Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

BULLETIN NO. 3B-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 (MARKETPLACE)

DATE: June 25, 2013

Qualified Health Plans (QHP), which are non-grandfathered individual or small group plans certified and offered through an Individual or SHOP Marketplace 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 Marketplace 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 provided training on the use of SERFF for application and plan submission to the Marketplace. 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 (SAD) Issuers should submit their applications with their rate and form filings between May 20, 2013 and June 30, 2013. Toward a requirement that consumers in each of Arkansas's 75 counties have a choice among at least two health insurance issuers, each issuer is required to submit to AID their planned service areas for 2014 by June 3, 2013 to allow the Commissioner adequate time for review of proposed service areas. If changes in a proposed issuer's service area are required, the Commissioner will contact that issuer as soon as possible. Please send this submission to insurance.exchange@arkansas.gov.

The Commissioner will maintain flexibility to conduct ongoing negotiations to achieve a competitive Arkansas Marketplace. AID will review issuer applications through July 31, 2013 and will submit all approved and 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 Marketplace 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.

Issuers notified the Marketplace of their intent to participate in the certification process by March 8, 2013 by sending an email to insurance.exchange@arkansas.gov. A secondary bulletin notifying issuers of the intent to participate by SAD Issuers was published on March 15, 2013.

On April 23, 2013, Arkansas enacted the Health Care Independence Act of 2013, establishing the Health Care Independence Program (hereinafter referred to as the "Private Option"). The intent of the Private Option is to create a fiscally sustainable, cost-effective, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; promote accountability, personal responsibility and transparency; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to Arkansans. The Act is expressly written to "improve access to quality health care…attract insurance carriers and enhance competition in the Arkansas Marketplace… [and] promote individually owned health insurance." See Act 1498 of 2013, p.3. Through authority granted by the Health Care Independence Act and using the Medicaid premium assistance model, Arkansas Medicaid will purchase QHPs doing business in the Marketplace for certain Medicaid eligible beneficiaries. In 2014, Private Option eligible individuals will include childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare and parents between the ages of 19 and 65 with incomes between 17% of the FPL and 138 % FPL who are not enrolled in Medicare. Individuals who have been determined disabled or who have been determined to be more effectively covered under the standard Medicaid program (such as an individual who is medically frail or other individuals for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex or would undermine continuity or effectiveness of care) will not be eligible for the Private Option.

Plan Year 2014 is considered a "transition to market" year and, as such, AID will allow flexibility with some certification standards in an effort to attract more issuers to the changing Arkansas Marketplace. Year one certification standards are outlined in the table below. In Plan Year 2015, AID expects to update these standards to include:

- Transition of current identified Medicaid populations off of Medicaid and on to the Private Option;
- Development of cost sharing parameters for 50-100% FPL; and
- Development of Health Savings Account and Medical Savings Account models for populations above 50% FPL.

In 2014, Private Option eligible individuals at or below 138% of FPL will be permitted to shop among and enroll in QHPs offered at the Silver metal level in the Marketplace, at the following actuarial value variations:

- ***Eligible Individuals with Incomes from 0-100% of the Federal Poverty Level:*** Zero Cost Sharing Silver Plan Variation (100% actuarial value) for year one. In year two, AID will implement cost sharing for this income group where actuarial value can be attained (e.g. 50-100% FPL).

- ***Eligible Individuals with Incomes from 101-138% FPL:*** High-Value Silver Plan Variation (94% +/- 1% actuarial value). To facilitate implementation of a consistent approach to cost sharing across all High-Value Silver Plan enrollees, AID will require that all QHP Issuers' High-Value Silver Plan variations conform with prescribed cost sharing amounts as defined

by AID. (See Bulletin Section "*Plan Variations for Individuals Eligible for Cost Sharing: State Standards*")

AID reserves the right to seek modified proposals and/or recommend non-certification of plans to the extent necessary to ensure cost effective pricing of QHPs across all seven rating areas. Because of significant reduction of uncompensated care for uninsured patients and related cost shifting, and increased competition in the marketplace, the State expects deflationary pressure on the cost of care which should reduce premium pricing.

