

Arkansas Insurance Department

Asa Hutchinson
Governor



Allen Kerr
Commissioner

BULLETIN NO. 3-2015

TO: ALL LICENSED INSURERS, HEALTH MAINTENANCE ORGANIZATIONS (HMOs), FRATERNAL BENEFIT SOCIETIES, FARMERS' MUTUAL AID ASSOCIATIONS OR COMPANIES, HOSPITAL MEDICAL SERVICE CORPORATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRODUCER AND COMPANY TRADE ASSOCIATIONS, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: 2016 PLAN YEAR REQUIREMENTS FOR QUALIFIED HEALTH PLAN CERTIFICATION

DATE: February 3, 2015

The Affordable Care Act (ACA) requires that all issuers and plans participating in the Federally-facilitated Marketplace Plan Management Partnership (Partnership) and the Arkansas Health Insurance Marketplace (AHIM) for SHOP plans meet federal and state certification standards for Qualified Health Plans (QHPs). The Arkansas Insurance Department (AID) and AHIM will require QHP Issuers to meet all state licensure requirements and regulations, as well as state specific plan and QHP requirements and regulations. QHP Issuers will also be responsible for all other State and Federal regulations already prescribed to insurance companies in today's market. The purpose of this Bulletin is to define the plan year 2016 federal and state requirements for QHP certification in the Arkansas individual and SHOP Health Insurance Marketplace. Though this Bulletin attempts to provide a cohesive source of information for both the state and federal requirements, issuers are advised to consult with the federal regulations, 2016 Issuer Letter, and state law in conjunction with this Bulletin to ensure full compliance.

Health insurance issuers should submit their applications to become QHP or Stand Alone Dental (SAD) Issuers together with form filings by March 15, 2015. AID is currently working with SERFF to determine the feasibility of granting additional time for template filings past March 15, 2015. Rate filings for new plans and QHPs seeking recertification must be submitted by SERFF by April 14, 2015. AID will review issuer applications and will submit all applications to CMS for certification by April 15, 2015; approved plan changes or revisions must be completed two days prior to submission. Due to the earlier federal required plan submission date, final recommendations of plans and rates may not be available prior to June 26, 2015. The 2016 open enrollment period is October 1, 2015 to December 15, 2015.

All issuers waiting until the final deadline to submit their application to offer a QHP should be aware that AID will review plans in the order received. Any plans not having undergone complete review and gaining state approval for recommendation prior to June 26th will be ineligible for offering a QHP through the Marketplace during the 2016 Open Enrollment Period. Issuers will be given an opportunity to address any data errors during the plan preview periods as designated by CMS. No changes will be allowed to QHP data after June 26, 2015, unless necessary to correct data errors or align QHPs with products and plans approved by the state. All such changes must be pre-approved by both CMS and AID. CMS will notify all issuers of the QHP Certification decision and complete the certification agreement in late August 2015 according to the timeline below.

Tentative QHP Application and Certification Timeline

2015 Key Dates	Description
February 15 th – March 15 th	QHP Applications must be submitted to AID by March 15 th
March 16 th – April 15 th	AID QHP Review Period
April 15 th – May 26 th	FFM Reviews Plan Data
May 27 th	FFM Notifies States of any Needed Corrections to QHP Data
June 6 th	Last date for Issuers to Resubmit Plan Data into SERFF
June 9 th	2nd SERFF Data Transfer
June 10 th – July 14 th	FFM Completes Re-review of Plan Data and State Recommendations
July 15 th	FFM Notifies States of any Needed Corrections to QHP Data
July 20 th	Final Deadline for Submission of QHP Data;
July 24 th	Final Deadline for State Plan Approval; Deadline for All Risk Pools with QHPs to be in “Final” Status in the URR System; Data Locked Down
July 27 th – August 14 th	Final FFM Review of Corrected QHP Application Submissions Received as of July 24
August 17 th – September 15 th	Certification Notices and QHP Agreements Sent to Issuers, Agreements Signed, QHP Data Finalized
October 1 st	Open Enrollment Begins

QHP Certification and Recertification Overview

All plans offered in the Marketplace must be certified (or recertified) prior to open enrollment, including stand-alone dental plans (SADPs)¹. All application materials are required for first-time certification applications as well as those plans currently offered in the marketplace submitted for recertification. The recertification process will largely resemble the initial certification process in that all application materials must be resubmitted. AID and CMS will review plans for compliance with QHP certification requirements.

A plan that was certified for plan year 2015 can maintain the same plan and HIOS identification numbers for plan year 2016 if there are no changes to the plan, unless the changes are considered *uniform modifications* under PHSA Sections 2702 and 2703 and subsequent proposed regulations². Uniform modifications include any changes pursuant to Federal or state law, including increasing annual limitations on cost-sharing as a result of the application of the premium adjustment

¹ Stand Alone Dental Plans offered outside the exchange in conjunction with medical plans in order to satisfy the pediatric dental EHB requirement must also be reviewed through the same certification process up to the point of certification agreement.

² Individual Regulations: 45 CFR 148.122; Group Regulations: 45 CFR §146.152

percentage. If the changes are not due to Federal and state law, then they may still meet the *uniform modification* criteria if the plan:

- Is offered by the same health insurance issuer and is the same product type (i.e. PPO or HMO);
- Covers a majority of the same counties in its service area;
- Maintains the same cost-sharing structure, except for actuarial adjustments that are a result of cost and utilization of medical care or in order to maintain the same A/V level of coverage; and
- Provides the same covered benefits, unless changes to benefits impact the rates only \pm 2%.

