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BULLETIN Docket No. INS 21-018-AB

TO: All New Hampshire Licensed Health and Dental Insurers
FROM: Commissioner Christopher R. Nicolopoulos, Esq.
DATE: March 26, 2021
RE: 2022 Plan Year Issuer Guidance

Issuers should note that the Bulletin reflects the guidance set forth in the Notice of Benefit and Payment Parameters for 2022 (NBPP) and the draft 2022 Letter to Issuers in the FFM (Letter) but is subject to revision for further state and federal guidance.

If an issuer is planning to introduce a new product or network in Plan Year 2022, they are strongly urged to contact the Department as soon as possible, but no later than the initial filing deadline in May. Issuers should provide notice to Jason Dexter at the New Hampshire Insurance Department (NHID), Jason.G.Dexter@ins.nh.gov or by phone at (603) 271-3041.

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I. 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 under 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 under NH RSA 400-A:15. Under New Hampshire law, the Insurance Department regulates licensing of health insurance related entities (NH RSA 400-A:15-h; NH RSA 402; NH RSA 420-A and NH RSA 420-B) and solvency of health insurers (NH RSA 400-A:36 and 37); reviews health insurance policy forms and benefit design (NH RSA 415, NH RSA 420-G); exercises prior approval authority over rates (NH RSA 415:1); monitors network adequacy and treatment of consumer claims (NH RSA 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), including health insurance marketing practices.

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, the NBPP, and the Letter.

II. Procedures and Timelines

A. Form Filing Deadlines

Health insurance issuers, as well as stand-alone dental issuers, requesting certification from CMS must submit their initial applications (including all state-required templates, submissions, and form filings) with initial binder submissions no later than May 10, 2021.

B. Rate Filing Deadlines

Issuers are permitted to file a rate template as a placeholder on or by May 10, 2021 and will be allowed to update the template prior to the initial rate filing deadline. Initial rate submissions must be finalized and submitted by June 14, 2021. Off-exchange only form and rate filings are due by July 14, 2021. Rate revisions for on-exchange plans are due on July 14, 2021. Final rate revisions are due by August 4, 2021.

The NHID will complete all reviews and make recommendations for certification by August 18, 2021. Any plan that is not certified under the below timeline (*Figure 1*) will be ineligible to be offered in the Marketplace during Plan Year 2022. Petition to the Centers for Medicare & Medicaid Services (CMS) is required for changes to service area after initial submission.

