Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

BULLETIN NO. 3-2013

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: REQUIREMENTS FOR QUALIFIED HEALTH PLAN CERTIFICATION IN THE ARKANSAS FEDERALLY-FACILITATED PARTNERSHIP EXCHANGE

DATE: February 19, 2013

Qualified Health Plans (QHP), which are non-grandfathered individual or small group plans certified and offered through an Individual or SHOP Exchange for Arkansas consumers, will be offered through the federally facilitated Health Insurance Marketplace beginning on October 1, 2013, with an effective date of coverage of January 1, 2014. The Affordable Care Act (ACA) requires that all issuers and plans participating in the Federally-facilitated Exchange Plan Management Partnership (Partnership) meet federal and state certification standards for QHPs. The Arkansas Insurance Department (AID) 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 illustrate the new federal and state requirements to be a QHP in the Arkansas individual and SHOP Health Insurance Marketplace.

Beginning on March 5, 2013, and lasting through April 2013, NAIC will be providing training on the use of SERFF for application and plan submission to the Exchange. Health Insurance issuers responding to this guidance should submit their applications to become QHP issuers together with included rate and form filings between March 28, 2013 and June 30, 2013. Stand alone dental issuers should submit their applications with their rate and form filings between May 15, 2013 and June 30, 2013. AID will review the applications, rate and form filings through July 31, 2013. AID will submit all recommended applications to CMS for certification on July 31, 2013. All Issuers waiting until the final deadline to submit their application to offer a QHP should be aware that AID will strive to review all filings and work with issuers to make QHP recommendations to CMS by July 31. Plans will be reviewed in the order received. Any plans not having undergone complete review gaining state approval for recommendation prior to July 31 will be ineligible for offering a QHP through the Exchange during the 2013 Open Enrollment Period. Issuers will be given an opportunity to address any data errors during the plan review period in late August. CMS will notify all Issuers of the QHP Certification decision and complete the certification agreement in early September 2013. The Federal Government has stated that there will not be any federal appeals related to non-certification during the 2014 plan year due to the shortened first year.

An Issuer must notify the Exchange of its intent to participate in the certification process by March 8, 2013 by sending an email to insurance.exchange@arkansas.gov. A secondary bulletin notifying carriers of the intent to participate by stand alone dental carriers will be published no later than March 15, 2013.

General Requirements	
Federal Standard 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	A QHP issuer must— (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 will be later defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agrees to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; (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 initial and annual open enrollment periods, well as special open enrollment periods; (10) Collect enrollment information, transmit such to the Exchange and reconcile enrollment files with the exchange 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) Segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception; (13) Timely notify the Exchange if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice; (14) 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; and (15) Meet all readability and accessibility standards.
State Standard	AID will utilize a certification approach to reviewing, recommending, and submitting the rate, form and QHP application filings for compliance with federal and state rules and regulations. Certification will be good 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.

	AID will work with CMS and the QHP issuers to move enrollees to other available certified QHPs should a certified QHP in which a consumer is enrolled become decertified or allows its certification to expire. Subject to stand alone dental carriers notifying AID of their intent to participate, AID will also require all QHP issuers offering a plan which has pediatric dental imbedded as part of its benefits to 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 stand alone dental carriers respond with their intent to participate. Furthermore, in future years of the Exchange AID may limit the number of plans or benefit designs that may be offered by a carrier per "metal tier" level on the Exchange.
Licensure and Solvency	
Federal Requirements 45 CFR 156.200	A QHP issuer must be licensed and in good standing with the State.
State Requirements	A QHP issuer must have unrestricted authority to write its authorized lines of business in Arkansas in order to be considered "in good standing" and to offer a QHP through the Health Insurance Marketplace. AID is the sole source of a determination of whether an issuer is in good standing. AID determinations of good standing will be based on authority found in the Ark. Code Ann. § 23-63-202. Such authority may include restricting a QHP issuer's ability to issue new or renew existing coverage for an enrollee. An issuer will be allowed to apply for Arkansas licensure and QHP issuer and plan certification simultaneously during the first QHP certification cycle; however, a QHP issuer may not be certified for participation in the Health Insurance Marketplace until state licensure has been established.
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)	A QHP issuer must ensure that the provider network of each of its QHPs is available to all enrollees and: (1) (a) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area. This must be done by demonstrating one of the following during the first year of the Exchange: • That the Issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP of each type available by county;