Further recertification guidelines will be found in the filing instructions posted in SERFF. Applications for recertification should include a redlined version of the plan forms and a written justification for any changes to cost-sharing and covered benefits.³

Memorandum of Understanding between Issuers and the Arkansas Insurance Department and Division of Medical Services

QHP Issuers must enter into a Memorandum of Understanding (MOU) with the Arkansas Department of Human Services, Division of Medical Services (DMS) and AID which outlines coverage coordination procedures, data and financial transactions, and reporting requirements for the Health Care Independence Program. QHP Issuers must agree to provide DMS and AID with information necessary to evaluate the Healthcare Independence Program in accordance with 1115 CMS Waiver evaluation requirements as reflected in the MOU. The MOU will include timeframes for quality reporting and other reporting as required. A draft form MOU is available from AID upon request. Please send requests to insurance.exchange@arkansas.gov.

Federal and State QHP Certification Standards

The table below outlines updated Federal and state QHP certification standards for plan year 2016.

General Requirements	
<p>Federal Standard 45 CFR §§ 153.400, 153.410 45 CFR. § 153.610 45 CFR § 147.104 45 CFR § 147.106 45 CFR 155 and 156 45 CFR 156.20 42 USC §18021 42 USC §18022 42 USC §18031 CMS Guidance Rules ACA §1311 ACA §1002 ACA § 1341</p>	<p>A QHP Issuer must—</p> <ol style="list-style-type: none"> (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in Arkansas; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agree to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through the Marketplace or whether the plan is offered directly from the issuer or through an agent;

³ A template for submission of plan change justifications will be posted in SERFF.

<p>ACA § 1343 45 CFR §155.420</p>	<ul style="list-style-type: none"> (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in annual open enrollment periods, as well as special enrollment periods for both individual and SHOP marketplace in accordance with 45 CFR §155.420 and CMS guidance; (10) Collect enrollment information, transmit such to the Marketplace and reconcile enrollment files with the Marketplace enrollment files monthly; (11) Provide and maintain notice of termination of coverage. A standard policy must be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency must be provided; (12) In the case of a decision to not seek recertification or plan discontinuation: <ul style="list-style-type: none"> a. Notify the Marketplace of its decision with at least a 90-day notice; b. Fulfill coverage obligations through the end of the plan/benefit year; c. Fulfill all data reporting obligations; d. Provide 90-day written notice to enrollees of discontinuation using the HHS standard notice of product discontinuation (to be finalized by HHS); and e. Terminate coverage for enrollees; (13) In the event that the QHP becomes decertified, terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage; (14) Upon plan renewal, provide standardized notice to consumers using the HHS standard notice of renewal (to be finalized by HHS); (15) Meet all readability and accessibility standards; (16) Pay the same commission to producers and brokers for the sale of plans inside the SHOP as to similar plans sold in the outside market; (17) Comply with market reform rules, including premium rating rules, guaranteed availability, guaranteed renewability, and single risk pool requirements. (18) Per guaranteed availability, provide a matching benefit plan and price off of the Marketplace for any plan certified as a QHP; (19) Participate in the reinsurance program, including making reinsurance contributions and receiving reinsurance payments; and (20) Participate in risk adjustment; and (21) Provide plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights to the Marketplace, HHS, and the Commissioner.
<p>State Standard</p>	<p>AID will review forms, templates, and rates for compliance with federal and state rules and regulations and will recommend the plan for certification to CCIIO. AID will review the pricing of all QHPs to ensure</p>

	<p>that the plans are adequately and appropriately priced for the Arkansas Marketplace. Certification will be valid for a period of one (1) plan year. If an issuer wishes to continue offering a certain QHP following that plan year, the issuer must apply to have that QHP recertified. Specific state rate and form filing requirements for plan year 2016 submissions will be posted in SERFF.</p>
Licensure and Solvency	
<p>Federal Requirements 45 CFR 156.200</p>	<p>A QHP Issuer must be licensed and in good standing with the State. The QHP Issuer must attest via the CMS State Partnership attestation form that it meets this requirement. Additionally, all complaints and QHP Issuer oversight findings from the prior plan year will be considered as a part of good standing determination.</p>
<p>State Requirements A.C.A § 23-63-202</p>	<p>AID determinations of good standing will be based on authority found in Ark. Code Ann. § 23-63-202. To be found in good standing, a QHP Issuer must have authority to write its authorized lines of business in Arkansas. AID is the sole source of a determination of whether an issuer is in good standing and may as a part of that finding restrict the QHP Issuer’s ability to issue or renew existing coverage for an enrollee.</p> <p>An issuer entering the AR marketplace in 2016 will be allowed to apply for Arkansas licensure and QHP Issuer and plan certification simultaneously; however, a QHP Issuer may not be certified for participation in the Marketplace until state licensure has been established. All licensure activities must be completed by close of business June 26, 2015.</p>
Network Adequacy	
<p>Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)</p>	<p>A QHP Issuer must ensure that the provider network of each of its QHPs is available to all enrollees. QHP Issuers will need to attest that they have met this standard and have a provider network with a sufficient number and type of providers, including providers that specialize in Mental Health and Substance Use Disorders. Additionally, issuers are required to submit a provider list in a format to be specified by CMS. CMS has indicated that the provider types likely to have the most in-depth review include hospital systems, mental health providers, oncology providers, and primary care providers.</p> <p>Additionally, at least 30% of available essential community providers (ECP) within the QHP’s service area must participate in the provider network and the QHP issuer must have offered contracts to at least one ECP in each ECP category in each county in the service area where that type of category is available and to all available Indian health providers in the service area. To be in compliance with the ECP requirement, QHP Issuers must contract with the corporate entities named on the CMS list that can be found at http://cciio.cms.gov/programs/exchanges/qhp.html. Additional ECPs may be added through the “write-in” process which is described in more detail in the letter to issuers.</p> <p>Federally-Qualified Health Centers (FQHC) are considered ECPs and a complete dataset of Arkansas FQHCs will be available in SERFF filing instructions.</p>

