Arkansas Health Connector Division
Arkansas Insurance Department

Arkansas Department of Human Services
Arkansas Medicaid

Plan Management Frequently Asked Question

General Questions

Q: Why is Arkansas pursuing a premium assistance approach through the Private Option during the first year of the Arkansas Marketplace?

A: By leveraging the purchasing power of Medicaid premium assistance for those with incomes at or below 138% of the Federal Poverty Level (FPL) to expand insurance coverage, decrease churn within the Arkansas Marketplace, provide for continuity of care, and reduce uncompensated care and increase competition, Arkansas intends to transition its health insurance marketplace to a more competitive environment. Additional coordinated strategies to improve the delivery system include the Arkansas Payment Improvement Initiative, consumer engagement and accountability strategies, and efforts to eliminate waste and inefficiency.

Q: What is the State's authority to use premium assistance for individuals below 138% of FPL to get health insurance?

A: Nationwide, Medicaid has historically used three mechanisms to finance and deliver healthcare for eligible individuals—direct provider payments (primary method used by Arkansas), competitive contracts directly with Medicaid managed care companies, or premium assistance through employers (limited to select cases where employer coverage was more cost effective). This new approach is effectively premium assistance through the newly established Health Insurance Marketplaces, achieving equivalent access for Medicaid beneficiaries and the privately insured while also incorporating private-sector cost-containment mechanisms.

Q: What are the federal agencies with authority and responsibility for regulating the new Health Insurance Marketplace and Arkansas's Private Option?

A: There are two agencies within the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS) that have regulatory oversight of Arkansas's Private Option approach. The Center for Medicaid and CHIP Services (CMCS) serves as the focal point for all national program policies and operations related to Medicaid and the Children's Health Insurance Program (CHIP) and has responsibility for approving Arkansas's premium assistance program. The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with implementing Health Insurance Marketplaces and other private insurance market reforms inside and outside of new marketplaces.

Q: Will the extending of an individual policy by changing the renewal date allowed under the bulletin issued last year extend to small groups?

A: Yes, but the carrier will have to file an amendment to the policy form and a rider to the group policy.

Arkansas Health Connector Division
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Rating & Service Areas

Q: How will the Commissioner determine price "outliers" while ensuring statewide QHP consumer choice?

A: The Commissioner will work with issuers to certify all appropriately and competitively priced QHPs to ensure statewide consumer choice through the Arkansas Marketplace.

Q: The Arkansas Insurance Department's (AID's) stated intent is to review each issuer's service area and negotiate changes before June 30. Rate development and actuarial validation can require a few weeks. Will revised rate filings be allowed after June 30?

A: AID's intent is to establish issuer service areas prior to June 30.

Q: Does AID have a target date in mind for concluding service area reviews?

A: AID intends to treat the letters of intent as a top priority and will review them as the letters are submitted. If AID determines that there is a deficiency in a given service area, the Commissioner will reach out to individual issuers as soon as possible.

Q: May the Commissioner deny qualified health plan (QHP) certification if an issuer will not cover certain service areas? Would the State consider a phased in approach to the submission of additional service areas beyond the initial QHP filing date of June 30 and prior to open enrollment?

A: The Commissioner is required to achieve at least two QHP Issuers in every service area and has established a goal of certifying three or more QHP Issuers in every service area. Approval of QHPs to serve any service area is secondary to the goal of achieving statewide consumer choice through approval of at least two issuers in each service area in the Arkansas Marketplace.

Eligibility

Q: Will the newly eligible Medicaid individuals (Private Option eligible) who enroll in QHPs need to be included in the Medical Loss Ratio (MLR) calculation? If so, and if there is a rebate that needs to be paid, who would be the recipient of the rebate?

A: The MLR requirement would apply to plans serving Private Option enrollees. Arkansas is discussing with the HHS the process for handling potential MLR rebates, if required, and will provide additional guidance as it becomes available.

Q: Will the eligibility for the Private Option eligible members be on an "individual" tier? This would facilitate the cost-sharing reduction processing versus having "2 person" tier, husband and wife policies.

A: Rating will be on an individual tier. Under the 2014 rating rules, only states with pure community rating (New York and Vermont) can have traditional family tiers. In Arkansas, couple policies will charge the same premium as if each spouse bought separate individual policies. Private Option eligibility is also determined on an individual basis.

Q: Would agents that are certified to sell via the Marketplace also be able to sell policies to the Private Option individuals? If so, are there any restrictions on commissions?

A: Agents will be able to sell to individuals utilizing the QHPs including both Private Option and Arkansas Marketplace eligible individuals. We do not plan to place any restrictions on broker's and agent's and producer's commissions at this time.

Q: Did CMS clarify whether or not risk corridors will apply for the Private Option?

A: HHS confirmed that risk corridors, in addition to risk adjustment and reinsurance programs, apply to the Private Option.