	• That the Issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its Issuer Application; or • That the Issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer application. **OR** (b) If an Issuer provides a majority of covered services through employed physicians or a single contracted medical group complying with the alternate ECP standard identified within federal regulations, the issuer must verify one of the following: • That the Issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 20% of available ECPs in the service area; • That the Issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or • That the Issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer application. (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and (3) Makes its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.
State Standard	AID will require an attestation from the QHP issuer that states it is in compliance with all network adequacy requirements in addition to one of the following: • The QHP issuer provides evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or • The QHP issuer provides sufficient information through a PDF submission related to its policies and procedures to determine that the Issuer's network meets the minimum federal requirements.

	Any QHP issuer that fails to achieve at least 10% ECP participation will undergo a stricter review of its Issuer Application. AID will not impose standards that exceed federal ACA standards in the first year. However, additional state standards may be imposed for future plan years of the Exchange.
Accreditation	
Federal Standard 45 CFR 156.275 45 CFR 155.1045	• QHP 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 CAHPS survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs. • The Partnership will accept existing commercial, or Exchange health plan accreditation from HHS-recognized accrediting entities. For the purposes of QHP issuer certification in 2013, these are the National Committee for Quality Assurance (NCQA) and URAC. • QHP issuers without existing commercial or Exchange 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. • 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 • 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 Partnership.
State Standard	AID will follow the Federal requirements related to accreditation and will require the authorized release of all accreditation data. Additionally, AID will require an attestation by QHP issuers not already accredited that those QHP issuers will schedule, become accredited on policies and procedures in the plan types used, and provide proof of such accreditation on policies and procedures prior to submission of any application for recertification. The QHP issuer must also indicate that it will receive and provide proof of receipt of full Exchange accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area is the geographic area in which an individual must reside or be employed in order to enroll in a QHP. 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.

State Standard	The state will allow the QHP issuers to choose their service area(s) for year one in as much as service areas may not be smaller than a county, but intends to investigate regional coverage with a goal of statewide service areas for future years.
Rating Area	
Federal Standard 45 CFR §156.255	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 seven (7) rating areas, within that State for purposes of applying the requirement of this title.
State Standard	AID has approved a configuration of seven (7) rating areas to be utilized in Arkansas. These areas are specifically described in Appendix C.
Quality Improvement Standards	
Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717	A QHP issuer must implement and report on a quality improvement strategy or 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: • 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 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; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
State Standard	AID acknowledges the emerging importance of Arkansas's Payment Improvement Initiative in advancing quality and affordability and recommends that the Partnership may engage or require carriers to adopt specific quality improvement strategies as a condition of having their QHPs certified to be marketed and sold on the Exchange. Any

	such requirement will not be implemented in the first plan year and will be subject to a future bulletin. Additionally, as much of the information that will required for quality reporting standards is dependent on the QHPs offering coverage through the individual Exchange and SHOP, this criterion cannot be implemented until a future date. AID will notify issuers during the 2014 plan year as the measures are developed. Until the measures are adopted and implemented, AID intends to use Consumer Assessment of Healthcare Providers and Systems (CAHPS) data results from accredited commercial product lines when the data are available for the same QHP product types and adult/child populations. AID will require all QHP Issuers to participate and report on the implementation of their quality improvement standards and results no less than quarterly. Any changes to the Issuer's quality improvement initiatives must be reported to AID within thirty (30) days.
General Offering Requirements	
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	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 either the individual Exchange or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. Additionally, a catastrophic plan may be filed to be sold on the Exchange in addition to the tiered metal levels. If an Issuer applies to be a QHP issuer in the Individual Exchange, the Issuer must also apply to offer a policy through the SHOP Exchange. 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. The definition of "meaningful difference" is due to be released from CMS "very soon." Moreover, the QHP, excluding stand alone 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. Additionally, the QHP must cover emergency services with no prior authorization, no limitation to participating or in-network providers. Emergency services must be covered at in-network cost-sharing level. Additionally, QHP issuers will be required to meet all annual limitation and cost sharing requirements without affecting the actuarial value of the plans within each of the tiers. The QHP issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations. Moreover, The QHP must contain no lifetime limits on the dollar value of any Essential Health Benefits (EHB), including the specific benefits and services covered under the EHB-Benchmark Plan. For plans issued in the small group market, the deductible under the plan shall not exceed either:

	• $2,000 in the case of a plan covering a single individual; and • $4,000 in the case of any other 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. If offered, Catastrophic Plans are offered only in the individual exchange and **not** in the SHOP. 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 FFE-SHOP if appropriate.
State Standard	Specific state rate and form filing requirements may be found in Appendix A, attached.
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	The QHP issuer must offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. This may be done by substituting benefits only if the QHP issuer demonstrates actuarial value of the substituted benefits. A QHP Issuer is not required to offer abortion coverage within their benefit plans. The QHP issuer will determine whether the benefits offered include abortion. 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. 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). 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. Finally, any state mandates in effect as of December 2011 must apply as an essential health benefit in the same way they apply in the current market. These benefits, as with all essential health benefits, must be offered without annual or lifetime dollar limitations.

State Standards	AID has 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 B to this Bulletin. AID will require an attestation from the QHP Issuer that states the issuer is in compliance with all Essential Health Benefit (EHB) standards.
Essential Health Benefit Formulary Review	
Federal Standards 45 CFR 156.120 45 CFR §156.295	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 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 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	AID will require an attestation of compliance with EHB Formulary Standards.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 FR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	(1) A QHP issuer must: • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: o Adjusting premiums based on genetic information; o Discriminating with respect to its QHP on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; o Utilizing any preexisting condition exclusions;

	o Requesting/requiring genetic testing; or o Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes. (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.
State Standard	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 Rules 11 and 19. QHP issuers may inform consumers in its 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. AID will require prior approval of QHP marketing material and an attestation that the QHP issuer meets all Marketing Standards. Marketing materials must be submitted in PDF format. 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 and will recommend the QHP for decertification.
Actuarial Value Standards	
Federal Standards 45 CFR 156.135	Plans being offered at the various metal tiers within the Exchange must meet the specified levels of actuarial value (or fall within the allowable variation): Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%) Stand alone dental plans must offer plans at either a 75% or 85% actuarial value level.
State Standards	AID will require an attestation of compliance with Actuarial Value standards.
Quality Rating Standards	
Federal Standard 45 CFR §156.265 (b)(2) 45 CFR §156.265 (f); 45 CFR §156.400 (d) 45 CFR §156.285 (c)	HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges with reporting requirements related to all QHP issuers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking

PHSA 2794	on quality reporting and disclosure requirements. QHP issuers must also 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 must be submitted to the exchange, HHS, and the state insurance commissioner.
State Standard	The state will adopt the Quality Rating Standards as provided in federal guidance. Any AID requests for quality information must be made available upon request.
Rate Filing	
Federal Standard	Premiums may be varied by the geographic rating area, but premium rates must be the same inside and outside the exchange. • Rating will be allowed on a per member basis. • ACA: premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) All rates filed for individual QHPs will be set for an entire benefit/plan year.
State Standard	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 *any* rate increase on its Web site. 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 smoke. AID may issue additional standards related to tobacco cessation in a subsequent bulletin.
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	The QHP issuer must offer three silver plan variations for each silver QHP and one zero cost sharing plan variation and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation. This will be completed via rate and benefit templates.
State Standard	AID will require an attestation of compliance with Plan Variation Standards.

JAY BRADFORD, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

2-19-13
DATE

Appendix A

✓	Category	Statute Section
	QHP Issuer Application Receipt	
	Exchange application data is complete	
	Explanation:	
	Page Number:	
	Received Final QHP Issuer Application Submission Attestations, including:	
	• Service Area Attestation • Rating Areas Attestation • Network Adequacy • Actuarial Value • Marketing Regulations and Transparency • Market Reform Rules • Licensure and solvency • Compliance with Essential Health Benefits • Accreditation	
	Explanation:	
	Page Number:	
	Evaluation of QHP Issuer Application	
	Accreditation and Quality Standards	*45 CFR 156.275*
	Applicant has *exchange* accreditation through NCQA and/or URAC, or:	
	Year 1- Applicant has applied for *exchange* accreditation through NCQA and/or URAC	
	Year 2- Issuer procedures and policies are accredited	
	Explanation:	
	Page Number:	
	Exchange accreditation is based on the following standards:	
	Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized CAHPS survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs.	
	Explanation:	
	Page Number:	