	<p>Plan networks that fail to meet the 30% ECP requirement will be required to submit a justification form. Required format and contents for the justification can be found in Appendix A.</p>
<p>State Standard Rule 106</p>	<p>In addition to the federal attestation and submission standards, AID has established state network adequacy targets found in Rule 106.</p> <p>According to the AID network adequacy standard, issuers must comply with one of the options below:</p> <ul style="list-style-type: none"> • The QHP Issuer provides evidence that it has accreditation from an HHS-approved accrediting organization that reviews network adequacy as a part of accreditation and submits annual GeoAccess Maps and performance metrics as required in Rule 106; or • The QHP Issuer must meet QHP Network Adequacy standards for non-accredited issuers and must provide documentation to demonstrate network adequacy. <p>Arkansas network adequacy requirements include standards such as distance targets for primary, behavioral health, and specialty providers; submission guidelines for GeoAccess maps, performance metrics, and network access policies and procedures; and standards for online provider directories. Additional state network adequacy standards include the following:</p> <ul style="list-style-type: none"> • Inclusion of school-based providers as “Other” ECP type and submission of a list of school-based providers; and • Requirement that at least one FQHC or Rural Health Center (RHC) is available in each regional service area of the plan network.
Accreditation	
<p>Federal Standard 45 CFR 156.275 45 CFR 155.1045</p>	<ul style="list-style-type: none"> • QHP Issuers, excluding SAD Issuers, must maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁴ survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs. • The State Partnership Marketplace will accept existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities. For the purposes of QHP Issuer certification for plan year 2016, these are the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) of HHS.

	<p>Ambulatory Health Care (AAAHC).</p> <ul style="list-style-type: none"> • To verify the accreditation information, QHP Issuers must upload their current and relevant accreditation certificates. • QHP Issuers must attest that they approve the use of accreditation data to be displayed on the Marketplace website. • QHP Issuers without existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities must schedule an accreditation review during their first year of certification and receive accreditation on QHP Issuer policies and procedures prior to their second year of QHP Issuer certification. • Plans certified in the first year must have their policies and procedures that are applicable to its Marketplace products accredited by time of recertification; accreditation status will be determined by the issuer accreditation status as of submission of the QHP application. If plans were already accredited, the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP. • Prior to the QHP Issuer’s fourth year of QHP Issuer certification and in every subsequent year of certification, a QHP Issuer must be accredited in accordance with 45 CFR 156.275.
State Standard	<p>AID will follow the Federal requirements related to accreditation. QHP Issuers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to AID and the State Partnership Marketplace.</p>
Service Areas and Rating Areas	
<p>Federal Standard 45 CFR 155.30 & 155.70 45 CFR §156.255</p>	<p>Service area for the Individual Marketplace is the geographic area in which an individual resides. Service area may additionally be the geographic area where an individual is employed for the purposes of SHOP. A QHP Issuer must specify what service areas it will be utilizing. The service area must be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations. Changes in service area will not be permitted except in limited circumstances such as to address limitations in provider contracting, expansions at the request of the state or CMS, or to address a data error in the issuer’s initial service area template.</p> <p>As it applies to QHPs, the ACA defines a “Rating Area” as a geographic area established by a state that provides boundaries by which issuers can adjust premiums. The ACA requires that each state establish one (1) or more rating areas, but no more than nine (9) rating areas within the State of Arkansas based upon its metropolitan areas, for purposes of applying the requirement of this title.</p>

<p>State Standard</p>	<p>QHP service areas will have the same geographic boundaries as rating areas as defined in Appendix B. However, an issuer’s service area may contain more than one rating area, thus an issuer may offer plans with a statewide service area while modifying rates based on allowed rating areas within that service area. Arkansas has a policy goal of issuers competing on a statewide basis.</p> <p>For the 2016 Plan Year, the state will allow QHP Issuers to choose their service area(s). The Commissioner reserves the right to require broader service areas. Any application not meeting this standard requires a justification as to why the QHP should be considered for certification and will be subject to stricter review and/or non-certification.</p> <p>AID will continue to use a configuration of seven (7) rating areas to be utilized in Arkansas. These areas are specifically described in Appendix B.</p>
<p>Quality Improvement Standards</p>	
<p>Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717 45 CFR 156.1110 42 C.F.R. 482.21 42 C.F.R. 482.43</p>	<p>A QHP Issuer must attest that it has implemented and will report on certain quality improvement strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of:</p> <ul style="list-style-type: none"> • A payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the family centered medical home model, for treatment or services under the plan or coverage; • Activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings; and • Compliance with transitional regulations in 45 CFR Section 156.1110 to document that all hospitals with greater than 50 beds is Medicare certified or issued a Medicaid only CMS Certification Number subject to the Medicare Hospital Condition of Participation requirements for quality assessment as specified in

	42 CFR 482.21 and discharge planning as specified in 42 CFR 482.43.
State Standard Rule 108	<p>In order to advance quality and affordability, Arkansas requires participation in the Arkansas Payment Improvement Initiative. As part of the participation requirements for Plan Year 2016, QHP issuers will at a minimum assign a primary care clinician; provide support for Patient Centered Medical Homes; and provide access to clinical performance data for providers. See Rule 108 for additional guidelines regarding support for Patient Centered Medical Homes. Participation in the Arkansas Payment Improvement Initiative will also include a requirement to contribute claims and encounter data for the purposes of measuring cost, quality and access. Timing and processes related to these requirements will be established in guidance from AID and/or established in an MOU agreement between the issuer and the Division of Medical Assistance and Arkansas Insurance Department.</p> <p>Additionally, AID will begin its Pilot Quality Review during the 2016 Plan Year submission period. Details related to this pilot can be found in Bulletin 1-2015.</p>