Q: If one parent loses a job, but the other continues to work, can both parents change insurance plans?

A: Eligibility is determined at the gross household income level. If a parent were to lose his or her job such that household income would fall within the income limits for Private Option eligibility, it would be considered a qualifying event where all of the family members could seek new policies.

Q: For how long must rate filings be posted to company web site? A13: One year, unless federal law dictates otherwise.

Q: Is there a definition of "emergency" for purposes of the 72-hour emergency supply?

A: A delay that would significantly increase risk to the member's health or a delay that would seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Q: Page 4 of the issuer bulletin states that AID may limit the number of plan designs in future years that a specific QHP issuer may offer. Can a QHP issuer add new plan designs in future years?

A: As of today, yes. However, if an issuer, for example, puts 20 plans on the market in 2014 and AID decides to limit the number of plans to 4 plans per issuer per metal tier, the issuer would need to determine which of its existing plans and which new plans it would use to meet the maximum number of plans limitation.

Q: Page 5 of the issuer bulletin states an issuer may apply for Arkansas licensure and QHP status simultaneously. Will there be a cut-off date by which Arkansas licensure must be obtained to achieve recognition as a QHP? Could approval of an Arkansas license and QHP approval be granted to an issuer after the start of the open enrollment period on October 1, 2013?

A: A new entrant in the Arkansas Marketplace could expect to receive licensure and QHP certification simultaneously provided the issuer and its products meet licensure and certification requirements. In year one, licensure must be obtained by the July 31 application approval deadline in order to meet requirement of licensure for QHP certification. Licensure could be granted after October 1, but in this case, QHP certification would not be for the 2014 plan year.

Q: Please provide additional guidance (or examples) of requirements of QHPs to submit marketing materials for approval.

A: PDF copies or links to the marketing material if it is too large to submit electronically (i.e. videos or audio recordings) to all planned marketing materials must be submitted through SERFF at least 30 days prior to use.

Q: Will the State prepare a Summary of Benefits and Coverage (SBC) for both the zero member liability plan and the 100%-150% high value Silver plan?

A: No, the State will not prepare a SBC for these plans. The health plan issuers are responsible for the SBCs.

EHB

Q: Page 11 of the issuer bulletin states "mandatory offerings" not embedded in the essential health benefits of a QHP must be offered from the QHP's own website and a link must be provided to this information. Who will be responsible for any premium payment relating to selected mandatory offerings? Is this solely the responsibility of the enrolling individual or will it be shared with federal or state subsidies?

A: The individual will be responsible for premium payment for these products. These products are not eligible for subsidy payments.

Q: Are issuers required to cover any weight loss surgical procedures?

A: Issuers are not required to cover weight loss surgical procedures.

Q: Is the coverage of barbiturates, benzodiazepines, and agents used to promote smoking cessation required?

A: Based on conversations with carriers regarding this issue, AID has determined that most if not all carriers intend to cover these pharmacological classes in their QHP formularies (in fact carriers must cover smoking cessation agents as part of the EHB.) As part of its plan review and certification process, AID will review QHP formularies to determine whether there are any gaps in coverage of these classes of drugs.

Q: Are ambulance services part of the emergency services that have to be covered at in-network cost-sharing even if they're out of network?

A: Yes, according to 42 USC Sec. 18022:

E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

Q: Is coverage of Autism Spectrum Disorders required for individual plans, or only group plans?

A: Arkansas code requires autism coverage in group plans. However, federal law required the States to pick a plan from the small group plans to be the benchmark plan for purposes of identifying essential health benefits for the individual and small group markets. As such, autism is now required to be covered in individual and small group policies as an EHB subject to the EHB rules.

Definitions

Q: Family deductible

A: From IRS Revenue Procedure 2013-25 http://www.irs.gov/irb/2013-21_IRB/ar08.html : "For calendar year 2014, the annual limitation on deductions under § 223(b)(2)(A) for an individual with self-only coverage under a high deductible health plan is $1,250 with a maximum of $6,350 OOP total (including deductible). For calendar year 2014, the annual limitation on deductions under § 223(b)(2)(B) for an individual with family coverage under a high deductible health plan is $2,500 deductible and $12,700 family maximum OOP.

Q: Definition/determination of plan versus calendar year benefits for small group.

A: A plan year is the 12-month period of enrollee benefit coverage, whereas a calendar year is the 12-month period beginning in January and ending in December. In 45 CFR §155.420(d)(6), special enrollment periods, the reference to

the employer's upcoming "plan year," is a reference to the upcoming benefit coverage period: (6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan.

Q: Family Out-of-Pocket Maximum

A: The standard out-of-pocket maximum in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage for plan year 2014 is $6,350 for individuals and $12,700 for families. The out-of-pocket expense is defined in the IRS Procedure as deductibles, co-payments, and other amounts, but not premiums. (See Revenue Procedure 2013-25 <http://www.irs.gov/pub/irs-drop/rp-13-25.pdf>).