Arkansas's outreach and enrollment efforts will be substantial in order to reach and enroll as many individuals eligible for QHP coverage and the Private Option during the Open Enrollment period beginning on October 1, 2013 and ending on March 31, 2014." These efforts will include targeted outreach to individuals enrolled in other low income programs such as SNAP, parents of AR Kids First enrollees, those receiving child care assistance, etc. AID will also establish a rolling Special Enrollment Period for individuals who are determined eligible or re-determined eligible for the Private Option. All Marketplace requirements with respect to Open Enrollment and Special Enrollment Periods will apply to all QHPs doing business on the Marketplace.

General Requirements	
Federal Standard 45 CFR §§ 153.400, 153.410 45 CFR. § 153.610 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 ACA § 1343	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) 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; (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, as well as special enrollment periods; (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) 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 Marketplace 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; (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) Provide a matching benefit plan and price off of the Marketplace if the plan offered within the Marketplace offers all ten Essential Health Benefits; (18) Participate in the reinsurance program, including making reinsurance contributions and receiving reinsurance payments; and (19) Participate in risk adjustment.
State Standard	AID will utilize a certification approach to reviewing, recommending, and submitting the rate, form and QHP Issuer 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. As part of the application, the QHP Issuer must fill out and submit the checklist that is attached in SERFF and is included for reference purposes only in this Bulletin as Appendix A. AID will review the pricing of QHPs, to ensure that all QHPs are adequately and appropriately priced for the Arkansas Marketplace. 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. Additionally, AID will allow individuals to enroll in or change from one QHP to another as a result of an individual being determined eligible for or re-determined eligible for the Private Option. 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 SAD plans become certified on the Marketplace. Three (3) SAD Issuers notified AID of their intent to participate as published in AID Bulletin 8-2013. Another SAD Issuer has since given AID notice to participate. This requirement will not have any affect on the QHPs actuarial value (AV) results related to either the embedded or unembedded plan as the AV Calculator does not review pediatric dental as part of the standard population. Furthermore, in future years of the Marketplace, AID may limit the number of plans or benefit designs that may be offered by a carrier per "metal tier" level on the Marketplace.

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 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 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 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 Marketplace: • 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 Marketplace for publication online in accordance with guidance from the Marketplace 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 QHP Issuer's network meets the minimum federal requirements and complies with all requirements in AID Bulletin 11A-2013 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. The percentage of ECPs in a network will be measured against the federal lists that can be found at https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu and https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq. To the extent that issuers subject to the alternate standard cannot meet the safe harbor or minimum expectation levels, factors and circumstances identified in the supplemental response along with an explanation of how the issuer will provide access to low-income and underserved populations will be taken into account. AID reserves the right to add additional state standards for future plan years of the Marketplace.

Accreditation	

Federal Standard
45 CFR 156.275
45 CFR 155.1045
	• 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®)[1] 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 Marketplace 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.
	
	  • To verify the accreditation information, QHP Issuers must upload their current and relevant accreditation certificates.
	
	  • QHP Issuers must complete attestations about the accreditation data that will be displayed on the Marketplace website.
	
	  • 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
	
	• 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.
	
	• 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	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