General Offering Requirements

<p>Federal Standard 45 CFR §155 and 156 45 USC §18022 45 C.F.R. § 156.130(a) 45 CFR §147.126 45 CFR §147.120 45 CFR §147.138 CMS Guidance Rules IRS Revenue Procedure 2013-25 Letter to Issuers</p>	<p>Levels of Coverage</p> <p>For participation in the Individual Marketplace, a QHP Issuer must offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level and a child-only plan at the same level of coverage as any QHP offered through the individual Marketplace to individuals who, as of the beginning of the plan year, have not attained the age of 21. This requirement may also be met by submitting an attestation that there is no substantive difference between having a child-only plan and issuing child only policies, and that the QHP Issuer will accept child only enrollees. Additionally, QHP Issuers may choose to offer a bronze or platinum metal level plan or a catastrophic plan. Catastrophic plans can be sold to individuals that have not attained the age of 30 before the beginning of the plan year; or an individual who has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. Child-only plans are not required to be offered at the catastrophic level of coverage. Additionally, catastrophic plans are required to provide no benefits for any plan year until the maximum out-of-pocket is reached, with the following exceptions: 1) Preventive health services in accordance with section 2713 of the PHS Act; and 2) At least 3 primary care visits per year.</p> <p>QHP Issuers participating in SHOP must also offer at least one QHP in the silver and at least one QHP in the gold coverage level. Bronze and Platinum plans may also be made available. Child only and Catastrophic plans will not be offered in the SHOP.</p> <p>The actuarial metal level and child-only plan requirements do not apply to SADPs. SADPs must submit plans at either the <i>low</i> actuarial value (70%) or <i>high</i> actuarial value (85%). However, SADPs are not required to submit both <i>low</i> and <i>high</i> A/V plans.</p>
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All plans must meet the AV requirements as specified in 45 CFR 155 and will be verified by use of the AV Calculator.

Meaningful Difference

All offerings by a QHP Issuer, excluding stand alone dental issuers, on a single metal tier must show a meaningful difference between the plans and comply with standards in the best interest of the consumer. CMS has expanded the definition of meaningful difference to state:

“A plan is considered meaningfully different from another plan in the same service area and metal tier (including catastrophic plans) if a reasonable consumer would be able to identify one or more material differences among the following characteristics between the plan and other plan offerings:

- (1) Cost sharing;*
- (2) Provider networks;*
- (3) Covered benefits;*
- (4) Plan type;*
- (5) Health Savings Account eligibility;*
- or*
- (6) Self-only, non-self-only, or child- only coverage offerings.”*

Exceptions to this standard are outlined in § 156.298 (c) and (d).

Summary of Benefits and Coverage (SBC)

QHPs are required to provide the Summary of Benefits and Coverage (SBC) in manner compliant with the standards set forth in 45 CFR 147.200 requiring that all group health plans and health insurance issuers offering group or individual health insurance coverage compile and provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. CMS expects that all URL links on the SBC to be easily accessible to consumers, including shoppers and link directly to the information referenced on the SBC. Issuers will be required to create separate SBCs for each plan variation and will not be allowed to combine information on multiple plan variation in one SBC.

Dependent Coverage

The QHP, excluding pediatric dental, must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. Pediatric dental and vision is required to cover dependents to age 19. The QHP must cover emergency services with no prior authorization and no limitation to participating or in-network providers. Emergency services, whether in or out-of-network, must be covered at in-network cost-sharing level.

Cost Sharing Limitations

QHP Issuers will be required to meet all annual maximum out-of-pocket limitations and cost-sharing requirements applicable to all plan metal levels. The annual limitation on cost sharing for embedded plans in the 2016 plan year will be \$6,850 for self-only coverage and \$13,700 for family coverage. For small group market plans, Issuers may establish separate out-of-pocket limits for medical and dental coverage as long as the total out-of-pocket limit does not exceed the total QHP limit for high deductible health plans. Moreover, the QHP must contain no lifetime or annual limits on the dollar value of any EHB, including the specific

	<p>benefits and services covered under the EHB-Benchmark Plan. Note that reasonable dollar limits for services are allowed, as long as there is no associated service or visit limit.</p> <p>SADPs must demonstrate that they have a reasonable annual limitation on cost sharing. For 2016, “reasonable” means any annual limitation on cost sharing that is at or below \$300 for a plan with one child enrollee or \$400 for a plan with two or more child enrollees.</p> <p>SHOP Tying Provision If a QHP Issuer would like to participate in the individual market, the QHP Issuer must also participate in the SHOP if the following requirements are met:</p> <ul style="list-style-type: none"> • The QHP Issuer offers products in the small group market and has at least a 20% market share in the small group market; or • The QHP Issuer is part of a holding company that also owns other issuers that participate in the small group market and that have at least a 20% market share of the small group market. <ul style="list-style-type: none"> • If the QHP Issuer under this example does not currently participate in the small group market, the affiliated QHP Issuer holding at least 20% of the small business market must participate in the SHOP. • If the QHP Issuer under this example does participate in the small group market, the QHP Issuer must participate in SHOP. <p>If a QHP Issuer offers a QHP in the SHOP, the QHP issuer will not be required to offer a QHP in the individual market.</p> <p>Third Party Payment of QHP Premiums</p> <p>CMS has published an interim final rule in 45 CFR §156.1250 regarding acceptance of certain third party payments. Issuers are required to accept premiums from Ryan White HIV/AIDS programs, Indian tribal organizations, and State and federal government programs (such as the Healthcare Independence program).</p>
<p>State Standard</p>	<p>Specific state rate and form filing requirements for plan year 2016 submissions will be posted in SERFF.</p> <p>In addition to federal requirements that at least one silver and at least one gold plan are offered in the individual market, QHPs in the Arkansas individual market are required to include at least one silver-level plan that contains only the EHBs included in the state base-benchmark plan.</p> <p>Riders are not permitted to be offered in conjunction with Marketplace plans, even if the riders are for non-EHB benefits.</p> <p>AID requires that all QHP Issuers offering a plan which has pediatric dental imbedded as part of its benefits also offer an identical plan which does not include pediatric dental as part of its benefits. This requirement will be null and void and all QHP Issuers will be required to have an imbedded pediatric dental benefit should no SADPs become certified on</p>

