Arkansas Insurance Department

Asa Hutchinson
Governor

Allen Kerr
Commissioner

BULLETIN NO. 3-2016

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: 2017 PLAN YEAR REQUIREMENTS FOR QUALIFIED HEALTH PLAN CERTIFICATION

DATE: March 1, 2016

The Affordable Care Act (ACA) requires that all issuers and plans participating in the Federally-facilitated Marketplace Plan Management Partnership (Partnership) and the Arkansas Health Insurance Marketplace (AHIM) for Small Business Health Options Program (SHOP) plans meet federal and state certification standards for Qualified Health Plans (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 define the plan year 2017 federal and state requirements for QHP certification in the Arkansas individual and SHOP Health Insurance Marketplace. Though this Bulletin attempts to provide a cohesive source of information for both the state and federal requirements, issuers are advised to consult with the federal regulations, 2017 Issuer Letter, and state law in conjunction with this Bulletin to ensure full compliance.

Health insurance issuers should submit their applications to become QHP or Stand Alone Dental Issuers together with form filings by April 1, 2016. Rate filings for new plans and QHPs seeking recertification must be submitted by SERFF by May 10, 2016. AID will review issuer applications and will submit all applications to CMS for certification by May 11, 2016; approved plan changes or revisions must be completed two days prior to submission. The 2017 Open Enrollment Period is November 1, 2016 to January 31, 2017.

All issuers waiting until the state's final submission deadline to submit their application to offer a QHP should be aware that AID will review plans in the order received. Any plans not having undergone complete review and gaining state approval for recommendation prior to August 23rd, 2016, will be ineligible for offering a QHP through the Marketplace during the 2017 Open Enrollment Period. If forms and rates are not approved by open enrollment, the products must be available for issue at any time throughout the year, and applicants cannot be denied coverage due only to the fact that it is not an open enrollment period.

Issuers will be given an opportunity to address any data errors during the plan preview periods as designated by CMS. No changes will be allowed to QHP data after August 23, 2016, unless necessary to correct data errors or align QHPs with products and plans approved by the state. All such changes must be pre-approved by both CMS and AID for individual plans and AID and AHIM for SHOP plans. CMS will notify all Individual plan issuers of the QHP Certification decision and complete the certification agreement in late

September 2015 according to the timeline below. Correspondingly, AHIM will notify all SHOP plan issuers of the QHP Certification decision and complete the certification agreement prior to open enrollment.

Tentative QHP Application and Certification Timeline

2016 Key Dates	Description
April 1st	QHP Applications must be submitted to AID
May 10th	QHP rate data must be submitted to AID
April 2nd – May 11th	AID QHP Review Period
May 11th	1st SERFF Data Transfer for Individual Plans
May 12th – June 10th	FFM Reviews Individual Plan Data
June 15th	FFM Notifies States of any Needed Corrections to Individual QHP Data
June 30th	Last date for States to Resubmit Individual Plan Data into SERFF for FFM Review
July 1st - August 2nd	FFM Completes Re-review of Individual Plan Data and State Recommendations
August 8th	FFM Notifies States of any Needed Corrections to Individual QHP Data
August 23rd	Final Deadline for Submission of Individual QHP Data to FFM Deadline for All Risk Pools with QHPs to be in "Final" Status in the URR System; Submission of finalized SHOP QHP to AHIM; Data Locked Down
August 24th –September 9th	Final FFM Review of Corrected Individual QHP Application Submissions
September 8th	Final Deadline for State Plan Approval to be sent to CMS for Individual Plans; Final Deadline for State Plan Approval to be sent to AHIM for SHOP Plans
September 15th – October 4th	Certification Notices and QHP Agreements Sent to Issuers, Agreements Signed, QHP Data Finalized
November 1st	Open Enrollment Begins