	Attestations and supporting documentation are accurate and complete or accreditation is verified in SERFF	
	Explanation:	
	Page Number:	
	Issuer has authorized release of accreditation data	*State Partnership Guidance 1/2013*
	Explanation:	
	Page Number:	

	Complaint and Compliance	
	Requested complaint and compliance information (from consumer services division) received and reviewed	
	Explanation:	
	Page Number:	

	Cost-Sharing Reductions	*42 CFR 18022(c); 45 CFR 156.130(a); PPACA Section 1302(c) 45 CFR §155.1030 45 CFR §156.420*
	Three silver plan variations for each silver QHP (automated review via rate and benefit templates). Review AV for non-standard plan designs. Silver plan variations should be offered for cost-sharing variations of 2/3, 1/2, and 1/3.	*PPACA 1402(a)-(c)*
	Explanation:	
	Page Number:	
	Eliminate cost sharing for an Indian (Section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income of 300 percent of the FPL who is enrolled in a QHP at *any level of coverage*	*PPACA 1402(d)*
	Explanation:	
	Page Number:	
	Cost-sharing incurred under plan do not exceed the dollar amount limits established by federal and state laws and regulations.	
	Explanation:	
	Page Number:	

	Benefit Design	*45 CFR 156.225; 42 USC 18022*
	Actuarial Value	

	Issuer has separately offered at least one QHP at each of the following Actuarial Values: *Gold: 80% (78 to 82%)* *Silver: 70% (68 to 72%)* *Child-Only (at same level of coverage)*	45 CFR 156.200
	Explanation:	
	Page Number:	
	Actuarial Memorandum and Certification Received *Verification that plan is substantially equal to benchmark plan*	
	If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits	*45 CFR 156.115*
	Compliance with premium rating factors including: *Self-only or family enrollment,* *geographic rating areas (7 areas)* *Age (3:1 for adults)* *Tobacco use (1.2:1)*	*PPACA 1201 SEC. 2701(a)* *PHSA 2701*
	Justification information received for rate increase, if applicable	
	Explanation:	
	Page Number:	
	Confirm Benefit Substitution A/V	
	TBD (Coming Soon!)	
	Explanation:	
	Page Number:	
	Confirm Actuarial Metal Level Submitted	
	Bronze (60%) *Silver (70%)* *Gold (80%)* *Platinum (90%)* *Catastrophic (<58%)* *(Allowable variance: +/- 2%)*	
	Explanation:	
	Page Number:	
	Meaningful Difference	
	TBD (Coming Soon!)	
	Explanation:	
	Page Number:	
	Inclusion of all 10 Essential Health Benefits that meet or exceed benchmark plan, including: ***Ambulatory patient services*** *Primary care physician visits* *Specialist office visit*	

	Services and procedures provided in the Specialist office other than consultation and evaluation *Outpatient Services* *Surgical Services - Outpatient* *Ambulatory Surgical Center Services* *Outpatient Diagnostics* *Advanced Diagnostic Imaging, subject to prior auth* *Outpatient Physical Therapy* *Outpatient Occupational Therapy* *Home Health* *Hospice Care for individuals with life expectancy of less than 6 months* *Qualified Assistant Surgeon Services*	
	Explanation: *Page Number:*	
	Emergency services *Emergency Care Services* *After-hours clinic or urgent care center* *Observation services* *Transfer to in-network hospital* *Ambulance Services*	
	Explanation: *Page Number:*	
	Hospitalization *Hospital Services* *Physician Hospital Visits* *Inpatient Services* *Hospital services in connection with Dental Treatment* *Surgical Services - Inpatient* *Inpatient Physical Therapy* *Inpatient Occupational Therapy* *Skilled Nursing Facility Services* *Organ Transplant Services*	
	Explanation: *Page Number:*	
	Maternity and newborn care *Certified nurse midwives* *Newborn care in the hospital* *In vitro fertilization* *Genetic testing to determine presence of existing anomaly or disease* *Complications of pregnancy* *Prenatal and Newborn Testing* *Maternity and Obstetrics, including pre and post natal care*	*§23-79-129 & Bulletin 1-84*
	Explanation: *Page Number:*	