Private Option

Q: How will Private Option eligible individuals be enrolled into QHPs?

A: The State will engage in extensive marketing and outreach efforts to promote enrollment of individuals eligible for the Private Option during the open enrollment period (October 1, 2013 –March 31, 2014), and continuing into 2014. Individuals eligible for QHP enrollment through the Private Option will enroll through the following process:

- Individuals will submit a joint application for insurance affordability programs (IAPs)— Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions— electronically, via phone, by mail or in-person.
- An eligibility determination will be made either through the federally facilitated marketplace (FFM) or the Arkansas Eligibility & Enrollment Framework (EEF).
- Once individuals have been determined eligible for coverage through the Private Option they will enter the State's web-based portal (EEF), to shop among QHPs available to Private Option eligible individuals.
- The MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the issuers.
- Issuers will issue insurance cards to Private Option enrollees.
- MMIS will pay premiums on behalf of beneficiaries directly to the issuers.
- MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more effectively treated due to complexity of need through the traditional Medicaid program.
- In the event that an individual is determined eligible for coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county.

Q: How will QHP auto-assignment work in the Private Option?

A: The State's goal is to minimize the number of Private Option participants who do not complete the QHP selection process, and therefore need to be auto-assigned. However, particularly in 2014, operational aspects of the enrollment process may result in a significant number of individuals being auto-assigned.

The State anticipates that the majority of Private Option eligible individuals who apply for Medicaid directly through

the state portal (EEF) will complete the eligibility and enrollment process, including QHP selection.

Importantly, due to the inability of the federally facilitated marketplace to support shopping and enrollment of Arkansas Private Option eligible individuals who apply for coverage through the FFM portal, the State must rely on the EEF to effectuate QHP selection and enrollment. As a result of this disjointed consumer experience, the Arkansas Department of Human Services (DHS) anticipates significantly higher levels of auto-assignment for those Private Option eligible individuals who apply for coverage through the FFM rather than through the state portal. For Private Option eligible individuals who do not select a QHP, DHS will auto-assign the eligible individual into a QHP and notify the new enrollee of the effective date of his or her QHP enrollment.

DHS will apply the following general rules of allocation for auto-assigned participants:

- In Plan Year 2014, Private Option auto-assignments will be distributed among issuers offering AID-certified Silver-level QHPs with the aim of achieving a target minimum market share of Private Option enrollees for each issuer in a rating region.
- The target minimum market share for an Issuer offering a cost-effective high-Silver QHP (or multiple cost-effective QHPs) in a rating region will vary based on the number of competing issuers as follows:
  - Two issuers: 33% of Private Option participants in that region.
  - Three issuers: 25% of Private Option participants in that region.
  - Four issuers: 20% of Private Option participants in that region.
  - More than four issuers: 10% of Private Option participants in that region.
- Auto-assignment will be conducted by rating region.
- AID and DHS will collaborate to refine and revise the auto-assignment methodology for Plan Years 2015 and 2016, based on factors including QHP premium costs, quality and performance experience.

Q: Given that issuers have had no experience with or premium exposure to the Private Option participants, how will State achieve cost-effective purchasing?

A: In addition to the market development and auto-assignment process described above, the State expects to implement policies over time that will further ensure cost-effective QHP purchasing. Given the expansion of health insurance coverage associated with the Private Option, uncompensated care is expected to decline significantly in 2014 and beyond, reducing the need for providers to "cost-shift," i.e., raise their contractual prices with private health insurance plans to make up for losses incurred by serving uninsured (or under-insured) patients. Also, the Private Option will result in the enrollment of a large number of Medicaid beneficiaries into QHPs, resulting in increased payments to providers for existing uninsured patients.

In sum, the Private Option helps transform and significantly expand the private insurance marketplace, and this new marketplace does not yet have established competitive price points for provider reimbursement. As a result of these large shifts in payment and compensation for providers, actuaries projecting the expected costs of Arkansas's Private Option for DHS estimated that contractual rates of reimbursement for providers participating in QHPs that serve Private Option participants would be, on average, about 5% less than existing provider contracts with commercial insurers today. To help ensure cost-effective use of taxpayer funds, the Private Option is employing a purchasing standard consistent with a transition to more competitive insurance markets during Plan Year 2014, and in future Plan Years expects to develop and adopt additional strategies to ensure the purchase of both competitively-priced and cost-effective plans.

Q: How will the State identify people who are medically frail or otherwise more effectively covered through the standard

Medicaid program and ensure that such individuals are not enrolled in QHPs though the Private Option?

A: DHS is designing a process to identify individuals who will be more effectively covered under the standard Medicaid program, such as an individual who is medically frail or individuals for whom coverage through the Private Option is determined to be impractical, overly complex or would undermine continuity or effectiveness of care. DHS will establish criteria for identifying such individuals; the criteria may include conditions, settings, or diagnoses. Individuals who meet the criteria will be ineligible for the Private Option.