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

	that it will receive and provide proof of receipt of full Marketplace accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area for the Individual Marketplace is the geographic area in which an individual must reside. 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.
State Standard	All QHP Issuers must file a statement of intent by June 3, 2013 indicating what service area(s) they intend to serve in 2014. Service areas will have the same geographic boundaries as rating areas as defined in Appendix C. The state will allow QHP Issuers to choose their service area(s) for year one with a goal of having at least three or more issuers per service area. The Commissioner reserves the right to require broader service areas as needed to achieve the state's coverage requirements of at least two issuers per service area. 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.
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 nine (9) rating areas, within the State of Arkansas based upon its metropolitan areas 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 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. Federal quality criterion is not established and therefore 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. ***In order to advance quality and affordability, Arkansas will require participation in Arkansas's Payment Improvement Initiative no later than year two of the Marketplace. As part of the participation requirements for Plan Year 2015, Arkansas intends to transition participation in the Arkansas Payment Improvement Initiative by requiring, at a minimum, that QHP Issuers will assign a primary care clinician; provide support for patient-centered medical home; and provide access of clinical performance data for providers. 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 are still under development and will be released in a future Bulletin.*** AID intends to establish during plan year 2014 a QHP submission process for 2014 claims and encounter data utilizing the X12 standards (www.X12.org) in eligibility files and medical claims, and the National Council for Prescription Drug Programs Standards in Pharmacy Claims Files. Submission will be implemented no sooner than three months from the end of the plan year (e.g., no sooner than April 2015) to support rate requests, assess network adequacy and support quality and payment improvement.
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 IRS Revenue Procedure 2013-25 Letter to Issuers	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 Marketplace or SHOP 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. QHP Issuers may also choose to offer a bronze or platinum metal level plan. All of the plans must meet the AV requirements as specified in 45 CFR 155 and will be verified by use of the AV Calculator. However, SAD plans may not use the AV Calculator and must demonstrate that the SAD plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85%, and with a de minis variation of +/-2%. This must be certified by an actuary accredited with the American Academy of Actuaries. Additionally, a catastrophic plan may be filed to be sold on the Marketplace in addition to the tiered metal levels. It should be noted that child-only policies are only available in the individual Marketplace. 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. Moreover, 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, 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 AV 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. IRS published the high-deductible health plan limit for 2014 on May 6, 2013 stating that the annual limitation on cost sharing for embedded plans in the 2014 plan year will be $6,350 for self-only coverage and $12,700 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 limits on the dollar value of any 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. However, an issuer may propose a higher deductible in order to meet

	the actuarial value of the plan that is proposed.
	
	SAD plans must demonstrate that they have a reasonable annual limitation on cost sharing. For 2014, "reasonable" means any annual limitation on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees. 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 Marketplace and **not** in the SHOP. Additionally, child-only plans are not required to be offered at the catastrophic level of coverage.
	
	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. It should be noted that no additional age rating may be included in SAD plans for pediatric dental for purposes of completing the QHP application, but SAD Issuers may indicate whether the rate is estimated or guaranteed. If the rate is estimated, the SAD Issuer may later add more age rating factors.
	
	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:
	• 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.
	  • 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.
	
	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.

State Standard	Specific state rate and form filing requirements may be found in Appendix A, attached. To the extent that Arkansas has benefits subject to "mandatory offering" statutes, these benefits, if not already imbedded into the QHP, must be offered by: • Providing a link to a plan brochure that describes the

	mandatory offering benefits and how to purchase; and • Including an application and description of mandatory offering benefits in the mailing with the consumer's plan identification card. Information regarding Arkansas mandatory offerings can be found at: http://www.insurance.arkansas.gov/LH/Mandates.html.
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. 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 EHB in the same way they apply in the current market. These benefits, as with all EHBs, 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. Additionally, Act 72 of 2013 was adopted which prohibits offering coverage of elective abortions as a part of EHBs on an Exchange established by Arkansas. AID will require an attestation from the QHP Issuer that states the issuer is in compliance with all 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. AID will require an attestation that the issuer: (1) provides response by telephone or other telecommunication device within 72 hours of a request for prior authorization, and (2) provides 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	(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, 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. 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.
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 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 submission 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 up to and including the recommendation of the QHP for decertification.
Actuarial Value Standards	
Federal Standards 45 CFR 156.135	Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of AV (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%) SAD plans must offer plans at either a 70% or 85% AV level.
State Standards	AID will require an attestation of compliance with AV 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) PHSA 2794	HHS intends to propose a phased approach to new quality reporting and display requirements for all Marketplaces 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 Marketplaces. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking 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 Marketplace, HHS, and the 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 for the same plan must be the same inside and outside the Marketplace. • Rating will be allowed on a per member basis. For SHOP plans, the geographic premium rating factor will be based on the geographic area of the employer. • 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. 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, SAD Issuers will be able to make premium adjustments for their SAD plans that are considered excepted benefits upon consumer enrollment, but must indicate that rates are not guaranteed for QHPs offered on the Marketplace. Outlier identification on 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. QHP Issuers, but not SAD Issuers, are required to submit the Unified Rate Review Template for rate increase.
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 later issue additional standards related to tobacco cessation.