	Mental health and substance use disorders, including behavioral health treatment *Professional Services(by licensed practitioners acting within the scope of their license)* *Diagnostics* *Inpatient hospital or other covered facility* *Outpatient hospital or other covered facility*	
	Explanation: *Page Number:*	
	Prescription drugs *Prescription Drugs:* *Plan covers at least the greater of: (1) One drug in every category and class; or (2) the same number of drugs in each category and class as the EHB-benchmark plan*	
	Explanation: *Page Number:*	
	Rehabilitative and habilitative services and devices *Physical, Occupational, and Speech Therapies* *Developmental services* *Durable Medical Equipment* *Prosthetic and Orthotic Devices* *Cochlear and other implantable devices for hearing, but not hearing aids* *Medical supplies*	
	Explanation: *Page Number:*	
	Laboratory services *Testing and Evaluation*	
	Explanation: *Page Number:*	
	Preventive and wellness services and chronic disease management *Case Management Communications made by PCP* *Preventive Health Services* *Routine immunizations* *US Preventive Services Task Force A or B rated benefits* *Weight Loss surgical procedures*	
	Explanation: *Page Number:*	
	Pediatric Dental (if applicable) *Consultations* *Radiographs* *Children's Preventive Services* *Space maintainers* *Restorations*	

	Crowns *Endodontia* *Peridontal Procedures* *Removable prosthetic services* *Oral Surgery* *Professional visits* *Hospital Services* *Oral Surgery* *Childhood development testing* *Dental Anesthesia and other services for children under 7 with an immediate need*	
	Explanation: *Page Number:*	
	Pediatric Vision *Eye Exam* *Surgical evaluation* *Eye wear* *Lenses* *Eye glass repair* *Lost/Broken Replacement* *Contact lenses* *Eye prosthesis* *Polishing services*	
	Explanation: *Page Number:*	
	Miscellaneous *Complications from Smallpox vaccine*	
	Explanation: *Page Number:*	
	Additional State Benefits	
	Autism Spectrum Disorders	*23-99-418*
	Breast Reconstruction/Mastectomy	*23-99-405*
	Children's Preventive Health Care	*23-79-141 et al. & Rule 45*
	Colorectal Cancer Screening	*23-79-1201 et al*
	Dental Anesthesia	*23-86-121*
	Diabetic Supplies/Education Diabetes Management Services	*23-79-601 et al & Rule 70*
	Equity in Prescription Insurance & Contraceptive Coverage	*23-79-1101 et al*
	Formula PKU/Medical Foods & Low Protien Modified Food Medical Foods and Low Protein Modified Foods	*23-79-701 et al*
	Gastric Pacemakers	*23-99-419*
	In-Vitro Fertilization (insurance companies only)	*23-85-137, 23-86-118 & Rule 1*
	Loss or Impairment of Speech or Hearing	*23-79-130*

	Maternity & Newborn Coverage *Mental Health parity* *Off-Label Drug Use* *Prostate Cancer Screening* *Orthotic & Prosthetic Devices or Services*	*23-99-404; 23-79-129* *23-99-501 et al* *23-79-147* *23-79-1301* *23-99-417*
	Explanation: *Page Number:*	
	Mandated Persons Covered, including:	
	Adopted Children	
	Handicapped Dependents	
	Explanation:	
	Page Number:	
	Mandated Providers	
	Ambulatory Surgery Center, Audiologists, Chiropractors, Dentists, Emergency Services, Nurse Anesthetists, Optometrists, Podiatrists, Psychologists, Physician Assistant	
	Explanation:	
	Page Number:	