Q: What are the data reporting requirements for QHP issuers in 2014?

A: For 2014, QHPs will be expected to report required operational and performance data as required by the FFM. In addition, The Health Care Independence Act requires participation in the Arkansas Payment Improvement Initiative. This includes a requirement to contribute claims and encounter data for the purposes of measuring cost, quality, and access. Plans will not be required to submit claims for Year 1 until the end of Quarter 1, Year 2 (Plan Year 2015). In Plan Year 2015, standard data collection will begin.

Q: What is "Private Option"?

A: The "Private Option" refers to the program established by the Arkansas Healthcare Independence Act. 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.

Q: How will the administration of the private option retroactive and pre-QHP enrollment coverage (Slide 10 of presentation made during the May 13) handle beneficiary out-of-pocket expenses incurred during the retroactive period?

A: Medicaid is in the process of determining Medicaid payment operational processes.

Q: The Federally Facilitated Marketplace has announced a 3.5% user fee. Is this fee applicable to the Private Option?

A: CMS has confirmed that the 3.5% user fee does not apply to the Private Option.

Q: The FFE Exchange Fee will not apply to Private Option members.

A: Correct

Q: The Risk Corridor program will apply to the Private Option.

A: Correct

Q: LTC is not an EHB, and we will not be required to cover it.

A: Correct- New High Value Silver Plan sample AV template has LTC removed.

Q: TCM is not an EHB, and we will not be required to cover it.

A: Correct- New High Value Silver Plan sample AV template has TCM removed.

Q: We will not be required to cover OON prescription drugs.

A: Correct

Q: We will not be required to reduce OON cost-sharing amounts for Silver CSVs.

A: Correct.

Q: We will not be required to reduce OON cost-sharing amounts for the Zero Cost Sharing Silver Plan Variation and the High-Value Silver Plan Variation.

A: You will not need to reduce OON benefit levels for the various cost sharing plans.

Q: Who are the Medically Frail?

A: For individuals who are eligible for the Private Option, enrollment in a QHP will be mandatory. Individuals who are determined to be medically frail/have exceptional medical needs are not eligible for the Private Option and such individuals will be excluded from enrolling in QHPs. Individuals excluded from enrolling in QHPs through the Private Option as a result of medical frailty/exceptional medical needs will be eligible for coverage under Title XIX and will have the option of receiving either the ABP or the standard Medicaid benefit package through the State Plan.

Arkansas will institute a process to determine whether an individual is medically frail/has exceptional medical needs—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the State's emerging plans to establish health homes and to provide services through the Community First Choice state plan option.

Arkansas has engaged consultants from the University of Michigan to develop a questionnaire with fifteen to twenty questions to assess whether an individual may be medically frail/have exceptional medical needs ("the Screening Tool"). The Screening Tool will be conducted online (unless an individualrequests a paper copy) and will consist of yes/no answers to a short series of questions that focus on a person's use of long term supports and services and mental health resources, and presence of complex medical conditions. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

The medical frailty/exceptional medical needs screening process is meant to be prospective at the time of enrollment and will be conducted annually by Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one. In the case of false negatives and for individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to traditional Medicaid. The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail/having exceptional medical needs but no longer appear to meet those criteria.

The exact details of the process will differ slightly depending on whether an individual applies for the Private Option through the federally facilitated marketplace (FFM) or through the State's eligibility system.

- Individuals Applying through FFM: After the FFM determines that an individual is eligible for Medicaid, the State will send a notice informing the individual that he/she appears to be eligible for the Private Option. The notice will, among other things, direct individuals who appear Private Option eligible to the State portal where they will first see the Screening Tool described above. If the answers on the Screening Tool indicate that the individual is not medically frail/has exceptional medical needs, the individual will move on to shopping and enrollment through the State's eligibility system. If the results of the Screening Tool indicate that the individual is medically frail/has exceptional medical needs, instead of advancing to the shopping and enrollment pages, the individual will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.

- Individuals Applying Through the State's Eligibility System: Immediately after an individual is determined to be Medicaid-eligible, the individual will be asked to complete the Screening Tool. Once the individual completes the Screening Tool, the individual will be directed to shopping and enrollment, if not determined to be medically frail/have exceptional medical needs, or will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for- service Medicaid.

The State will comply with all requirements set forth in Section 1937 of the Social Security Act, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other ABP-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive through fee-for-service Medicaid either the ABP or the standard Medicaid benefit package.

Q: Will the GUIDES and CAC and Agents/Brokers be aware to enroll the above and other Medically Frail on the traditional Medicaid?

A: As a part of the enrollment process, all types of assisters will be made aware of this step in the Private Option enrollment process. As the Medical Frailty screen is a consumer self-administered questionnaire, navigators, guides, CACs and other application assisters will not be administering the Medically Frail screen directly.

