The State of New Hampshire
Insurance Department
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Commissioner

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BULLETIN
Docket #INS 25-023-AB

TO: All New Hampshire Licensed Health and Dental Insurers
FROM: Commissioner David J. Bettencourt
DATE: March 17, 2025
RE: 2026 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 2026 (NBPP) and the draft 2026 Letter to Issuers in the federally-facilitated exchanges (Letter) but is subject to revision for further state and federal guidance.

Issuers planning to introduce a new product or network or discontinuing an existing plan in Plan Year 2026, 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 Victoria Fowler at the New Hampshire Insurance Department (NHID), Victoria.W.Fowler@ins.nh.gov or by phone at 603-271-4080.

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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); apply the standards, and enforce the consumer protections and market reforms set forth in the Affordable Care Act (ACA) (NH RSA 420-N:5) 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 ACA establishes the legal authority for qualified health plan (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 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 1, 2025.

b. Rate Filing Deadlines

Issuers are permitted to file a rate template as a placeholder on or by May 1, 2025, 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 9, 2025. Off-exchange only form and rate filings are due by June 23, 2025. Rate revisions for on-exchange plans are due on July 9, 2025. Final rate revisions are due by July 31, 2025.

The NHID will complete all reviews and make recommendations for certification by August 13, 2025. Any plan that is not certified under the below timeline (Figure 1)

will be ineligible to be offered in the Marketplace during Plan Year 2026. Petition to CMS is required for changes to service area after initial submission.

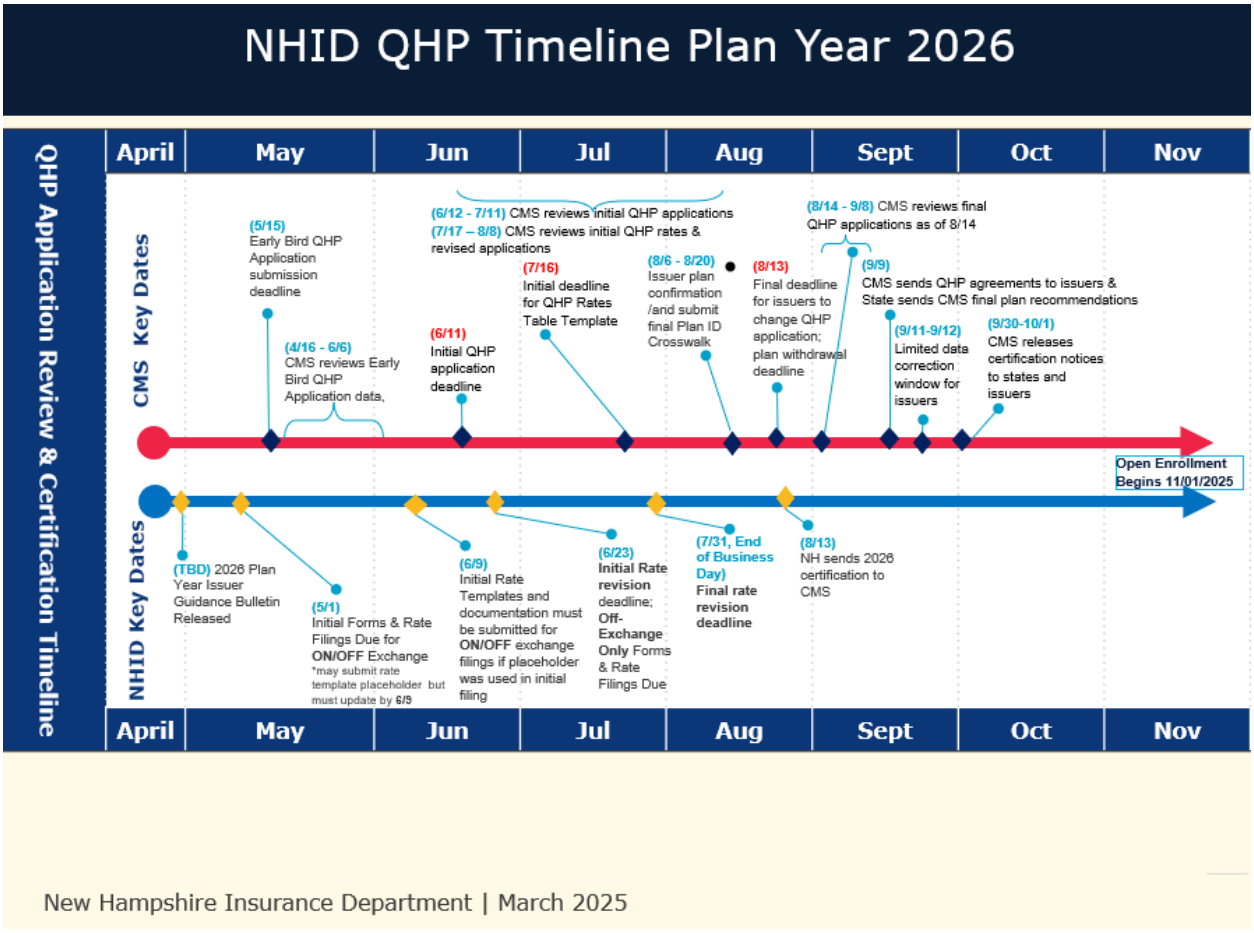

Figure 1: NHID QHP Timeline Plan Year 2026

c. Rate Filing Procedures

New Hampshire's Reinsurance Program (Program) is supported by a Section 1332 State Innovation Waiver. For all years that the Program is in place and for federal pass-through funding calculation purposes, individual market issuers are 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. 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. The "without waiver" rates should consider the cumulative impact of the Program payments and should not allocate the Program impact to any particular services. As such, there should only

be one URRT template submitted for each "with waiver" and "without waiver" scenario. Additional information regarding the Program and its annual parameters can be found on the New Hampshire Health Plan (NHHP) website at https://nhhp.org/historical-governance-documents/governance-documents-nh-reinsurance-program/.