	Discriminatory benefit design	*PPACA §1311(c)(1)(A); PPACA §1302(b)(4)(B)*
	Plan does not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health care needs	*PPACA §1311(c)(1)(A)*
	Explanation: *Page Number:*	
	Benefits not designed in a way that discriminates against individuals because of age, disability, or expected length of life	*PPACA §1302(b)(4)(B)*
	Explanation: *Page Number:*	
	Completed form filings for certification that submission meets provisions of the Unfair Sex Discrimination rule in Sale of Insurance (New or revised filings must contain this certification)	*AID Rule and Regulation 19, Ark Code Ann. 23-66-201*
	Explanation: *Page Number:*	

	Pre-existing conditions	*42 USC 300gg-3*
	Plan must contain no preexisting condition exclusions	
	Explanation: *Page Number:*	

	State licensure, solvency, and good standing	*45 CFR 156.200(b)(4)*
	Issuer properly licensed	
	Explanation: *Page Number:*	
	Company financially solvent and in good standing	
	Explanation: *Page Number:*	

	Marketing Standards	*45 CFR 156.220*
	Meets marketing standards as described in any applicable State Laws	*45 CFR 156.225 Ark. Rule 19 and 11; Ark. Code Ann §23-66-201 et seq.*
	Explanation: *Page Number:*	
	Meets requirement for transparency of coverage with attestation to include: Cost-sharing data is published on Internet Web Site Reporting requirements as listed in 45 CFR 156.22	*45 CFR 156.220*
	Explanation: *Page Number:*	
	Complies with Arkansas Discriminatory Benefit Design Regulations	*Ark. Code Ann. § 23-66-201 et seq.; 23-86-314; 23-98-106; Ark. Rule 19; Ark. Rule 28; Ark. Rule 42; Attorney General Opinion 2004-274; Directive 2-2005*
	Explanation: *Page Number:*	
	Received Attestation of compliance with marketing/discriminatory benefit design regulations	
	Explanation: *Page Number:*	

	Market Reform Rules	*PHS 2701; PHS 2702; PHS 2703; PPACA 1302(e); PPACA 1312(c);PPACA 1402; 42 CFR*

		156; 42 CFR 147
	QHP compliance with market reform rules in accordance with state and federal requirements	
	Explanation: *Page Number:*	
	Received QHP Market Reform Attestation of QHP compliance with market reform rules in accordance with state and federal requirements.	
	Explanation: *Page Number:*	
	Guaranteed availability of Coverage	*45 CFR § 147.104*
	Explanation: *Page Number:*	
	Guaranteed Renewability of Coverage	*45 CFR § 147.106*
	Explanation: *Page Number:*	
	Single Risk Pool	*45 CFR § 156.80*
	Explanation: *Page Number:*	
	Catastrophic Plans	*45 CFR § 156.155*
	Explanation: *Page Number:*	
	Cost-sharing incurred under plan does not exceed the dollar amount limits established by federal and state laws and regulations (currently for individuals with household incomes between 100 and 250 percent of the FPL.)	PPACA § 1402; A/V and Cost-Sharing Reductions Bulletin
	Explanation: *Page Number:*	

	Network Adequacy	*45 CFR 156.230; 45 CFR 156.235; PHS SEC.2702(c) ; PPACA 156.230*
	Submission of provider-enrollee ratios for each QHP network	*45 CFR 156.230*
	Explanation: *Page Number:*	
	Submission of time/distance measures for each QHP network	*45 CFR 156.230*
	Explanation: *Page Number:*	
	Essential community providers listed	*45 CFR 156.235*
	Explanation: *Page Number:*	
	Accredited policies and procedures that includes network adequacy	*PHS SEC.2702(c)*
	Explanation: *Page Number:*	

	Evaluation of issuer's network OR Attestation detailing issuer's ability to meet network adequacy standards including company policy for ensuring an adequate network	*State Partnership Guidance 1/2013*
	Explanation: *Page Number:*	
	Provider directory is available for online publication with indication of providers no longer accepting new patients	*PPACA 156.230*
	Explanation:	
	Page Number:	
	Provider directory available to individuals in English and Spanish	*PPACA 156.230*
	Explanation: *Page Number:*	

	Rating Areas and Actuarial Value	
	Rate-setting practices are consistent with the approved metrics	*PHS SEC.2701(a)*
	Explanation: *Page Number:*	
	Attestation of compliance with state rating areas (7 rating areas)	*PHS SEC.2701(b)*
	Explanation: *Page Number:*	