	the Marketplace.
Additional Healthcare Independence Program Requirements	
State and Federal Requirements Act 1498 of 2013 CMS 1115 Waiver	<p>All carriers participating in the Arkansas Health Insurance Marketplace must participate in the Health Care Independence Program by offering coverage conforming to the applicable requirements of the Arkansas Healthcare Independence Act of 2013, including:</p> <ul style="list-style-type: none"> • Offering silver-level plans restricted to cost-sharing amounts that do not exceed Medicaid cost-sharing limitations (see Appendix C for High (94% AV) Silver cost-sharing requirements); • Maintaining at least an 80% MLR ratio for individual and small group policies; and • Participation in the Arkansas Payment Improvement Initiative’s Patient Centered Medical Home model as defined in the Arkansas State Innovation Plan. See Rule 108. <p>The Healthcare Independence Act additionally establishes cost-sharing and Independence Accounts for individuals between 50% and 138% FPL. Legislation has been introduced that would exempt those between 50-99% FPL from participation in Independence Accounts. Should this legislation be passed, cost sharing will revert to Plan Year 2014 levels with those above 100% FPL having 94%AV Silver Plans and Independence Accounts and those below 100% FPL having 100% AV Plans with no Independence Accounts.</p>
Essential Health Benefit Standards	
Federal Standards 45 CFR 156.115 42 U.S.C. § 18022 45 CFR §147.130 45 CFR §148.170 45 CFR §155.170 45 CFR §156.110 45 CFR §156.125 AR 23-79-156	<p>The QHP Issuer must offer coverage that is substantially equal to the coverage offered by the state’s base benchmark plan. QHP issuers are required to attest that plans are in compliance with all EHB standards</p> <p>A QHP Issuer is not permitted to offer elective abortion coverage within QHPs except for meeting requirements of the Hyde Amendment. If the QHP Issuer chooses to offer abortion benefits, public funds may not be used to pay for these services unless the services are covered as part of the Hyde Amendment exceptions. The QHP Issuer must provide notice through its summary of benefits if such benefit is being made available.</p> <p>The QHP must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention).</p> <p>Additionally, coverage for the medical treatment of mental illness and substance use disorder must be provided under the same terms and conditions as that coverage provided for other illnesses and diseases.</p> <p>Finally, any state mandates in effect as of December 2011 must apply as an EHB in the same way they apply in the current market. These benefits,</p>

	<p>as with all EHBs, must be offered without annual or lifetime dollar limitations.</p> <p>CMS expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, that are specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number or otherwise navigate the issuer’s website before locating it. If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHP(s).</p>
<p>State Standards A.C.A § 23-79-1502</p>	<p>AID adopted the Health Advantage Point of Service Plan as the Base Benchmark Plan to set the essential health benefits for Arkansas. AID substituted the mental health benefit with the Federal QualChoice Mental Health Benefit. AID also supplemented the Health Advantage Plan with the AR Kids B (CHIP) pediatric dental and vision plans. Finally, AID has adopted a definition of habilitative services, which may be found in Appendix D to this Bulletin along with guidelines for establishing parity with rehabilitative services.</p> <p>A detailed checklist of benefits included in the Arkansas state benchmark plan can be found in SERFF.</p> <p>Additional EHBs</p> <p>In-vitro fertilization is a mandated AR benefit for PPO plans and is considered an EHB for those plans, because mandates applicable to the individual market prior to December 2011 continue to apply to plans in the individual market, even if the state benchmark plan is a small group plan.</p> <p>Due to Arkansas statutory language and the CCIIO requirement that riders not be allowed with any filing, TMJ and Hearing Aids will be considered Essential Health Benefits and must be included in all QHPs, unless the plan is an HMO not subject to the AR mandatory hearing aid offering requirement or a SADP not subject to medical EHB requirements.</p>
Essential Health Benefit Formulary Review	
<p>Federal Standards 45 CFR 156.120 45 CFR §156.295</p>	<p>The QHP must cover at least the greater of one drug in every U.S. Pharmacopeial Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan. Issuers must attest to compliance with benefit standards, including formulary drug list.</p> <p>Issuers must report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or issuer); percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the issuer; total</p>

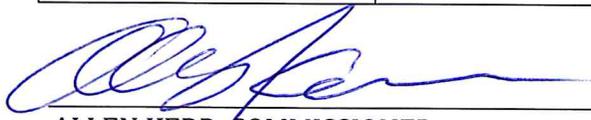
	number of prescriptions that were dispensed; aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
State Standards	Issuers must: (1) provide response by telephone or other telecommunication device within 72 hours of a request for prior authorization, and (2) provide for the dispensing of at least a 72-hour supply of covered drugs in an emergency situation.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 CFR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	<p>(1) A QHP Issuer must:</p> <ul style="list-style-type: none"> • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits, including a review across multiple benefit categories that are associated with the treatment of specific medical conditions such as bipolar disorder, diabetes, HIV, rheumatoid arthritis and schizophrenia; and • Refrain from: <ul style="list-style-type: none"> ○ Adjusting premiums based on genetic information; ○ Discriminating with respect to its QHP on the basis of race, color, national origin, disability, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; ○ Utilizing any preexisting condition exclusions; ○ Requesting/requiring genetic testing; ○ Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes; or ○ Placing all or most drugs for a specific condition on the highest cost tiers. <p>(2) A QHP Issuer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.</p> <p>Outliers in benefit design with regards to QHP cost sharing as part of its QHP certification reviews to target QHPs for more in-depth reviews will be identified. Specific focus areas identified by CMS include: Inpatient hospital stays, inpatient mental/behavioral health stays, specialist visits, emergency room visits, and prescription drugs. With respect to prescription drugs, CMS has indicated they intend to review plans that are outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class. CMS also will review the drugs for clinical appropriateness to</p>