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, 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. SAD plans are excluded from cost-sharing reduction (CSR) requirements. However, SAD plans must have a "reasonable" annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees. This will be completed via rate and benefit templates.
State Standard	AID will require an attestation of compliance with Plan Variation Standards. In support of the Private Option, AID will require that all QHP Issuers' High-Value Silver Plan variations (94% +/- 1% AV) conform to prescribed cost sharing amounts as defined by AID in Appendix D.
Stand Alone Dental Plans	
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)	SAD Issuers and SAD plans must meet the same QHP certification standards as medical plans unless exceptions were noted in the above sections. Additionally, SAD plans are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Moreover, SAD plans may impose up to a 24 month waiting period for orthodontia services. SAD plans 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.
State Standard	There are no additional state standards for SAD plans. SAD plans must comply with the AR EHB benchmark plan: AR Kids B (CHIP) pediatric dental.

Jay Bradford

JAY BRADFORD, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

June, 25 2013

DATE

APPENDIX A

✓	Category	Statute Section
	QHP Issuer Application Receipt	
☐	Marketplace application data is complete	
☐	Received Final QHP Issuer Application Submission Attestations, including: • Service Area Attestation • Rating Areas Attestation • Network Adequacy • Actuarial Value • Plan Variation Standards • Marketing Regulations and Transparency • Market Reform Rules • Licensure and solvency • Compliance with Essential Health Benefits • Accreditation • Child Only policy equivalence (if applicable) • AHIP EHB Formulary Compliance • AHIP Pharmacy Prior Authorization	
	Evaluation of QHP Issuer Application	
	Accreditation and Quality Standards	*45 CFR 156.275*
☐	Applicant has *Marketplace* accreditation through NCQA and/or URAC, or: **Year 1-** Applicant has applied for *Marketplace* accreditation through NCQA and/or URAC **Year 2-** Issuer procedures and policies are accredited	
☐	Attestations and supporting documentation are accurate and complete or accreditation is verified in SERFF	
☐	Issuer has authorized release of accreditation data	*State Partnership Guidance 1/2013*
	Complaint and Compliance	
☐	Requested complaint and compliance information (from consumer services division) received and reviewed	
	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 cost-sharing variations are submitted for each silver-level QHP.	*PPACA 1402(a)-(c)*
☐	High-Value Silver Plan Variation (94% +/- 1% actuarial value) meets AHIP requirements.	
☐	SAD plans must have a "reasonable" annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees.	