QHP Certification and Recertification Overview

All plans offered in the Marketplace must be certified (or re-certified) prior to open enrollment. Additionally, stand-alone dental plans (SADPs) offered in the Marketplace or outside of the Marketplace as an option to satisfy the pediatric dental Essential Health Benefit requirement in conjunction with medical plans must also seek certification (or recertification). All application materials are required for first-time certification applications as well as those plans currently offered in the marketplace submitted for recertification. The recertification process will largely resemble the initial certification process; however, applications for recertification should include a redlined version of the plan forms and a written justification for any changes to cost-sharing and covered benefits. Plans seeking recertification may maintain the same plan and Health Insurance Oversight System (HIOS) identification numbers if there are no changes to the plan from the preceding plan year other than changes considered *uniform modifications* under Public Health Service Act (PHSA) Sections 2702 and 2703 and subsequent regulations. AID will review plans for compliance with QHP certification requirements. Further recertification guidelines will be found in the filing instructions posted in System for Electronic Rate and Form Filing (SERFF).

Memorandum of Understanding between Issuers and the Arkansas Insurance Department and Department of Human Services

QHP Issuers must enter into a Memorandum of Understanding (MOU) with the Arkansas Department of Human Services (DHS) and AID which outlines coverage coordination procedures, data and financial transactions, and reporting requirements. QHP Issuers must agree to provide DHS and AID with information necessary to evaluate the Healthcare Independence Program or its replacement in accordance with 1115 CMS Waiver evaluation requirements. The MOU will include timeframes for quality reporting and other reporting as required. A sample MOU is available from AID at http://rhld.insurance.arkansas.gov/AboutResources.

Federal and State QHP Certification Standards

Generally, QHPs must meet all requirements impacting QHP criteria detailed in the Patient Protection and Affordable Care Act (ACA), and associated regulations and guidance from CMS. AID will review forms, templates, and rates for compliance with federal and state insurance rules and regulations and will recommend the plans for certification to either CMS or AHIM as appropriate. AID will review the pricing of all QHPs to ensure that the plans are adequately and appropriately priced for the Arkansas Marketplace. Certification will be valid for a period of one (1) plan year. If an issuer wishes to continue offering a certain QHP following that plan year, the issuer must apply to have that QHP recertified. Specific state and federal rate and form filing requirements for plan year 2017 submissions will be posted in SERFF.

Licensure and Solvency

A QHP Issuer must be licensed and in good standing with the State. AID determinations of good standing will be based on authority found in Ark. Code Ann. § 23-63-202. To be found in good standing, a QHP Issuer must have authority to write its authorized lines of business in Arkansas. Additionally, all complaints and QHP Issuer oversight findings from the prior plan year will be considered as a part of good standing determination. AID is the sole source of a determination of whether an issuer is in good standing and may as a part of that finding restrict the QHP Issuer's ability to issue or renew existing coverage for an enrollee.

Network Adequacy

A QHP and/or SADP Issuer must ensure that the provider network of each of its plans is available to all enrollees. QHP Issuers will need to attest that they have met this standard and have a provider network with a sufficient number and type of providers, including providers that specialize in Mental Health and Substance Use Disorders and Essential Community Providers targeting underserved populations. Federal and state requirements, particularly Arkansas Rule 106, must be met. General information and instructions for initial data preparation required for complying with Network Adequacy is available at http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy. Instructions for all subsequent data submissions after the initial data preparation phase will be posted in SERFF and related Arkansas specific templates will be available at http://rhld.insurance.arkansas.gov/Info/Public/Templates. Arkansas has adopted the U.S. Department of Health and Human Services (HHS) hosted National Provider Identifier (NPI) Registry as an important artifact in its Network Adequacy regulation program and requires issuers to reach out to providers to ensure accurate taxonomic classification information.

A list of Essential Community Providers may be found at:
http://cciio.cms.gov/programs/exchanges/qhp.html"Other Qualified Health Plan Application Resources under "Other Qualified Health Plan Application Resources."

A list of School Based Providers may be found at:
http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy

Accreditation

QHP Issuers, excluding SADP Issuers, must maintain accreditation on the basis of local performance in the following categories: Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS); Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers

and Systems (CAHPS®) survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs. Accrediting authorities recognized by AID for Plan Year 2017 are the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC).

QHP Issuers within their first year of certification who are without existing commercial or Marketplace health plan accreditation must schedule an accreditation review during their first year of certification and receive accreditation on their policies and procedures that are applicable to its Marketplace products prior to recertification. If plans were already accredited, the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP. QHP Issuers must be fully accredited by the fourth year of certification.