Q: Will the enrollment process include questions to determine if the person meets the medically frail definition and then directs the member to enroll in Medicaid?

A: Yes. As noted above, the medically frail screen will be applied after an individual has been determined to be eligible for Medicaid in the new adult group and before he or she enrolls in a QHP.

Q: What if a member enrolls and the carrier later finds out that the member meets the medically frail definition, how does the carrier transfer the member to Medicaid?

A: A medical frailty screening will be conducted for all Private Option participants as a part of the enrollment process. The medically frailty screening will also be conducted annually upon re-enrollment. During a plan year, Medicaid and the participant retain the decision regarding any transfers from the Private Option to standard Medicaid due to Medical Frailty status. An individual may seek a determination of medical at any time, including after initial enrollment in a plan.

Dental

Q: Is pediatric orthodontia a required part of the pediatric dental benefits?

A: No.

Q: If a medical carrier embeds the pediatric dental, can they have a separate deductible for the medical and the pediatric dental?

A: Yes, as long as the total combined deductible does not exceed the overall limit.

Q: Are there preventive services for pediatric dental?

A: The "preventive services" aspect of the QHP is part of the Public Health Services Act and dental plans are not subject to that Act. Therefore, only if the pediatric dental benchmark plan required coverage of what would otherwise be identified under USPSTF as a preventive dental service would a dental plan have to cover that preventive service

Q: Does a SADP have to have the same price for a product that is offered both on and off the exchange?

A: No. As an "excepted benefit" off the exchange, there is flexibility for plans offered off the exchange such that the pricing does not have to be the same.

Q: Can a SADP use the "gold" and "silver" names in association with its 85% and 70% AV products?

A: Yes. The "gold" and "silver" names can be used, however, there is concern that a consumer might be misled with the "gold" reference since the AV for medical and dental at that level are different. However, if member literature explains that the "gold" is at an 85% AV in order to avoid confusion then there should not be an issue.

Q: Dental carriers have not historically contracted with facilities/clinics. The Essential Community Providers (ECP) requirement suggests this would have to change. Will Arkansas accept the ECP listing of ECPs even if there is no contract as long as the SADP includes a list of the individual dentists within the ECP with it's filing.

A: Only facilities should be listed on the ECP template, not individual providers. If an issuer of a Stand-Alone Dental Plan does not believe the ECP standard can be met due to the limited number of dental-specific ECP providers, then the issuer should submit a narrative justification using the ECP Supplemental Response Form to describe why the standard cannot be met and how the existing network would provide access for low-income and medically underserved populations. If an issuer of a SADP contracts with ECP-like providers, but not the facilities listed on the list, then this should also be described in the ECP Supplemental Response Form. For the submission of the ECP template, please follow the instructions for entering "dummy data" on page 9 of the Chapter 7 Instructions for the Essential Community Providers Application section if you do not have any dental ECPs to submit. The Chapter 15 SADP Application Instructions also contain additional information.

Cost Sharing

Q: In a FEE Exchange, a silver cost-sharing reduction (CSR) variant must have the same price as the base silver plan. We plan to offer multiple base silver plan designs.

Aa. Should the issuer price the Zero Cost Sharing Silver Plan Variation and the High- Value Silver Plan Variation independently of a base silver plan?

Aa: No. The high value and zero cost sharing silver plan variations are not independent plans from a standard silver plan. Each high value and zero cost sharing silver plan variant should be based on a standard silver plan and should vary from the standard silver plan only in cost sharing parameters. The standard silver plans and their variants should otherwise be identical, including in premium.

Ab. Should the issuer choose which base silver plan to associate with these variants?

Ab: See answer Aa, and note that issuers are required to offer all silver plan variants for all standard silver plans offered in the FFE. 45 C.F.R. § 156.420(a).

Q: How will monthly advanced CSR payments be calculated for the Zero Cost Sharing Silver Plan Variation and the High-Value Silver Plan Variation?

A: Issuer estimates the monthly advanced CSR payments which are reconciled at year end with Medicaid Advance monthly CSR payments will be calculated in the same way for individuals between 138 and 250% of the federal poverty level (FPL) who are eligible for federal CSRs and for individuals below 138% FPL enrolled in the Private Option; the only difference will be that HHS will make the federal CSR payments and Arkansas Medicaid will make the Private Option CSR payments. Under this method, issuers would, before each benefit year, estimate monthly allowed claims for essential health benefits for each standard silver plan and report this information to the Exchange (for APTC/CSR eligible enrollees) and Arkansas Medicaid (for Private Option enrollees). For the zero cost sharing plan variation, HHS or Medicaid will multiply this estimate by 1.12 to reflect induced utilization for the higher AV and then multiply that product by the difference between zero cost sharing plan variation AV and standard silver plan AV (i.e. 0.3). The same formula is used for the high-value silver plan variant, using the same induced demand factor of 1.12 and substituting 0.24 for 0.3 for the AV factor. Issuers will receive per member per month payments during the benefit year on the basis of this formula. These payments will be subject to reconciliation at the conclusion of the benefit year based on actual CSRs that are utilized. If an issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the issuer will be entitled to at reconciliation, the issuer may ask HHS or Arkansas Medicaid to adjust the advance payments. See 45 C.F.R. § 156.430; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15487-88, 15494-95 (Mar. 11, 2013).

