conference calls with issuers upon their request to review and discuss the submission of plans on the Marketplace.

[13] "High" or "low" for SADPs.

[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2017-Implementation-of-Vertical-Choice.html .

Appendix I: NHID QHP Review Timeline



Appendix II: CCIIO QHP Timeline

Activity		Dates (Approximate)
QHP Application Submission and Review Process	Initial QHP Application Submission Window	5/10/2017 – 6/21/2017
	CMS Reviews Initial QHP Applications as of 6/21/2017	6/22/2017 – 7/25/2017
	CMS Sends First Correction Notice	8/1/2017 – 8/2/2017
	Deadline for Effective Rate Review Program (ERRP) states to post online (or link to) proposed rate increases subject to state review	8/1/2017
	Deadline for Service Area Petition	8/4/2017
	Final Deadline for Issuer Changes to QHP Application; Deadline for all risk pools with QHPs to be in "final" status in the Unified Rate Review System	8/16/2017
	CMS Reviews Final QHP Submissions as of 8/16/2017	8/17/2017 – 9/11/2017
	CMS Sends Final Correction Notice to Issuers with Agreements for Signature and Plan Lists for Confirmation	9/14/2017 – 9/15/2017
	States Send CMS Final Plan Recommendations	9/27/2017
QHP Agreement, Plan Confirmation, and Final Certification	Issuers Send Signed Agreements, Confirmed Plan Lists and Final Plan Crosswalks to CMS	9/16/2017 – 9/27/2017
	Limited Data Correction Window: Outreach to Issuers with CMS or State Identified Data Errors; Issuers Submit Corrections; CMS Reviews and Finalizes Data for Open Enrollment	9/15/2017 –10/7/2017
	CMS Sends Certification Notices with Countersigned Agreements and Final Plan Lists to Issuers	10/11/2017 – 10/12/2017
Open Enrollment		11/1/2017 – 12/15/2017

Appendix III: 2018 Final Standardized Options
Applicable in New Hampshire (Set Two)

	Bronze	HSA-eligible bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	62.79%	61.97%	71.03%	73.88%	87.70	94.68	80.60%
Deductible (Med/Rx)	$6,650	$6,000	$3,500/ $500 Rx	$3,000/ $200 Rx	$700/$0	$250/$0	$1,400/$0
Annual Limitation on Cost Sharing	$7,350	$6,000	$7,350	$5,850	$2,450	$1,250	$5,000
Emergency Room Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Urgent Care	$75 (*)	No charge after deductible	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*)
Inpatient Hospital Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Primary Care Visit	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Specialist Visit	$75 (*)	No charge after deductible	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*)
Mental Health/ Substance Use Disorder Outpatient Office Visit	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Imaging (CT/PET Scans, MRIs)	40%	No charge after deductible	20%	20%	20%	5%	20%
Speech Therapy	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)

Occupational Therapy/ Physical Therapy	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Laboratory Services	40%	No charge after deductible	20%	20%	20%	5%	20%
X-rays and Diagnostic Imaging**	40%	No charge after deductible	20%	20%	20%	5%	20%
Skilled Nursing Facility	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Generic Drugs	$35 (*)	No charge after deductible	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*)
Preferred Brand Drugs	$40 (copay applies only after deductible)	No charge after deductible	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*)
Non-Preferred Brand Drugs	$45 (copay applies only after deductible)	No charge after deductible	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*)
Specialty Drugs	$50 (copay applies only after deductible)	No charge after deductible	$150 (copay applies only after deductible)	$150 (copay applies only after deductible)	$75 (*)	$20 (*)	$100(*)

(*) = not subject to the deductible

** Note: Excludes x-rays and diagnostic imaging associated with office visits.

Appendix IV: Standards and Tools Applicable to SADPs

Standard or Tool Applies (* denotes modified standard)	
Essential Health Benefits*	Actuarial Value*
Annual Limits on Cost Sharing*	Licensure
Network Adequacy	Inclusion of ECPs
Non-discrimination	Service Area
Acceptance of Third Party Premium and Cost-sharing Payments	Data Integrity Tool
Rates submission*	Machine Readable* (SADPs must comply with provider directory standards but not drug formulary standards)
Transparency in Coverage Reporting	

Standard or Tool Does Not Apply	
Accreditation	Patient Safety
Quality Reporting and Quality Improvement Strategy	Meaningful Difference
Prescription Drugs	Standardized Options
Cost Sharing Reductions	Out-of-Pocket Cost Comparison Tool