Service Areas and Rating Areas

A "Service Area" for the Individual Marketplace is the geographic area in which an individual resides. Service area may additionally be the geographic area where an individual is employed for the purposes of SHOP. A "Rating Area" is a geographic area established by a state that provides boundaries by which issuers can adjust premiums. Arkansas will require service areas to have the same geographical boundaries as rating areas for 2017. An issuer's service area may contain more than one rating area, thus an issuer may offer plans with a statewide service area while modifying rates based on allowed rating areas within that service area. The areas are defined in Appendix A.

QHP Issuers will be allowed to choose their service area(s). Any QHP Issuer requesting to cover less than a full service area must submit a justification as to why the QHP should be considered for certification, as well as an explanation of how the limited area was 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. QHP Issuers seeking an exemption through the justification process will be subject to a stricter review.

General Offering Requirements

QHPs must meet all federal insurance requirements, including meeting cost sharing, meaningful difference, and actuarial minimum standards, for participation in the Marketplace. At least one Silver (68 – 72% AV) and at least one Gold (78-82% AV) plan must be offered in the individual and SHOP markets. Additionally, QHPs in the Arkansas individual market are required to include at least one Silver plan that contains only the Essential Health Benefits (EHBs) included in the state base benchmark plan and that utilizes the 94% cost share variation meeting the parameters as described in Appendix C. All Silver plans, including the EHB only plan, must also include all cost sharing reduction variations (73%, 87%, 94%, and 100% AV). Though Silver and Gold plans must be offered, QHP Issuers are not required to offer Catastrophic, Bronze (58-62% AV) or Platinum (88-92% AV) plans. However, QHP Issuers must offer matching child only plans for each of the ACA metal level plans offered or attest that the plans offered are available to child only members. See ACA §1201. Similarly, SADP Issuers are not required to offer both low (75% AV) and high (85% AV) plans. Actuarial Value (AV) will be determined by use of the CMS AV Calculator.

AID requires that all QHP Issuers offering a plan which has pediatric dental imbedded as part of its benefits also offer an identical plan which does not include pediatric dental as part of its benefits. This requirement will be null and void and all QHP Issuers will be required to have an imbedded pediatric dental benefit should no SADPs become certified on the Marketplace.

Child only and Catastrophic plans will not be offered in the SHOP. Riders are not permitted to be offered in conjunction with Marketplace plans, even if the riders are for non-EHB benefits.

Specific state rate and form filing requirements for plan year 2017 submissions will be posted in SERFF.

Essential Health Benefit Standards

QHP Issuers must offer coverage that is substantially equal to the coverage offered by the state's Base Benchmark Plan. 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.

A QHP Issuer is not permitted to offer elective abortion coverage within QHPs except for meeting requirements of the Hyde Amendment. The QHP Issuer must provide notice through its summary of benefits if such benefit is being made available.

Arkansas has adopted the Gold 1000.1 Health Advantage Point of Service Plan as the base benchmark plan to set the essential health benefits for Arkansas. The base benchmark plan was supplemented with the AR Kids B (CHIP) pediatric dental plan. Finally, AID has adopted a definition of habilitative services, which may be found in Appendix B to this Bulletin along with guidelines for establishing parity with rehabilitative services. Due to the number of questions related to the definition of "developmental services," additional detail has been provided within Appendix B for clarification.

A detailed checklist of benefits included in the Arkansas state benchmark plan can be found in SERFF. Copies of the Base Benchmark Plans may be found at: http://rhld.insurance.arkansas.gov/AboutResources. Please note that the following benefits are displaying incorrectly on Healthcare.gov, but are in the 2017 Benchmark Plan and required of all QHP submissions:

- Orthodontia-Child-2017 listed as **"Covered"** but should be "**Not Covered.**"
- Abortion for which Public Funding is Prohibited- 2017 listed as **"Covered"** but should be "**Not Covered**"
- Dialysis- 2017 listed as **"Not Covered"** but should be "**Covered**"
- Hearing Aids – 2017 listed as **"Not Covered"** but should be listed as "**Covered**"

Additional EHB

In-vitro fertilization is a mandated AR benefit for PPO plans and is considered an EHB for those plans, because mandates applicable to the individual market prior to December 2011 continue to apply to plans in the individual market, even if the state benchmark plan is a small group plan.

