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**BULLETIN**

**Docket No. INS 22-019-AB**

**TO:** All New Hampshire Licensed Health and Dental Insurers

**FROM:** Commissioner Christopher R. Nicolopoulos, Esq. *CRN*

**DATE:** March 30, 2022

**RE:** 2023 Plan Year Issuer Guidance

Issuers should note that the Bulletin reflects the guidance set forth in the proposed Notice of Benefit and Payment Parameters for 2023 (NBPP) and the draft 2023 Letter to Issuers in the Federally-facilitated Exchanges (Letter) but is subject to revision for further state and federal guidance.

Issuers that are planning to introduce a new product or network in Plan Year 2023, or discontinue an existing plan, 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](mailto: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 (1) 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); (2) reviews health insurance policy forms and benefit design (NH RSA 415, NH RSA 420-B, NH RSA 420-G); (3) exercises prior approval authority over rates (NH RSA 415:1, NH RSA 420-B:8); (4) monitors network adequacy and treatment of consumer claims (NH RSA 420-J); and (5) has authority to take enforcement action with respect to violations of health insurance regulatory standards (NH RSA 400-A:15, NH RSA 415:20, NH RSA 420-B:13, 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 Qualified Health Plan (QHP) certification as well as other operational standards, codified in federal regulations, 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*

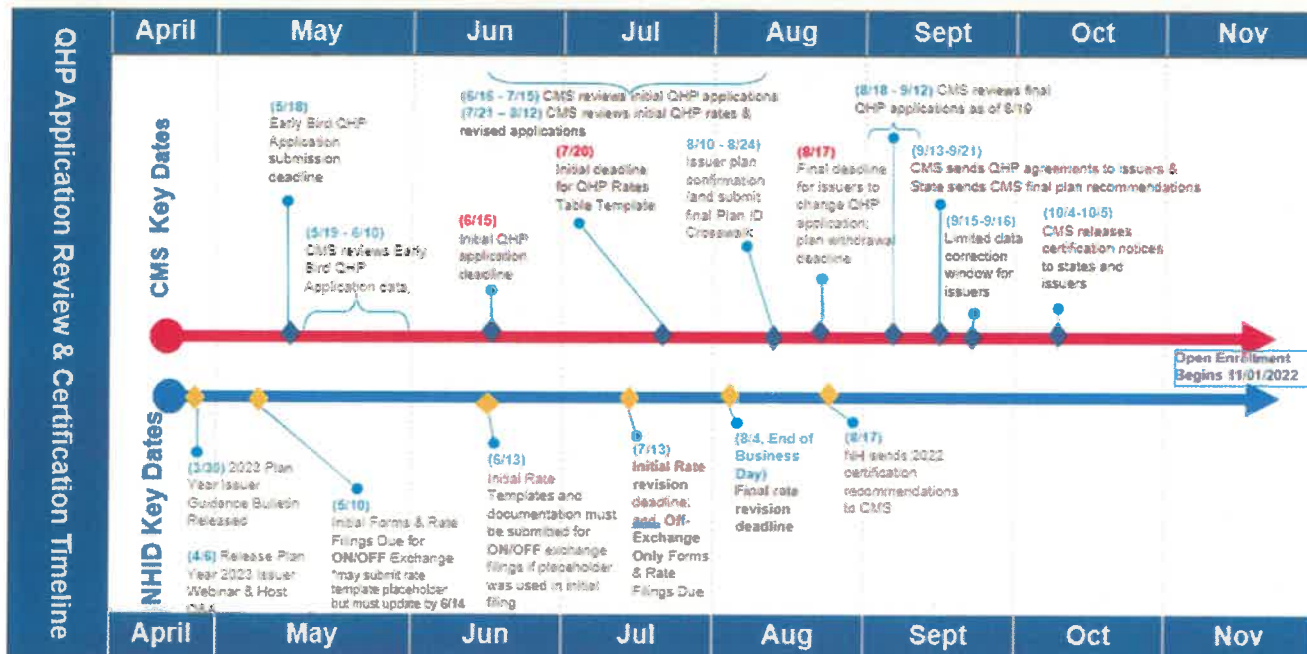
Health insurance issuers, as well as stand-alone dental issuers, requesting certification from the Centers for Medicare & Medicaid Services (CMS) must submit their initial applications (including all state-required templates, submissions, and form filings) with initial binder submissions no later than May 10, 2022.

### *B. Rate Filing Deadlines*

Issuers are permitted to file a rate template as a placeholder on or by May 10, 2022 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 13, 2022. Off-exchange only form and rate filings are due by July 13, 2022. Rate revisions for on-exchange plans are due on July 13, 2022. Final rate revisions are due by August 4, 2022.