☐	For each QHP at each level of coverage issuer must submit to the Exchange for certification the health plan and two variations of the health plan: • No Cost Sharing Plan for individuals eligible for cost- sharing reductions under § 155.350(a) • Limited Cost Sharing Plan for individuals eligible for cost- sharing reductions under § 155.350(b)	*PPACA 1402(d)*
☐	Cost-sharing incurred under plan do not exceed the dollar amount limits established by federal and state laws and regulations ($6,350 for self-only coverage and $12,700 for family coverage in plan year 2014).	
	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%)*	45 CFR 156.200
☐	*Child-Only* Plans are offered at each level of coverage (submitted as separate plans or confirmed by issuer 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. Catastrophic plans are excluded from this requirement.	PPACA 1302(f)
☐	Actuarial Memorandum and Certification Received	
☐	*Verify 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*	
☐	Confirm Benefit Substitution A/V	
☐	**Confirm Actuarial Metal Level Submitted** *Bronze (60%)* *Silver (70%)* *Gold (80%)* *Platinum (90%)* *Catastrophic (<58%)* *(Allowable variance: +/- 2%)* *For Stand Alone Dental:* *Low (70%)* *High (85)* *(Allowable variance +/- 2%)*	
☐	**Meaningful Difference** Compare all plans an issuer offers to identify multiple, identical plans that are offered in the same counties or have limited variation between deductible and out-of-pocket maximum.	
☐	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*	
☐	***Emergency services*** *Emergency Care Services* *After-hours clinic or urgent care center* *Observation services* *Transfer to in-network hospital* *Ambulance Services*	
☐	***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*	
☐	***Maternity and newborn care*** *Certified nurse midwives* *Newborn care in the hospital* *In vitro fertilization for PPO plans* *Genetic testing to determine presence of existing anomaly or disease* *Prenatal and Newborn Testing* *Maternity and Obstetrics, including pre and post natal care*	*§23-79-129 & Bulletin 1-84*
☐	***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*	
☐	***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* *Includes barbiturates, benzodiazepines, and agents used to promote smoking cessation,*	

	including agents approved by the Food and Drug Administration as over-the-counter drugs for the purposes of promoting tobacco cessation.	
☐	***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*	
☐	***Laboratory services*** *Testing and Evaluation*	
☐	***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*	
☐	***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* *Medically-Necessary Orthodontia*	
☐	***Pediatric Vision*** *Eye Exam* *Surgical evaluation* *Eyeglasses – one pair per year* *Lenses* *Medically-Necessary Contact lenses* *Eye prosthesis*	

	Polishing services Vision Therapy Developmental Testing	
☐	**Miscellaneous** *Complications from Smallpox vaccine*	
☐	***State Mandated 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	*23-79-601 et al & Rule 70*
	Diabetes Management Services	
	Equity in Prescription Insurance & Contraceptive Coverage	*23-79-1101 et al*
	Formula PKU/Medical Foods & Low Protein Modified Food	*23-79-701 et al*
	Medical Foods and Low Protein Modified Foods	
	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	*23-99-404; 23-79-129*
	Mental Health parity	*23-99-501 et al*
	Off-Label Drug Use	*23-79-147*
	Prostate Cancer Screening	*23-79-1301*
	Orthotic & Prosthetic Devices or Services	*23-99-417*
☐	**Mandated Persons Covered, including:**	
☐	*Adopted Children*	
☐	*Handicapped Dependents*	
☐	**Mandated Providers** *Ambulatory Surgery Center, Audiologists, Chiropractors, Dentists, Emergency Services, Nurse Anesthetists, Optometrists, Podiatrists, Psychologists, Physician Assistant*	
☐	**Mandated Benefit Offerings** Mandatory benefit offerings not in the benchmark plan (including hearing aids and TMJ) are included in the QHP, OR issuer demonstrates that they will be offered through URL to brochure that describes the mandatory offering benefits and how to purchase or mailed with an application and description of mandatory benefit offerings with the consumer's plan identification card.	
☐	**Elective Abortion** Coverage of Elective Abortion is prohibited	Act 72 of 2013
	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)*

☐	Benefits not designed in a way that discriminates against individuals because of age, disability, or expected length of life	*PPACA §1302(b)(4)(B)*
☐	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*
	Pre-existing conditions	*42 USC 300gg-3*
☐	Plan must contain no preexisting condition exclusions	
	State licensure, solvency, and good standing	*45 CFR 156.200(b)(4)*
☐	Issuer properly licensed	
☐	Company financially solvent and in good standing	
	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.*
☐	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*
☐	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*
☐	Received Attestation of compliance with marketing/discriminatory benefit design regulations	
	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	
☐	Received QHP Market Reform Attestation of QHP compliance with market reform rules in accordance with state and federal requirements.	
☐	Guaranteed Availability of Coverage	*45 CFR § 147.104*
☐	Guaranteed Renewability of Coverage	*45 CFR §*