Under the American Rescue Plan Act (ARPA) in 2021, advanced premium tax credits (APTCs) were temporarily expanded to provide increased financial assistance to people buying health insurance through the ACA Marketplaces. These enhanced subsidies were extended by the Inflation Reduction Act (IRA) in 2022 and are currently set to expire after 2025. Extension of these APTCs past 2025 will require an act of Congress. Although there are currently efforts underway to extend these APTCs, it is uncertain whether these efforts will be successful. Therefore, New Hampshire will be requiring all on-exchange plans to file two sets of rates, one set assuming the APTCs are extended and one set assuming the APTCs are not extended. Each set of rates will need have "with waiver" and "without waiver" rates included. Thus, NHID will require a total of 4 rates as summarized in the chart below:

APTCs are extended	"With waiver" rates
	"Without waiver" rates
APTCs are NOT extended	"With waiver" rates
	"Without waiver" rates

Because the URRT tab can only be used on one rate filing per period, per company, per market type, the issuer will need to submit one template with URRT and the other template without URRT (checkbox unchecked). The URRT tab that is checked should be the rates assuming the APTCs are not extended.

III. Guidance to Issuers on Select QHP Requirements

a. Cost Sharing

As CMS does annually, it has updated 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.

Category	2026	
		Other than Self-Only
Maximum Annual Limit on Cost-Sharing	$10,150	$20,300
Individuals eligible for CSR's under § (household income greater than or equal to 100% and less than or equal to 150% or	$3,350	$6,700
Silver 87% AV* CSR Plan Variant: Individuals eligible for CSR's under § 155.305(g)(2)(ii) (household income greater than 150% and less than or equal to 200% of FPL)	$3,350	$6,700
Individuals eligible for CSR's under § (household income greater than 200% and less than or equal to 250% of FPL)	$8,100	$16,200

*Under Section 1402(d) of the ACA, American Indian/Alaska Native (AI/AN) enrollees with incomes under 300% of FPL are eligible for Zero Cost Sharing plan variants. Additionally, all AI/AN QHP enrollees are eligible for no cost sharing for items and services provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services. Under § 155.305(g)(1)(ii), all other enrollees must be enrolled in a silver plan variant to be eligible for cost-sharing reductions.

b. Prescription Drug Rebates

By March 1st of each year, 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. The report must be submitted via email to our Data Analytics Team address at: healthcareanalytics@ins.nh.gov.

Please refer to Bulletin INS 24-067-AB (https://mm.nh.gov/files/uploads/nhid/documents/20241024-bulletin-ins-24-067-ab.pdf) for further information related to rebates and details regarding the reporting requirements.

c. Network Adequacy

For PY2026, issuers shall complete and submit the Network Adequacy template for each QHP filing. The new template, along with guidelines, can be found on the NHID website at https://www.insurance.nh.gov/about-us/life-health-division.

In addition, on-exchange plans are required to meet both state and federal appointment wait time standards. State appointment wait time standards can be found in Administrative Rule Ins 2701.09 and the federal standards can be found in Chapter 2, section 3.ii.b of the 2023 Letter to Issuers. The table below summarizes the appointment wait time standards for various services in New Hampshire along with the applicable authority for each:

Service Type	Appointment Wait Time	Authority
Primary Care (Routine)	15 business days	Federal
Primary Care (Urgent)	48 hours	State
Behavioral Health (Non-urgent)	10 business days	Both
Behavioral Health (Urgent)	48 hours	State
Specialty Care (Non-urgent)	30 business days	Federal

If an issue is identified, form reviewers will reach out to the carrier directly to discuss any required corrective action(s) necessary.

d. Mental Health Parity Quantitative Treatment Limits (QTL) Reporting Tool

Issuers will be required to complete and submit the NHID QTL Reporting tool starting this year. Issuers must complete the tool for each QHP plan and submit the completed tool through SERFF. The QTL Reporting Tool and Instructions for completing the template can be found on the NHID website.

The purpose of this tool is for insurers to demonstrate that their plans are in compliance with the Mental Health Parity requirements under the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The tool will review Quantitative Treatment Limitations and financial requirement (QTL) testing outcomes.

The QTL tool will be due on May 1, 2025, along with the application. The tool can be found at our website: https://mm.nh.gov/files/uploads/nhid/documents/nh-mhpea-tool.xlsx.

Please submit the tool for every plan in the Binder.

When completing the template, all covered services must be listed and should include all services that are listed in the Certificate of Coverage. Projected claims should be reported as a total dollar amount and not on a "PMPM" basis. Projected claims should be based on plan level, but a product may be used if there is insufficient experience. The methodology used to estimate claims must be

reasonable and in compliance with applicable Actuarial Standards of Practice. If a plan has a tiered network, all tiered information must be included, as well as an explanation about what qualifies as a tier (see 45 CFR 146.136 and Fact Sheet & FAQ, multiple network tiers at https://www.cms.gov/marketplace/resources/fact-sheets-faqs).

Detailed instructions as to how to complete the template are located on the first tab of the tool. Results are auto-populated based on what information is provided for each covered service.

For PY2026, NHID will be requiring the QTL tool to be submitted for ALL plans (small-group, non-QHP etc.)

e. Drug Tools

As in years past, issuers are required to run the Essential Health Benefit (EHB) Category and class Drug Count Tool, the Adverse Tiering Tool, and the Non-Discrimination Clinical Appropriateness Tool. NHID will be verifying the results of these tools and submitting further inquiries to the carriers related to justifications, as warranted.