The New Hampshire Insurance Department (NHID) will complete all reviews and make recommendations for certification by August 17, 2022. Any plan that is not certified under the below timeline (*Figure 1*) will be ineligible to be offered in the Marketplace during Plan Year 2023. Petition to CMS is required for changes to service area after initial submission.

# NHID QHP Timeline Plan Year 2023, as of 3/30/2022



New Hampshire Insurance Department | March 2022

Figure 1: NHID QHP Timeline Plan Year 2023

### C. Rate Filing Procedures

New Hampshire’s reinsurance program (Program), which is supported by a Section 1332 State Innovation Waiver, remains in place 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 are required to file two sets of rates and to include explanation of such rate assumptions in the actuarial memorandum for all plans eligible for participation in the Program<sup>1</sup>. 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](#).

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

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

#### A. Standardized Plans

If required in the final NBPP, issuers must offer standardized plans for the 2023 plan year at every product network type and metal level throughout each service area at which they offer non-standardized plans. The following standardized plan designs were outlined by CMS in the proposed NBPP for 2023: one Bronze plan, one expanded Bronze plan, one Silver plan, one of each of the income-based Silver Cost-Sharing Reduction (CSR) plan variations, one Gold plan, and one Platinum plan. Issuers should consult the proposed NBPP – and the final NBPP when issued - for the detailed standardized plan requirements that apply in New Hampshire. Issuers are not limited in the number of non-standardized plans they offer.

#### B. Coverage of Telehealth Services

The New Hampshire Telemedicine Act (RSA 415-J) requires 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 video and audio, audio-only, or other electronic media.

#### C. Catastrophic Plans and High-Deductible Health Plans

Issuers should 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.

#### D. 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 submission must include complete and accurate information in the fields included in the NETWORK TEMPLATE TAB. Issuers must adhere to requirements to ensure an accurate and timely review of network adequacy submissions. CMS released proposed review standards for network adequacy in the 2023 NBPP and Letter; as a result, at this time, issuers should use the existing filing process for PY 2023.

We strongly encourage issuers to review the guidelines prior to completing the template.

#### E. Cost Sharing

As CMS does annually, it has updated the maximum annual limits on cost sharing. The updates for 2023 were included [in guidance issued on December 28, 2021](#). Issuers are expected to comply with final cost sharing and maximum annual limits as set forth annually.

| Category  | 2023      |                      |
|---|-----------|----------------------|
|   | Self-only | Other than Self-Only |
| Maximum Annual Limit on Cost-Sharing  | \$9,100   | \$18,200             |
| Reduced Annual Limit on Cost-Sharing for Individuals between 100% and 150% of the Federal Poverty Level (FPL) | \$3,000   | \$6,000              |
| Reduced Annual Limit on Cost-Sharing for Individuals between 150% and 200% of the FPL                         | \$3,000   | \$6,000              |
| Reduced Annual Limit on Cost-Sharing for Individuals between 200% and 250% of the FPL                         | \$7,250   | \$14,500             |

*F. Actuarial Values for Metal Levels (De Minimis Variation)*

When designing plans, issuers must comply with the actuarial value (A/V) requirements for the applicable metal level. While “de minimis variation” from the A/Vs is permitted, the variation permitted has changed starting with Plan Year 2023. Issuers may file expanded Bronze plans that have A/Vs within +5/-2 percentage points and individual market Silver plans that have A/Vs within +2/0 percentage points. Plans filed in all other metal levels in the individual and small group markets may have A/Vs within +/-2 percentage points. Income-based cost-sharing reduction plans are limited to a variation of +1/0 percentage points.

*G. Prescription Drug Rebates*

By July 1<sup>st</sup> 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*

Issuer filings must comply with state and federal balance billing limitations. In addition to reviewing RSA 329:31-b, issuers should review the federal No Surprises Act 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.

For more information on the No Surprises Act and how it intersects with existing state law, issuers should consult the Insurance Department's bulletin [INS 21-103-AB, Federal No Surprises Act and State Balance Billing Protections](#).

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

#### *I. Transition Coverage*

On March 23, 2022, CMS released an [Insurance Standards Bulletin](#) extending the policy allowing issuers to renew transition coverage in the individual and small group markets for policy years beginning after October 1, 2022 and remaining in place indefinitely until CMS announces that such coverage must come into compliance. The Department is adopting that guidance subject to the 12-month rate guarantee period under RSA 420-G:4, I (a). Issuers must comply with notice requirements outlined in the CMS guidance.

#### *J. Discriminatory Benefit Design*

The Department intends to comply with new Essential Health Benefits (EHB) standards that require the EHB design (1) to be based on clinical evidence, (2) to be supported by evidence-based guidelines, and (3) to rely upon current and relevant peer-reviewed medical journal articles, practice guidelines, or other reputable sources, as finalized in the forthcoming final NBPP or Letter for Plan Year 2023.

### **IV. Contact Information**

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