		147.106
☐	Single Risk Pool	*45 CFR § 156.80*
☐	Catastrophic Plan Requirements, including but not limited to: • Provides coverage for at least three primary care visits per year before the deductible is met. • No annual limits on the dollar value of EHBs; • Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance; • Plan is offered only in individual market, not in SHOP; • Coverage for emergency services required; and • Does not provide a bronze, silver, gold, or platinum level of coverage.	*45 CFR § 156.155*
	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*
☐	Submission of time/distance measures for each QHP network	*45 CFR 156.230*
☐	Essential community providers listed	*45 CFR 156.235*
☐	Accredited policies and procedures that includes network adequacy	*PHS SEC.2702(c)*
☐	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*
☐	Provider directory is available for online publication with indication of providers no longer accepting new patients	*PPACA 156.230*
☐	Provider directory available to individuals in English and Spanish	*PPACA 156.230*
	Rating Areas and Actuarial Value	
☐	Rate-setting practices are consistent with the approved metrics	*PHS SEC.2701(a)*
☐	Attestation of compliance with state rating areas (7 rating areas)	*PHS SEC.2701(b)*
	Service Areas	
☐	QHP service area covers at least one geographic rating area, OR issuer has submitted a hardship waiver that is approved by the Commissioner.	*PPACA 155.1055(a)*
☐	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);* PHS Act 2705
	Receive Rate and Benefit Data and Information	
☐	Plan data and supporting documentation complete	
☐	Issuer submission of data completed before end of open enrollment period	
☐	QHP rate and benefit data and information approved	
	QHP Certification Agreement	
☐	Issuer application and plan data approved	
☐	Submit issuer and plan data to CMS	

☐	CMS Certification Received	
	Issuer or Plan Non Certification	
☐	Notify issuer of non-certification of QHP(s) or Issuer	
☐	Update QHP(s) and Issuer Account Information	

APPENDIX B

DEFINITION OF HABILITATIVE SERVICES

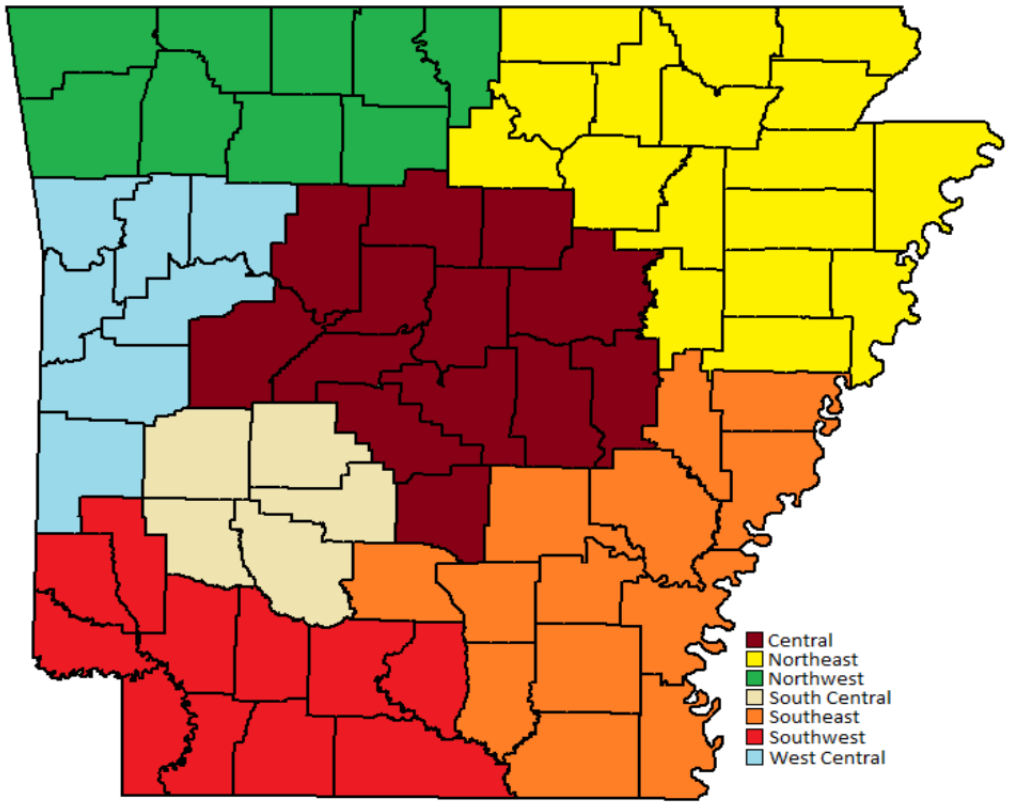
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