Q: How will monthly advanced CSR payments for the Zero Cost Sharing Silver Plan Variation and High- Value Silver Plan Variation be reconciled against actual cost cost-sharing reduction amounts?

Aa. If the issuer should price these variants independently of a base silver plan, we would like to request guidance regarding reconciliation and the cost-sharing levels that will be assumed for reconciliation.

Ab. If an issuer may choose one and only one base plan to associate with these variants, our assumption is that the advance payments would be reconciled against the cost- sharing of the base plan.

Aa & b: At the conclusion of the benefit year, each issuer will report actual cost sharing reduction amounts to HHS (for members receiving APTCs/CSRs) and Arkansas Medicaid (for members enrolled in the Private Option) to reconcile CSR amounts with the advance payments. The Arkansas Medicaid process for such reconciliations will be modeled on the HHS process. HHS has announced that issuers may choose one of two methods to calculate the actual cost sharing reductions. The standard method requires the issuer to adjudicate each claim and determine the plan's liability twice: first calculating plan liability using the standard silver plan cost sharing and a second time with reduced cost sharing under the silver plan variant. The CSR payment the issuer is entitled to is the difference between the second number and the first. The simplified methodology does not require re-adjudication of claims. Instead, issuers will enter certain basic cost sharing parameters of its silver plans into a DHHS formula that will model the amount of CSR payments, based on total incurred claims. Issuers may choose either method, but a single issuer must apply the same method to all its plans. Furthermore, if an issuer selects the standard method in 2014, it may not select the simplified method in future years. 45 C.F.R. § 156.430(c).

Q: If a carrier must choose a base silver plan to associate with the High-Value Silver Plan Variation, will an issuer be permitted to change from a copay structure for a benefit specified in the High-Value Silver Plan Variation to a coinsurance structure for a benefit in the 87%, 73% and base silver plan variations? If so, will an actuarial

certification be required to demonstrate that the copay cost-sharing for the benefit at the higher AV variant will always be less than the coinsurance cost- sharing at the lower AV variant?

A: As discussed above, each silver plan variant will differ from a silver plan only in cost sharing. Each silver plan variant will need to comply with the requirement that cost-sharing never be lower in lower AV variants. If an actuary can certify that this condition will be satisfied, variations in cost sharing among silver plan variants can involve switching among copays and coinsurance.

Qa: The AID plan specification requires out of network (OON) benefits. Our understanding is that these OON benefits must also be offered with the CSV (Cost Sharing Variant) alternatives for individuals eligible for cost sharing reductions. Based on guidance received from the AID, it is our understanding that the standard CSVs, the Zero Cost Sharing Silver Plan Variation, and the High-Value Silver Plan Variation are not required to reduce OON benefit levels from the base amount. For example a silver base plan with 70% AV in-network (IN) and a 50% AV OON, is allowed to have an 87% CSV alternative benefit design IN and a 50% AV OON.

Aa: Carriers will not need to adjust OON benefit levels at different CSVs.

Qb: If an issuer may choose one and only one base plan to associate with the Zero Cost Sharing Silver Plan Variation and High-Value Silver Plan Variation, our assumption is that the OON benefits from the base plan will apply to these variants. Can you confirm this assumption? If the issuer should price these variants independently of a base silver plan, we ask for guidance regarding appropriate OON cost- sharing levels.

Ab: OON benefits of the base plan will apply throughout all variants. Again, carriers will not need to adjust OON benefit levels.

Premium Payment

Q: Since the Exchange Fee of 3.5% of Premium will not apply to the private option enrollees, and the base silver premium includes this fee, how should we remove that fee from premiums?

a. Should total projected Exchange Fees be spread across premiums for all members? This would be based on an assumed enrollment distribution between members above and below 138% of the FPL.

Aa: QHP issuers offering products through the Federally Facilitated Marketplace (FFM) will be required to pay a user fee equal to 3.5% of premiums for QHP enrollments through the FFM. CMS has confirmed that the FFM user fee will not apply to Private Option enrollments. The final rule on the single risk pool requires an issuer to make a market-wide adjustment to the index rate for its plans based on total expected market-wide Exchange user fees, 45 C.F.R. § 156.80(d)(1). This means the Exchange user fee must be spread across the premium for all plans inside and out of the Exchange. Each issuer would estimate the proportion of its enrollment that will be subject to a user fee and spread that user fee across all its individual market products.

b. We note that this issue is very similar to the ACA provision which requires premium prices to be the same for identical plans sold on and off the exchange. Issuers must balance the broker commissions off the exchange with the exchange fee for plans sold on the exchange.