	<p>ensure that the plan offers a sufficient number and type of drugs needed to treat bipolar disorder, diabetes, rheumatoid arthritis and schizophrenia, and are not restricting access through lack of coverage or inappropriate use of utilization management techniques.</p> <p>Issuers must attest to compliance with all marketing standards in the state partnership attestation form.</p>
<p>State Standard A.C.A §23-66-201 AID Rule 11 AID Rule 19</p>	<p>QHP Issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers, including Ark. Code Ann. §23-66-201 et seq., Unfair Trade Practices Act and the requirements defined in AID Rules 11 and 19.</p> <p>QHP Issuers may inform consumers in QHP marketing materials that the QHP is certified by the Partnership as a QHP. The QHP Issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP.</p> <p>AID will require submission of QHP marketing materials in PDF format prior to use. Any multi-media marketing materials should be provided through a link within a pdf document. AID reserves a right to request a timely upload of the multi-media files for review. If AID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, AID will enforce through use of state remedies up to and including the recommendation of the QHP for decertification.</p>
Actuarial Value Standards	
<p>Federal Standards 45 CFR 156.135</p>	<p>Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of AV (or fall within the allowable variation) as specified below. Issuers must attest to compliance with the A/V standards.</p> <p>Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%)</p> <p>SADPs must meet the following actuarial value levels: High: 85% (83 to 87%) Low: 70% (68 to 72%)</p>
<p>State Standards</p>	<p>QHP issuers must comply with federal A/V standards; compliance will be reviewed with CMS A/V calculator.</p>
Rate Filing	
<p>Federal Standard 45 CFR § 147.102</p>	<p>Premiums may be varied by enrollee age (by a factor of 3:1), tobacco use (by a factor of 1.5:1), and geographic rating area (per the seven rating areas identified in Appendix B). Geographic rate adjustments are determined based on the enrollee’s residential address or the principle address of the employer in SHOP. Premium rates for the same plan must be the same inside and outside the Marketplace. All rates filed for QHPs in the individual market will be set for the plan year and cannot be</p>

	<p>changed during the year.</p> <p>Additional guidelines for rates in SHOP</p> <p>Composite premiums (average enrollee premiums) are allowed in SHOP as long as the plans meet the following requirements:</p> <ul style="list-style-type: none"> • Tobacco rates are not included in the composite premiums but are applied separately on a per-member basis; • Premium composite cannot be changed during the plan year; • Composite option must be uniformly available for a product (i.e. cannot be limited to employers of a certain size); and • Composite premiums are offered in two tiers: adults age 21 and over and children under age 21. <p>Pediatric Dental</p> <p>For Marketplace plans with an embedded dental benefit, the dental issuer is not allowed to use different geographic area factors and/or network factors than the medical plan geographic and network factors. However, SADP issuers will be able to make premium adjustments for their SADPs that are considered excepted benefits upon consumer enrollment, but must indicate that rates are not guaranteed for QHPs offered on the Marketplace. It should be noted that no additional age rating may be included in SADPs for pediatric dental for purposes of completing the QHP application, but SADP issuers may indicate whether the rate is estimated or guaranteed. If the rate is estimated, the SADP Issuer may later add more age rating factors.</p> <p>Outlier Identification</p> <p>Outlier identification of QHP rates will be conducted to identify rates that are relatively high or low compared to other QHP rates in the same rating area. Identification of a QHP rate as an outlier does not necessarily indicate inappropriate rate development. CMS will notify AID of the results of its outlier identification process. If AID confirms that the rate is justified, CMS expects to certify the QHP if the QHP meets all other standards.</p> <p>QHP Issuers, but not SADP issuers, are required to submit the Unified Rate Review Template for rate increase.</p>
<p>State Standard</p>	<p>A QHP Issuer must comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates must be based upon the analysis of the plan rating assumptions and rate increase justifications in coordination with AID and timely submitted to the FFM if appropriate.</p> <p>AID will continue to effectuate its rate review program and will review all rate filings and rate increases for prior approval. Rate filing information must be submitted to AID with any rate increase justification prior to the implementation of an increase. A QHP Issuer must prominently post the justification for <i>any</i> rate increase on its Web site.</p>