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

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 D

HIGH LEVEL SILVER PLAN COST SHARING VARIATION REQUIREMENT

High-Value Silver Plan
100% FPL - 150% FPL

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	$ 20	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 E

SUMMARY OF CHANGES FROM FEBRUARY 19, 2013 RELEASE

- "Exchange" was changed to "Marketplace" throughout.
- Page 1, A Letter of Intent to cover specific service areas to the Commissioner must be submitted by June 1.
- Page 2-3, Information was added related to the Health Care Independence Program, including the requirement to submit a letter of intent to AID by June 1, 2013 describing the QHP Issuer's intended service areas.
- Page 3-4, General Requirements: Lines numbered 16 and 17 were added to be in compliance with the recently released federal rule.
- Page 4, General Requirements/State Standards: Additional information related to the high value silver plan variations was added. Clarifications to requirements for SAD Issuers and Plans were included.
- Page 7, Network Adequacy/State Standards: A link to the ECP lists was included, as well as information clarifying how the standard would be measured.
- Page 7, Accreditation: Additional information was added related to SAD and clarifying what accreditation information must be submitted.
- Page 8, Service Area: Updated service area requirements.
- Page 8, Rating Areas: The federal definition of rating areas was updated to be in compliance with the recently released federal rule.
- Page 9, Quality Improvement Standards: Requirements to participate n the Arkansas Payment Improvement Initiative and reporting requirements were added.
- Page 10, General Offering Requirement: Information related to requirements for SHOP, child-only plans, mandatory benefit offerings, and high deductible health plan limits, SAD plan rating limitations were all added.
- Page 13, Essential Health Benefit Standards/State Standards: Notification of requirement to provide medically necessary orthodontia and prohibition to offer coverage of elective abortion as an EHB.
- Page 14, Essential Health Benefit Formulary Review: Requirement to provide at least a 72 hour supply of drugs in emergency situations, as well as the requirement to cover additional pharmaceuticals.
- Page 14-15, Nondiscrimination Standards in Marketing and Benefit Design: Marketing must be submitted to AID before it may be used. The original bulletin stated that all

marketing must be prior approved. CMS has since clarified its position that all marketing is not required to be prior approved, but that a state must at a minimum provide for spot checking marketing material. This new standard will allow for the state to be able to maintain compliance with that standard while giving more flexibility to the QHP issuers. Additionally, information related to outlier benefit review was included.

- Page 16, Rate Filing: Information added related to SAD Issuer/Plan rating requirements, outlier analysis Unified Rate Review Template and SHOP rating requirements.
- Page 17, Plan Variation for Individuals Eligible for Cost Sharing: Added information related to SAD Issuers/Plans and requirements for the high level silver plan variation.
- Page 18, Stand Alone Dental Plans: New section related to SAD Issuer/Plan requirements.
- Page 18, Appendix A: Checklist updated to match new information as included above.
- Page 37, Appendix C: Added rating area numbers to match federal templates and updated name to indicate that this is indicative of both rating and service areas.
- Page 38, Appendix D: Added High Level Silver Plan Cost Sharing Variation requirements.

SUMMARY OF CHANGES FROM JUNE 25, 2013 RELEASE

- The State Standard section under Quality Improvement standards was updated to show requirements related to the Arkansas Payment Improvement Initiative.
- Appendix D was updated with new information.