Ab: Commissions must be the same on/off the Exchange. Only licensed producers/brokers may be paid commissions.

Q: What is the premium payment flow of funds?

a: Will premium information be sent on a monthly basis?

Aa: Yes, premium information will be sent monthly.

b: How often can the subsidy level change or will it be an annual determination?

Ab: It is possible that subsidy changes could be made on a monthly basis. It is envisioned that subsidy changes would occur annually. However, consumers are required to notify the Exchange and/or Medicaid whether they have experienced a change of life situation such as loss or gain of a job. Theseparticular change of life situations would trigger the consumer being eligible for shopping for new insurance and would also trigger a re-evaluation of subsidy determinations.

c: What is the reconciliation process?

Ac: Please see Q55.

d: What if the premium amount received does not match the issuer's premium?

Ad: This shouldn't happen and would be a system error, if it occurred at all.

Premium Rating

Q: Will Tobacco-Use Factors apply for the Private Option enrollees?

a. How much of the additional premium for tobacco-use will the member have to pay?

b. Will this vary by income?

c. If tobacco-use factors may not apply to the Private Option, then will, for a specific age, the average Private Option premium be allowed to reflect the higher average cost for smoking that would exist compared to the Non-smoker Exchange premium?

Aa,b,c: Premiums under the private option may include an additional surcharge of up to 20% for tobacco users at the issuer's discretion. If there is a tobacco rating surcharge applied, premiums will be higher for tobacco users and lower for non-tobacco users. Private option participants will not pay premiums, regardless of their status as a smoker or non-smoker. On balance, the net cost of these premiums to Medicaid is not expected to have a meaningful impact as a result of the application of the smoking rating factor.

Stand-Alone Dental

Q: We have received guidance that the Department expects several Stand-Alone Dental issuers to offer Dental plan in the Marketplace and that we will not need to embed pediatric dental into our product. As such, we will not apply to

offer any plans with pediatric dental embedded.

A: Correct

Q: Are current stand-alone plans considered excepted benefits and, therefore, exempt from the ACA regulation? Does the same answer apply to stand-alone family dental plans on the Exchange?

A: Yes, SADPs are excepted benefits under HIPAA and are exempt from ACA regulations. Yes, this applies inside and outside the Exchange. However, if sold on the Exchange, there are some additional requirements.

Q: Are stand-alone dental plans subject to the zero-cost sharing requirement for preventive services? What about when the pediatric dental EHB is embedded in a medical plan?

A: No, SADPs are not subject to the zero-cost sharing requirement. If the benefits are embedded in a medical plan, then they are subject to the zero-cost sharing requirement.

Q: Are SADPs offering pediatric dental EHB on or off exchange subject to provide at least the same open enrollment and special enrollment periods as required in the Exchange?

A: If the SADP is offered on the Exchange, then it is subject to the enrollment and special enrollment periods. If the SADP is offered off the Exchange, then it is not subject to the periods.

Q: Will members enrolled in dental plans be allowed to change during the year from "one child" to "two child" rates and coverage, and vice versa when a child ages out?

A: SADPs can do whatever is allowed under state law.

Q: If a child is covered by a medical plan that has an embedded pediatric dental benefit and the family purchases a standalone dental benefit from another carrier which also has pediatric coverage, who is the primary payer?

A: State law and current practices apply.

Q: Can carriers sell adult only stand-alone dental plans off the Exchange? Can existing products be modified to be adult only products?

A: Adult-only plans cannot be sold on the Exchange – all SADPs on the Exchange must have pediatric dental EHBs. Outside the Exchange adult-only plans can be sold and modified as allowed for under state law.

Q: Do SADPs offered outside the Marketplace have to be filed just like health insurance outside of the Marketplace?

A: SADPs must comply with state requirements.

Q: What must happen for a plan to be reasonably assured that the consumer has pediatric dental? A69: Since this is outside the Exchange, the state has wide latitude on how to define "reasonably assured", or it is up to the carrier. The carrier would be responsible if it sells to someone without dental coverage. Simultaneous enrollment and proof of coverage are good examples. SADP/Medical Plan coordination could work. Including pediatric dental is always and option.

Q: Does a medical carrier need to be reasonably assured that an individual 19 or over with no under-19-year-old dependents has purchased a Marketplace certified stand-alone dental plan that covers the pediatric EHB?

A: Yes, this requirement is applied to everyone outside the Exchange, not just children. Best if carriers have a plan with all benefits, and then one without pediatric dental for those who have coverage.

Q: May a State-based Marketplace (SBM) certify plans for sale on the Marketplace solely so that a carrier can meet the

"reasonable assurance" requirement?