	AID will limit the use of tobacco use as a rating factor to 1.2:1, applicable only to the individuals in the family that use tobacco.
Plan Variations for Individuals Eligible for Cost-Sharing Reductions	
<p>Federal Standard 45 CFR §155.1030 45 CFR §156.420 45 CFR § 355.300(a)</p>	<p>For plans in the individual market only, QHP issuers must submit cost-sharing variations to facilitate cost-sharing reductions for the following eligible individuals:</p> <ul style="list-style-type: none"> • Individuals with incomes up to 250% FPL (silver plan variations); • Indians with incomes up to 300% FPL (zero cost-sharing variation); and • Indians above 300% FPL when services are provided by an Indian health provider (limited cost-sharing variation). <p>Issuers must attest to compliance with required plan variations.</p> <p>Silver Plan Variations For individuals with incomes up to 250% FPL, the QHP Issuer must offer three silver plan variations for each silver QHP at the 73%, 87% and 94% A/V levels. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and A/Vs that meet the required levels within a <i>de minimis</i> range of ± 2%. Benefits, networks, non-EHB cost-sharing, <u>out-of-network</u> cost sharing, and premiums must be consistent with the corresponding standard silver plan.</p> <p>Zero Cost Sharing Plan Variations All plans offered at any A/V level except catastrophic (including bronze, silver, gold, platinum) in the individual market are required to include a zero cost sharing variation and limited cost sharing variation.</p> <p>The zero cost sharing variation plan is intended for Indians with income up to 300% FPL. Both in-network and out-of-network <u>EHB</u> cost sharing must be eliminated for the zero cost sharing plan variation. Zero cost sharing plan variations must have zero cost sharing for both in-network and out-of-network services for EHBs. Out-of-network cost sharing for non-EHBs must be equivalent to the corresponding standard plan.</p> <p>Limited cost sharing plans must be equivalent to the standard plan in all benefits and cost-sharing, except when the plan is used by an Indian enrolled in a QHP receiving services from an urban Indian organization or through referral under contract health services.</p> <p>SADPs are excluded from cost-sharing reduction (CSR) requirements. However, SADPs must have a “reasonable” annual limit on cost sharing that is at or below \$350 for a plan with one child enrollee or \$700 for a plan with two or more child enrollees.</p> <p>Cost-sharing variations are submitted in the CMS Plans and Benefits template through SERFF. Further instructions can be found in QHP application and template instructions provided by CMS.</p>
State Standard	To ensure a consistent approach to cost sharing across all silver plan variations, AID will require that all QHP issuers’ cost sharing in all silver plan variations conform to prescribed cost sharing amounts as defined by

	<p>AID. (See Bulletin Section “Plan Variations for Individuals Eligible for Cost Sharing: State Standards”). Additionally, the following cost sharing template will be used for purchase of QHPs in the Healthcare Independence Program:</p> <table border="1" data-bbox="527 317 1398 428"> <tr> <td data-bbox="527 317 760 359">0-50% FPL*</td> <td data-bbox="760 317 1398 359">Zero Cost Sharing Plan variation</td> </tr> <tr> <td data-bbox="527 359 760 428">50-138% FPL*</td> <td data-bbox="760 359 1398 428">High-Value Silver Plan variation (94% +/- 1% actuarial value).</td> </tr> </table> <p>Cost-sharing for the High-Value Silver Plan Variation is limited to copays and coinsurance as specified in Appendix C and a deductible that is paid by Medicaid on behalf of consumers.</p> <p>* Legislation has been introduced that would exempt those between 50-99% FPL from participation in Independence Accounts. Should this legislation be passed, cost sharing will revert to Plan Year 2014 levels with those above 100% FPL having 94%AV Silver Plans and Independence Accounts and those below 100% FPL having 100% AV Plans with no Independence Accounts.</p>	0-50% FPL*	Zero Cost Sharing Plan variation	50-138% FPL*	High-Value Silver Plan variation (94% +/- 1% actuarial value).
0-50% FPL*	Zero Cost Sharing Plan variation				
50-138% FPL*	High-Value Silver Plan variation (94% +/- 1% actuarial value).				
Stand Alone Dental Plans					
<p>Federal Standard 45 CFR 155 and 156 45 C.F.R. § 155.1065 PHS Act section 2791 45 C.F.R. § 146.145(c) 45 C.F.R. § 156.440(b)</p>	<p>SAD Issuers and SADPs must meet the same QHP certification standards as medical plans unless exceptions were noted in the above sections. Additionally, SADPs are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Moreover, SADPs may impose up to a 24 month waiting period for orthodontia services.</p> <p>SADPs intended to be utilized outside the Marketplace only for use to supplement medical plans such that the medical plans will comply with federal requirement of offering all 10 EHBs outside the Marketplace as required under the Public Health Services Act must follow the Marketplace certification filing process as described within this Bulletin.</p>				
<p>State Standard</p>	<p>There are no additional state standards for SADPs. SADPs must comply with the AR EHB benchmark plan: AR Kids B (CHIP) pediatric dental. Note that medically-necessary orthodontia is not included in the CHIP pediatric dental plan and so is not an EHB in Arkansas.</p>				



ALLEN KERR, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

February 3, 2015

DATE

Appendix A

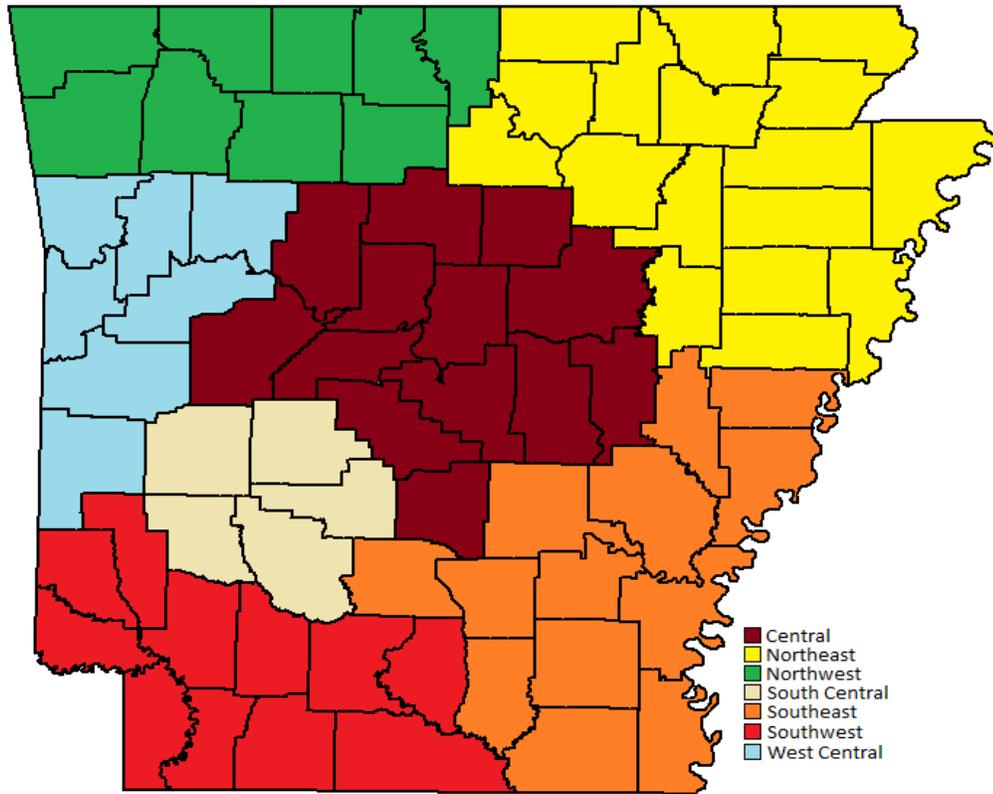
Essential Community Provider Narrative Justification

