Arkansas Insurance Department

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Governor

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Commissioner

BULLETIN NO. 4-2018

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: 2019 PLAN YEAR REQUIREMENTS FOR QUALIFIED HEALTH PLAN, STAND ALONE DENTAL PLAN CERTIFICATION AND REQUIREMENTS FOR ACA-COMPLIANT, OFF-MARKETPLACE HEALTH PLAN SUBMISSIONS

DATE: April 13, 2018

The Affordable Care Act (ACA) requires that all Issuers and plans participating in the Arkansas Health Insurance Marketplace (AHIM) State Based Marketplace-Federal Portal 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 2019 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, 2019 Issuer Letter, and state law in conjunction with this Bulletin to ensure full compliance. Those companies issuing plans off of the Marketplace will continue to be responsible for meeting state regulation and must meet the tentative filing timeline made available through this bulletin.

Health insurance issuers should submit their applications (templates and network adequacy information) to become QHP or Stand Alone Dental Issuers by **May 18, 2018**. All forms related to the application must be filed no later than **June 1, 2018**. Off Marketplace plan submissions must be made by **August 1, 2018**. Rate filings for new plans seeking certification and QHPs seeking recertification must be submitted through SERFF by **July 23, 2018**. AID will review issuer QHP applications and will submit all applications with a recommendation to certify or not certify to AHIM. The 2019 Open Enrollment Period is November 1, 2018 to December 15, 2018.

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 QHP recommendation prior to September 25, 2018, will be ineligible for offering a QHP through the Marketplace during the 2019 Open Enrollment Period. If QHP or Off-Marketplace 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 or special enrollment period.

Issuers will be given an opportunity to address any data errors during the plan preview periods as designated by CMS and/or AHIM. No changes will be allowed to QHP data after August 17, 2018, 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 AHIM, CMS, and AID. CMS will notify all Individual plan Issuers of the QHP Certification decision and complete the certification agreement in early October 2018 according to the timeline below.

Tentative Timeline

Key Dates	Description
May 18th	QHP and ACA-Compliant health plans (Off-Marketplace) Network Adequacy templates and QHP application templates, including the Rate Data Template and the Rating Business Rules Template, due to AID.
May 18th – June 20th	AID QHP Review Period
June 1st	All QHP and Off-Marketplace forms except the Summary of Benefits and Coverage and Schedule of Benefits are due to AID. SADP forms due to AID
June 20th	AHIM to submit 1st SERFF Data Transfer for Individual Plans to CMS
July 23rd	QHP Rates and Binder rate data due to AID.
July 25th	Initial Rates due to CCIIO.
July 2nd – August 8th	AHIM review Period
August 1st	Off-Marketplace forms and Binder data, excluding rates and Binder rate data, due to AID. CMS Notifies Arkansas of any Needed Corrections to Individual QHP Data
August 9th	CMS and AHIM notify Arkansas of any Needed Corrections to Individual QHP Data
August 10th	Deadline for Issuers to Change Service Areas
August 17th	Final changes to QHP rates and QHP applications due to AID.
August 22nd	Deadline for Final Changes to the Individual QHP Application to CMS and AHIM. AID submits recommendation to AHIM for certification of QHPs.
August 25th	Off-Marketplace Rates and SADP Rates and Binder rate data due to AID. (Group SADP rates are not reviewed.)
September 17th	CMS Posts Plans and Correction Notices.
September 25th	AHIM submits certified plans to CMS. Final Summary of Benefits and Coverage and Schedule of Benefits are due to AID.
October 4th	CMS Completes Certifications and Agreements with Issuers.
October 15th	Rates finalized with CCIIO.
November 1st	Open Enrollment Begins. Final Rates posted.

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 Arkansas Works Program in accordance with 1115 CMS Waiver evaluation requirements. A sample MOU is available from AID at https://insurance.arkansas.gov/pages/industry-regulation/regulatory-health-link/resources/. Additional information may be found at this same link as to any purchasing guidelines developed by the Department of Human Services for PY2019.

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 CMS and AHIM. AHIM and CMS will verify the results of AID's review through utilizing the federal tools available and will communicate any inconsistencies discovered to AID for processing. AHIM will determine whether QHPs and SADPs (both on-Marketplace and off-Marketplace seeking certification) are to be certified.

AID has the final authority over approval of rates and 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 2019 submissions will be posted in SERFF.

Licensure and Solvency

An 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, an issuer must have authority to write its authorized lines of business in Arkansas. Additionally, all complaints and 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 an issuer's ability to issue or renew existing coverage for an enrollee.

Network Adequacy

A QHP, Off-Marketplace, and/or SADP Issuer must ensure that the provider network of each of its plans is available to all enrollees. 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 described in the document *"PY2019 SERFF Network Adequacy Data Submission Instructions"* available within SERFF's "Plan Management General Instructions" section and also at http://rhld.insurance.arkansas.gov/Info/Public/Templates.

It is highly recommended that QHP, Off-Marketplace, and/or SADP Issuers participate in the maintenance of Provider-Type-NPI-Pools for an accurate and common classification of providers, twice a year per timelines posted in *"NA Review Process"* available at http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy. Since 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, issuers are encouraged to reach out to providers to verify accuracy of Registry information including taxonomic classification information.