	Service Areas	
	Issuer service areas specified	
	Explanation: *Page Number:*	
	Evaluate that QHP area covers a minimum geographical area that is at least an entire county, or group of counties	*PPACA 155.1055(a)*
	Explanation: *Page Number:*	
	Evaluate that QHP service area is established without regard to racial, ethnic, language, health status related factors, or other specified factors	*PPACA 155.1055(b)*
	Explanation: *Page Number:*	

	Receive Rate and Benefit Data and Information	
	Plan data and supporting documentation complete	
	Explanation: *Page Number:*	
	Issuer submission of data completed before end of open enrollment period	
	Explanation: *Page Number:*	

	QHP rate and benefit data and information approved	
	Explanation: *Page Number:*	

	QHP Certification Agreement	
	Issuer application and plan data approved	
	Explanation: *Page Number:*	
	Generate QHP approval and add to issuer account	
	Explanation: *Page Number:*	
	Submit issuer and plan data to CMS	
	Explanation: *Page Number:*	
	CMS approval received for ratified recommendations for Certified QHPs	
	Explanation: *Page Number:*	

	Issuer or Plan Non Certification	
	Notify issuer of non-certification of QHP(s) or Issuer	
	Explanation: *Page Number:*	
	Update QHP(s) and Issuer Account Information	
	Explanation: *Page Number:*	

APPENDIX B

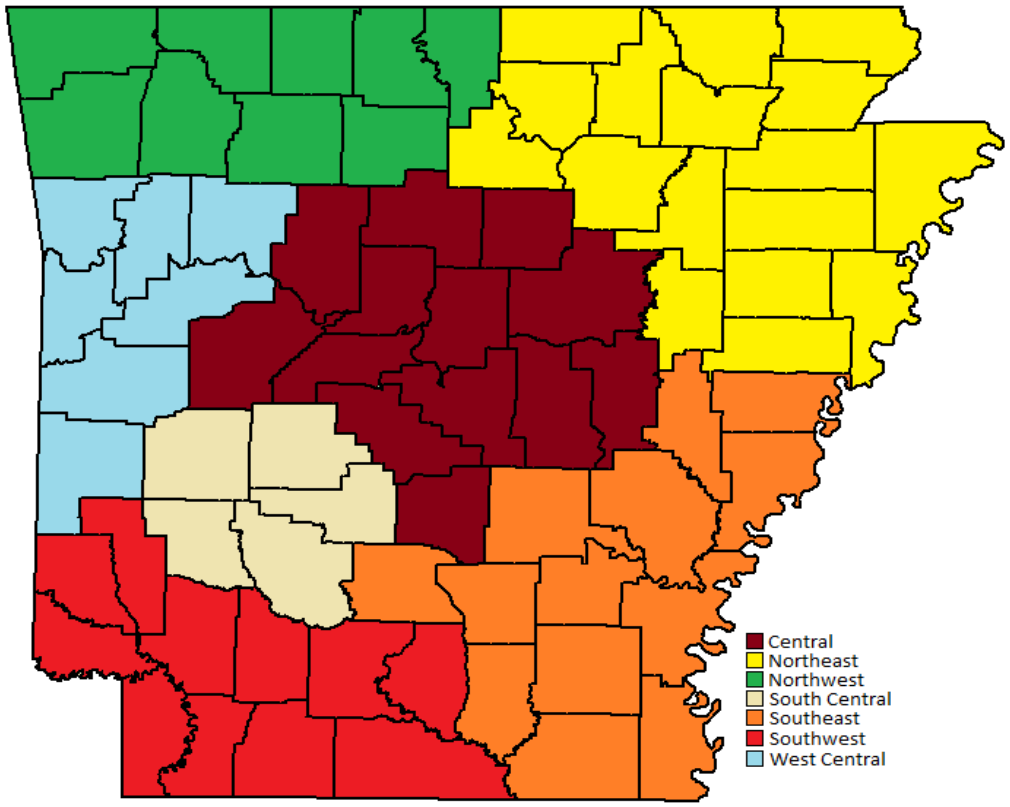
DEFINITION OF HABILITATIVE SERVICES

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.

APPENDIX C



Arkansas Counties by Region

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