If issuers do not meet the requirement that 30% of available ECPs are included in the plan network, a justification must be submitted that includes the following information:

- (a) Number of contracts offered to ECPs for the 2016 plan year;
- (b) Number of additional contracts issuer expects to offer for the 2016 plan year and the timeframe of those planned negotiations;
- (c) Name of ECP hospitals and FQHCs to which the issuer has offered contracts, but an agreement with the providers has not been reached;
- (d) Attestation that the issuer has satisfied the “good faith” contracting requirement with respect to offering contracts to all available Indian health providers, and one ECP in each major ECP category per county, where an ECP in that category is available; and
- (e) Contingency plans for how, absent participation of the available ECP and Indian health providers, the plan will be able to provide adequate care to enrollees who might otherwise be cared for by relevant ECP providers. For example, if available Hemophilia Treatment Centers, Ryan White HIV/AIDS Program providers or Indian health providers are missing from the network(s), the Application must explain how its target populations will be served.

APPENDIX B

STATE RATING AND SERVICE AREAS



Arkansas Counties by Region

Region

Central Rating Area 1	Cleburne Lonoke Pulaski Yell	Conway Perry Saline	Faulkner Pope Van Buren	Grant Prairie White
Northeast Rating Area 2	Clay Fulton Jackson Randolph Woodruff	Craighead Greene Lawrence Sharp	Crittenden Independence Mississippi St. Francis	Cross Izard Poinsett Stone
Northwest Rating Area 3	Baxter Madison Washington	Benton Marion	Boone Newton	Carroll Searcy
South Central Rating Area 4	Clark Pike	Garland	Hot Spring	Montgomery
Southeast Rating Area 5	Arkansas Cleveland Jefferson Phillips	Ashley Dallas Lee	Bradley Desha Lincoln	Chicot Drew Monroe
Southwest Rating Area 6	Calhoun Lafayette Ouachita	Columbia Little River Sevier	Hempstead Miller Union	Howard Nevada
West Central Rating Area 7	Crawford Scott Polk	Franklin Sebastian	Johnson	Logan

APPENDIX C

HIGH VALUE SILVER PLAN (94% A/V) VARIATION COST SHARING REQUIREMENTS

High-Value Silver Plan 100% - 150% FPL

High-Value Silver Plan
94% Actuarial Value Plan

Overall Deductible:	\$150
Service Specific Deductibles:	
Medical	\$0
Brand Drugs	\$0
Dental	\$0
Member Out-of-Pocket Max (all services combined):	\$754

General Service Description	Subject to Deductible	Unit of Service	Copays	Coinsurance
Behavioral Health - IP	Yes	Day	\$ 140	100%
Behavioral Health - OP	No	Visit	\$ 4	100%
Behavioral Health - Professional	No	Visit	\$ 4	100%
Durable Medical Equipment	No	Service	\$ 4	100%
Emergency Room Services	No	Visit	\$ -	100%
FQHC	No	Visit	\$ 8	100%
Inpatient	Yes	Day	\$ 140	100%
Lab and Radiology	No	Visit	\$ -	100%
Skilled Nursing Facility	Yes	Day	\$ 20	100%
Other	No	Visit	\$ 4	100%
Other Medical Professionals	No	Visit	\$ 4	100%
Outpatient Facility	Yes	Visit	\$ -	91%
Primary Care Physician	No	Visit	\$ 8	100%
Specialty Physician	No	Visit	\$ 10	100%
Pharmacy - Generics	No	Prescription	\$ 4	100%
Pharmacy - Preferred Brand Drugs	No	Prescription	\$ 4	100%
Pharmacy - Non-Preferred Brand Drugs	No	Prescription	\$ 8	100%
Pharmacy - Specialty Drugs (i.e. high-cost)	No	Prescription	\$ 8	100%

APPENDIX D

HABILITATIVE SERVICES COVERAGE DEFINITION AND LIMITATIONS

DEFINITION OF HABILITATIVE SERVICES

Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

COVERAGE OF HABILITATIVE SERVICES

Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

ESTABLISHING PARITY

QHPs must offer habilitative services at parity with rehabilitative services. Because developmental services are generally less expensive and required on a long-term basis, the department has determined that parity must be established through the use of unit equivalency. All medical QHPs must include developmental services with unit limits at an acceptable level of parity with Outpatient and Inpatient Rehabilitation for the 2016 plan year policies. The minimum acceptable limits are included in the table below:

Coverage of Rehabilitative and Habilitative Services at Parity

	Rehabilitation (OT, PT, ST)	Habilitative Services (OT, PT, ST)	Habilitative Developmental Services
Outpatient	30 visits (1 visit = 1 unit = 1 hour or less)	30 visits (1 visit = 1 unit = 1hour or less)	N/A
Inpatient	60 days	N/A	180 units (1 unit = 1 hour)