A list of Essential Community Providers for QHPs may be found at:
https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy

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 2018. 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 and Off-Marketplace Issuers will be allowed to choose their service area(s). Any QHP or Off-Marketplace Issuer requesting to cover less than a full service area must submit a justification as to 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, 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 for each region in which the company is participating. If a company also has a multi-state plan offering in in the same service area, the company will not be required to have a gold plan for both its local company offering and its multi-state plan offering so long as at least the multi-state plan offering offers a Gold plan. 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 embedded 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 embedded 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. Non-EHB benefits may be submitted for use in plans under separate form numbers.

Off-Marketplace plans have different offering requirements. Specific state rate and form filing requirements for QHP and Off-Marketplace submissions will be posted in SERFF.

Essential Health Benefit Standards

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: https://insurance.arkansas.gov/pages/industry-regulation/regulatory-health-link/resources/. Please note that the following benefit is displaying incorrectly on Healthcare.gov, but is in the Benchmark Plan and required of all QHP submissions:

- 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

QHPs and Off-Marketplace plans 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; and (3) have an exception process for a drug not on the formulary. QHPs must also 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.

Non-Discrimination Standards and Marketing and Benefit Design

Issuers offering QHPs or Off-Marketplace plans 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. Advertising for Off-Marketplace plans do not have to be filed and approved, but still must comply with all statutes, regulations, and guidance.

Rate Filing

All rates filed for QHPs and Off-Marketplace plans 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 and Off-Marketplace Issuers 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 website. Please refer to Arkansas Bulletin 2-2015 and the 2018 Federal Payment Parameters Rule.

Premiums may be varied by enrollee age (by a factor of 3:1), tobacco use, 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. Additionally, any premium amounts due to lack of federal Cost Sharing Reduction funding should be attributed to the silver level variants for Marketplace filings.

Rate filings must include information as to the amount of funds utilized for administration and the amount of funds utilized for claims. Additionally, a separate break out section from this should be included to describe the amount of funds that account for administrative costs paid to Pharmacy Benefit Managers (PBM) and the amount of funds used relative to pharmacy claims. Rate requests seeking an increase over 15% will be published for comment at healthcare.gov and insurance.arkansas.gov.

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 https://insurance.arkansas.gov/pages/industry-regulation/regulatory-health-link/resources/.

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 cosmetic 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.

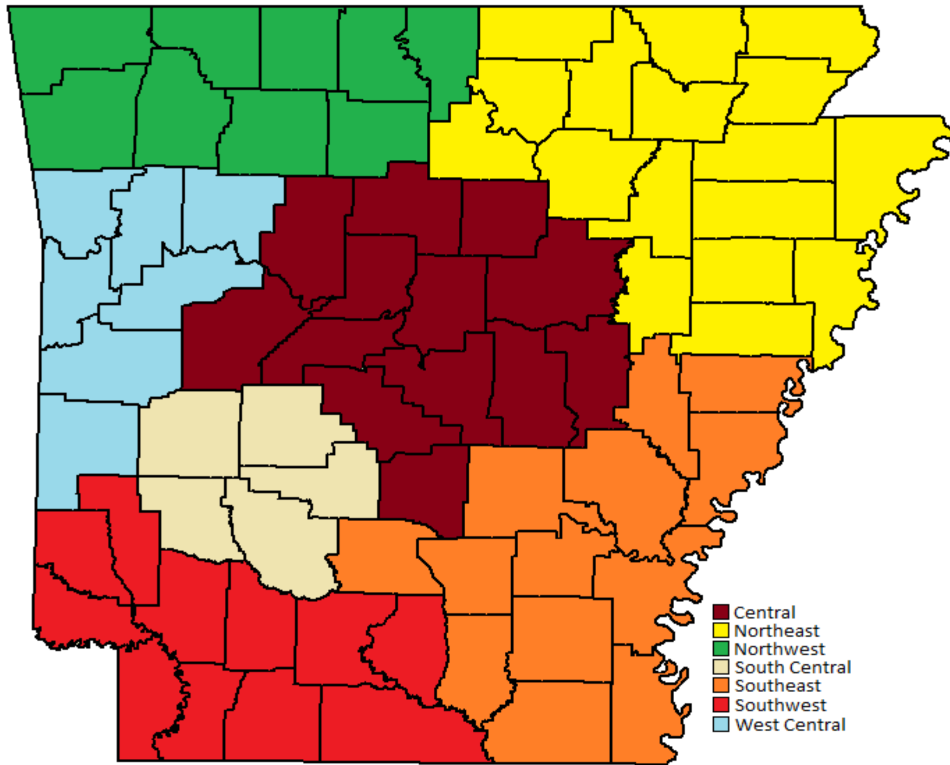
Questions related to this bulletin may be directed to the Regulatory Health Link Division at (501) 683-4170 or by email at: insurance.regulatory.health.link@arkansas.gov.

ALLEN KERR
INSURANCE COMMISSIONER
STATE OF ARKANSAS

April 13, 2018
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	$550
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$790

General Service Description	Subject to Deductible	Unit of Service	Copays	Coinsurance
Behavioral Health - IP	Yes	Day	$ 60	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	$ 60	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%