NHID QHP Timeline Plan Year 2022

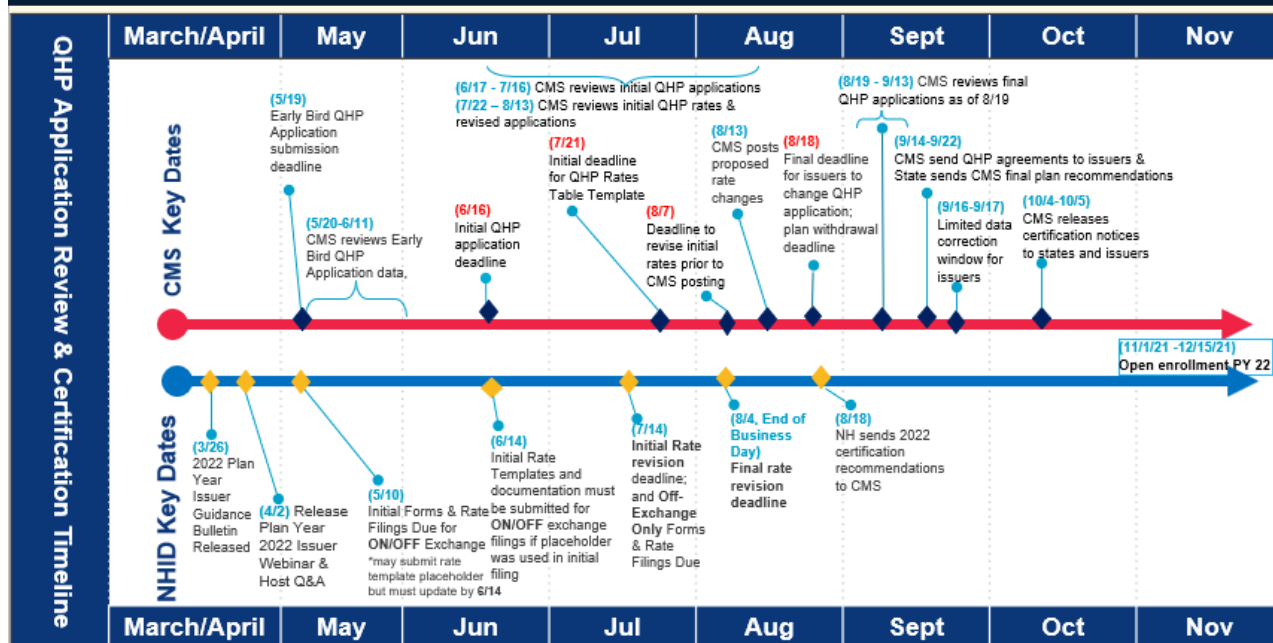


Figure 1: NHID QHP Timeline Plan Year 2022

C. Rate Filing Procedures

New Hampshire has received a Section 1332 State Innovation Waiver, allowing the state to implement a reinsurance program (Program) in the individual market. For all years that the Program is in place (Plan Year 2021 through Plan Year 2025) and for federal pass-through funding calculation purposes, individual market issuers will be required to file two sets of rates to include explanation of such rate assumptions in the actuarial memorandum for all plans eligible for participation in the Program.¹ Issuers should submit the following: a “with waiver” rate template that factors in the estimated impact of Program payments on rates and a “without waiver” rate template (into the Supporting Documentation tab) that shows the anticipated rates if there were no Program or Program payments. The “with waiver” rates must be reflective of the issuer’s estimate of the actuarial impact that the Program will have on the issuer’s plan(s) for the upcoming benefit year.

For each Plan Year that the program is in place, the NHID will post the Program parameters on its [website](#).

III. Guidance to Issuers on Select QHP Requirements

A. COVID-19 Related Filing and Coverage Requirements

The Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act, as well as other legislation, orders and guidance published at the federal and state levels include new requirements for issuers relative to COVID-19. Issuers should note that some of these requirements are limited to the duration of the public health emergency, while others are permanent. The following is an overview of those new requirements,

¹ All single risk pool individual market plans that comply with program requirements will be eligible for payments.

but issuers should review federal and state requirements in-depth while developing plan and rate filings.

B. Coverage of COVID-Related Items and Services

The FFCRA and the CARES Act require issuers to provide coverage of items and services related to testing for COVID-19 during the public health emergency. This coverage must be provided without cost sharing, prior authorization, or medical management. This includes services delivered by out-of-network providers. Section 3203 of the CARES Act also requires issuers to cover the COVID-19 vaccine without cost sharing, including the administration of the vaccine. CMS released FAQ documents on April 11, 2020 (FAQs about Families First Coronavirus Response Act and Coronavirus, Aid, Relief, and Economic Security Act Implementation 42) and February 26, 2021 (FAQs about Families First Coronavirus Response Act and Coronavirus, Aid, Relief, and Economic Security Act Implementation 44) as additional guidance for issuers.

Issuers should also consult:

- Insurance Department Order 20-016-AP, which was issued on March 10, 2020 and addresses required coverage related to COVID-19. The Order remains in effect until repealed.
- CMS guidance related to FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19) issued by CMS on March 12, 2020, related to EHB coverage and the coverage of COVID-19 diagnosis, treatment, and vaccines. These requirements extend for the duration of the public health emergency.

C. Coverage of Telehealth Services

[House Bill 1623-FN](#), passed in 2020, amended the New Hampshire Telemedicine Act (RSA 415-J) to require plans to provide coverage and reimbursement for telemedicine services on the same basis of coverage and reimbursement as for in-person services. This applies to all modes of telehealth services, including services delivered via audio-only phone or platform, and has no sunset date. Furthermore, [New Hampshire Emergency Order #8](#) to Executive Order 2020-04 requires plans to cover medically necessary treatment related to COVID-19 and delivered via telehealth by in-network providers without cost-sharing until the earlier of the end of the state of emergency or the Order being rescinded. More information is also available in NHID Bulletin INS 20-024-AB released on April 8, 2020.

D. Catastrophic Plans and High-Deductible Health Plans

Issuers should also consult federal guidance regarding catastrophic plans, including:

- CMS's FAQs on Catastrophic Plans and the Coronavirus Disease of 2019 (COVID-19) regarding coverage of diagnosis and treatment of COVID-19 prior to the deductible by catastrophic plans.
- CMS's FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19) regarding the coverage of telehealth services both related and unrelated to COVID-19 prior to the deductible.