Essential Health Benefit Formulary Review

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. Additionally, Issuers must: (1) provide response by telephone or other telecommunication device within 72 hours of a request for prior authorization; (2) provide for the dispensing of at least a 72-hour supply of covered drugs in an emergency situation; (3) provide a URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, that are specific to a given QHP; and (4) have an exception process for a drug not on the formulary.

Non-Discrimination Standards and Marketing and Benefit Design

QHP Issuers and QHPs must comply with federal laws and state laws and regulations regarding marketing and benefit design by health insurance issuers, including Ark. Code Ann. §23-66-201 et seq., Unfair Trade Practices Act and the requirements defined in AID Rules 11 and 19.

QHP Issuers may inform consumers in QHP marketing materials that the QHP is certified as a QHP after entering into a certification agreement with either CMS for Individual Plan Offerings or AHIM for SHOP

plan offerings. 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 submission of QHP marketing materials in searchable PDF format prior to use. Any multi-media marketing materials should be provided through a link within a pdf document. AID reserves a right to request a timely upload of the multi-media files for review. If AID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, AID will enforce through use of state remedies up to and including the recommendation of the QHP for decertification.

Rate Filing

All rates filed for QHPs in the individual market will be set for the plan year and cannot be changed during the year. SHOP rate revisions may be filed quarterly. Please see Bulletin 13-2015. 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 justifications in coordination with AID and timely submitted to the FFM if appropriate. All rates will be analyzed for outliers and subject to testing to identify if discriminatory design practices are present.

AID will continue to effectuate its rate review program and will review all rate filings and rate adjustments for prior approval. Rate filing information must be submitted to AID with any rate adjustment justification prior to the implementation of an adjustment. A QHP Issuer must prominently post the justification for *any* rate adjustment on its web site. Please refer to Arkansas Bulletin 2-2015 and the 2016 Federal Payment Parameters Rule.

Premiums may be varied by enrollee age (by a factor of 3:1), tobacco use (by a factor of 1.5:1), and geographic rating area (per the seven rating areas identified in Appendix A). 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.

Additional guidelines for rates in SHOP

Composite premiums (average enrollee premiums) are allowed in SHOP as long as the plans meet the following requirements:

- Tobacco rates are not included in the composite premiums but are applied separately on a per-member basis;
- Premium composite cannot be changed during the plan year;
- Composite option must be uniformly available for a product (i.e. cannot be limited to employers of a certain size);
- Composite premiums are offered in two tiers: adults age 21 and over and children under age 21; and
- The Composite otherwise meets the requirements as found at http://rhld.insurance.arkansas.gov/AboutResources.

Stand Alone Dental Plans (SADP)

SADP Issuers and SADPs must meet the same QHP certification standards as medical plans unless exceptions were noted. SADPs must comply with the Arkansas base benchmark plan: AR Kids B (CHIP) pediatric dental. Moreover, SADPs may impose up to a 24 month waiting period for orthodontia services, which is not an Arkansas EHB.

SADPs intended to be utilized outside the Marketplace only for use to supplement medical plans such that the medical plans will comply with federal requirement of offering all 10 EHBs outside the Marketplace as required under the Public Health Services Act must follow the Marketplace certification filing process as described within this Bulletin.

Quality Standards

In order to advance quality and affordability, Arkansas requires participation in the Arkansas Payment Improvement Initiative. As part of the participation requirements for Plan Year 2017, QHP issuers will at a minimum assign a primary care clinician; provide support for Patient Centered Medical Homes; and provide access to clinical performance data for providers. See AID Rule 108 for additional guidelines regarding support for Patient Centered Medical Homes. Participation in the Arkansas Payment Improvement Initiative will also include a requirement to contribute claims and encounter data for the purposes of measuring cost, quality and access. Additional timing and processes related to these requirements will be established in guidance from AID and/or established in an MOU agreement between the issuer and the Division of Medical Assistance and Arkansas Insurance Department.