A: They are free to take different approaches. FFM requires SADPs to be certified by the Exchange, even if sold only off the Exchange, if they want to be a plan that covers pediatric dental EHBs.

Q: Do off-Exchange SADP issuers need to comply with the open enrollment, special enrollment, grace period, etc. provisions as the certification attestation requires?

A: No, they are only required for plans on the Exchange.

Q: How much variability will be allowed for stand-alone dental plans offered outside of the Exchange from the specific plans submitted as long as AV levels are met, OOP max is met, and lifetime and annual limits are eliminated?

A: The pediatric dental EHB provisions need to meet these standards. Other provision in the plan may vary.

Q: Are certified stand-alone dental plans off the Exchange required to go to a calendar year in 2015?

A: SADPs sold on the Exchange must move to calendar year on January 1, 2015. SADPs sold offExchange are not required to do so.

Q: Does a qualified stand-alone dental plan have to participate in both the individual and SHOP markets in an Exchange?

A: No, the standard for medical plans does not apply to SADPs.

Q: What differentiation in requirements will be allowed for web site, language translations, for SADPs?

A: For SADPs sold on the Exchange, these requirements would apply as additional standards. Guidance is still to come.

Q: Do QHP grace premium grace period rules apply on the Marketplace to SADPs? What if an individual receives APTC for medical but not for the stand-alone dental plan?

A: The grace period only applies if the enrollee is receiving APTC for dental benefits.

Q: Template question: If a company has contracts directly with ECP providers, may they submit additional information/explanation and still found to be in compliance with ECPs even if the contract is not with the entire clinic?

A: The company can provide this information in the justifications (upload separately).

Q: Template question: How does the 0-20 age band in the rating template work for SADPs?

A: Annual Letter says that rating reforms do not apply. For purposes of the template, SADPs need to either guarantee the rates listed, or say that they may vary. SADPs may enter the most applicable rate for 0-20.

Q: EHB requirements [Must be substantially equal with the benchmark for pediatric dental benefits. AV of 70% (+/- 2%) or 85% (+/- 2%). Dental plans can have different OOP, set by Exchange. No annual or lifetime limits on pediatric dental EHBs.]

a: Can dental issuers call their 70% and 85% plans gold and silver?

Aa: CCIIO has stated that plans may do this. However, they express concern that this could be confusing because 85% does not match a traditional gold plan as defined by statute. Federal Exchange will call them High and Low. State Exchanges can do what they want.

b: Is there flexibility in the stand-alone dental plan regulations to require plans to submit 75% and 85% instead of 70% and 85%?

Ab: No, regulation explicitly states 70% and 85%. Initial proposal was 75%, but cost and variation concerns led to 70% limit.

c: Do stand-alone dental plans with a benchmark of FEDVIP need to offer at the 85% AV only, since the default is the "high option standard" in FEDVIP?

Ac: No, the benchmark is the benefits, not the cost-sharing.

d: If a medical carrier embeds the pediatric dental, can they have a separate deductible for the medical and the pediatric dental?

Ad: It is permissible to have separately accumulated deductible and OOP, but the total for dental and medical cannot exceed the total limit.

e: How is medically necessary orthodontia defined?

Ae: Non-medically necessary orthodontia not included in EHBs. There is no guidance on the definition of "medically necessary" – it is up to issuer. If benchmark includes orthodontia, then issuer can determine medically necessity.

f: Can dental issuers offer a pediatric orthodontia rider?

Af: SADPs cannot offer as a rider if the benefit is in the benchmark and medically necessary. SADPs can offer a rider for non-medically necessary orthodontia, but it will not be listed in the federal Exchange.

g: Are waiting periods on the pediatric dental EHB permissible if there are waiting periods included in the benchmark?

Ag: FEDVIP has a 24-month waiting period on medically necessary orthodontia. Yes, waiting periods can be included in SADPs as long as it is substantially equivalent to the benchmark.

h: Template question: What data elements should be included in a template for the benchmark plan?

Ah: The plan sold must be substantially equal to benchmark – this includes far more info than what is in the template.

Q: Does a child rider have to include pediatric dental EHB?

A: No, unless they choose to be certified.

Q: Do SADPs that are certified, but only to operate off the Exchange, have to follow enrollment periods?

A: Off the Exchange enrollment periods do not apply.

Q: Is there Reasonable Assurance for Adults, too?

A: Yes, the law applies to all plans sold in the individual and small group market, not just to families with children.

Q: Must Off Exchange plans offering pediatric benefit meet OOP and deductible? A84: Yes, if covering the pediatric dental benefit.

Q: Does a carrier use a different rate table for SADP?

A: No, FFM requires use of the same template and table. The carrier can set the rate for 0-19 as an estimate, and use different when sold.

Q: Adults can buy SADP in the Exchange?

A: Yes, there may be additional benefits.

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