Similarly, the CARES Act provides a temporary safe harbor for high deductible health plans, allowing them to cover telehealth and other remote care services prior to the deductible. This safe harbor will be in effect for plan years beginning on or before December 31, 2021. More information is available in CMS FAQ 42, noted above.

E. Network Adequacy

To demonstrate compliance with N.H. Code of Admin. R. PART Ins 2701, HEALTH AND DENTAL BENEFIT PLAN NETWORK ADEQUACY Ins 2700, issuers must submit the NHID Network Adequacy Template. The Department has revised the NHID Network Adequacy Template to consolidate all the templates used last year (NHID Network Adequacy Template; NH Hospital Template; NH Hospital-Based Provider Template).

In addition, the Department has updated the Guidelines tab to provide further explanation on how to complete the template. As is specified in the template, the submission must include complete and accurate information in the fields included in the NETWORK TEMPLATE TAB. Issuers must adhere to Template Guidelines and requirements to ensure an accurate and timely review of network adequacy submissions.

We strongly encourage issuers to review the updated guidelines prior to completing the template, and note the changes made for PY 2022 including, but not limited to the following:

- Each distinct network must be submitted on a separate workbook template, and issuers should not submit multiple networks on tabs.
- Issuers must use the naming conventions included in the Network Template Guidelines Tab when populating the workbook.
- Issuers must review Column K categorizations and ensure that you include and accurately categorize providers and facilities.
- Issuers must review the in-network provider designations in Column L.

F. Cost Sharing

As CMS does annually, it will update the maximum annual limits on cost sharing. Issuers are expected to comply with the final cost sharing and maximum annual limits as set forth annually.

G. Prescription Drug Rebates

By July 1st of each year and, unless extended, until July 1, 2024, issuers will be required to ensure compliance with RSA 415-A:7. Issuers must file a report with the New Hampshire Insurance Department demonstrating compliance with the law.

At a minimum, the report must detail how issuers comply with RSA 415-A:7, II by certifying:

- If rebates are remitted via 415-A:7, II (a), 415-A:7, II (b), or both.
- If remitted via 415-A:7, II (b), provide a brief explanation how rebates are applied to “its plan design and in future plan years to offset the premium for covered persons.”

The report may be submitted to the Department through SERFF or email.

H. Out-of-Network Services and Balance Billing

In addition to reviewing RSA 329:31-b, issuers should review the federal No Surprises Act, which goes into effect for plan and policy years beginning on or after January 1, 2022 to ensure compliance. Provisions applicable to plan and rate development include:

- Payment for out-of-network emergency services and non-emergency services that are provided at an in-network facility by certain types of out-of-network providers;
- Disclosures required to be included on insurance cards related to deductibles, out-of-pocket maximums, and consumer assistance;
- Continuity of care requirements; and
- Requirements related to maintaining up-to-date provider directories.

As the federal rulemaking process develops, the Insurance Department intends to issue further guidance with greater detail regarding these requirements.

Issuers must also continue to comply with 45 CFR 156.230(e) and RSA 420-J:8 as outlined in last year's Plan Year Issuer Guidance.

I. Transition Coverage

As in previous years, the NHID has adopted the CMS transitional guidance issued on January 19, 2021 and will allow the renewal of transition coverage. In accordance with the current guidance, such coverage may remain in place until January 1, 2023, and must come into compliance on that date. Due to the 12-month rate guarantee period under RSA 420-G:4, I (a), New Hampshire will not allow renewals for less than a 12-month period.

IV. Key State Legislative Changes

Several other bills related to health insurance coverage passed at the state level over the past year. Issuers should review state legislative changes to understand their impact on plan and rate development, including:

- [HB 1162](#) regarding prohibition of cost sharing for early intervention services.
- [HB 1280](#) regarding copayments for insulin, insurance coverage for epinephrine and auto-injectors, and the timeline for approval of prior authorization requests for prescription drugs.
- [HB 1639](#) regarding:
 - Prior authorization for emergency services and interfacility transport related to the treatment and diagnosis of certain biologically-based mental illness;
 - Coverage of long-term antibiotic therapy for tick-borne illness;
 - Coverage of biologically-based mental illnesses and reimbursement parity;
 - Coverage for medication-assisted treatment; and
 - Coverage of Oral Anti-Cancer Therapies.

V. Contact Information

Please direct questions related to this Bulletin to Jason Dexter at Jason.G.Dexter@ins.nh.gov or by phone at (603) 271-3041.