Quality Improvement and Quality Rating Standards

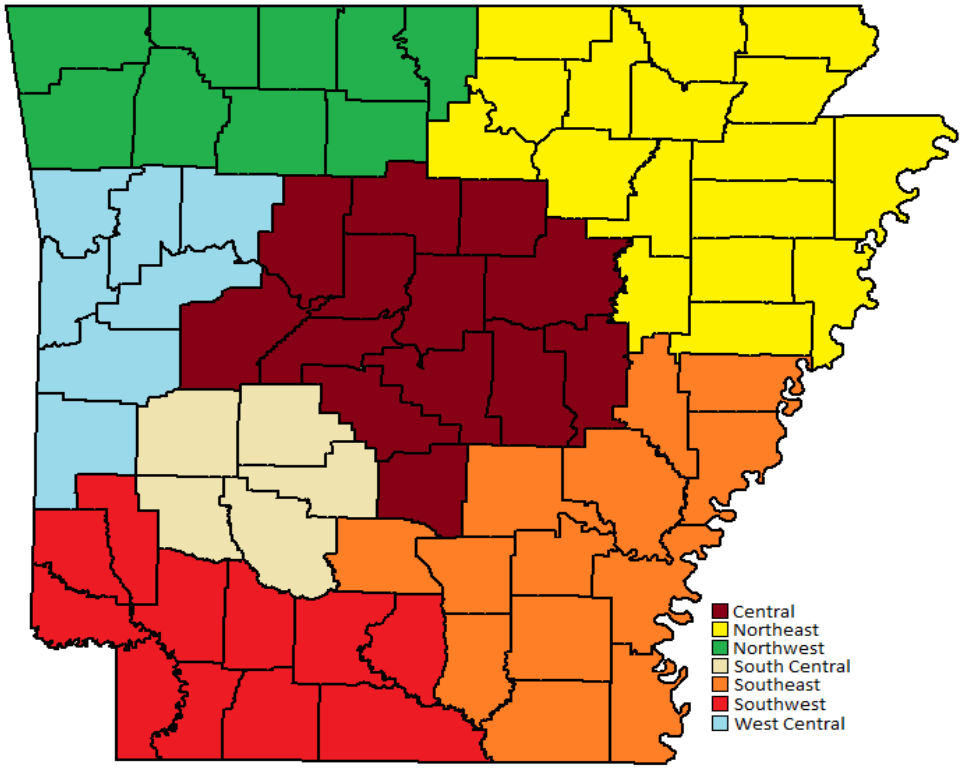
All federal standards must be met. Issuers are advised to refer to the 2017 Annual Letter to Issuers for more details.

ALLEN KERR
INSURANCE COMMISSIONER
STATE OF ARKANSAS

March 1, 2016
DATE

APPENDIX A

STATE RATING AND SERVICE AREAS



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 B

HABILITATIVE SERVICES COVERAGE DEFINITION AND LIMITATIONS

DEFINITION OF HABILITATIVE SERVICES

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

COVERAGE OF HABILITATIVE SERVICES

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

ESTABLISHING PARITY

QHPs must offer habilitative services at parity with rehabilitative services. Because developmental services are generally less expensive and required on a long-term basis, AID has determined that parity must be established through the use of unit equivalency. All medical QHPs must include developmental services with unit limits at an acceptable level of parity with Outpatient and Inpatient Rehabilitation for the 2017 plan year policies. The minimum acceptable limits are included in the table below:

Coverage of Rehabilitative and Habilitative Services at Parity

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

DEFINITION OF DEVELOPMENTAL SERVICES

Developmental Services are assistance activities that are coordinated with physical, occupational, and speech therapy to reinforce impact of such therapy provided in connection with Habilitative Services. Examples include, but are not limited to: toileting; dressing, using fine motor skills; crawling/walking; categorization; expressing oneself (making wants and needs know); .

APPENDIX C

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

High-Value Silver Plan 100% - 150% FPL

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

Service Specific Deductibles:	
Medical	$250
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$854

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