Arkansas Insurance Department
Health Benefits Exchange Partnership Division

Arkansas Department of Human Services
Arkansas Medicaid

Please note questions #11 & #20 have been revised June 21, 2013

General Questions

Q1: Why is Arkansas pursuing a premium assistance approach through the Private Option during the first year of the Arkansas Marketplace?

A1: 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.

Q2: What is the State's authority to use premium assistance for individuals below 138% of FPL to get health insurance?

A2: 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.

Q3: What are the federal agencies with authority and responsibility for regulating the new Health Insurance Marketplace and Arkansas's Private Option?

A3: 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.

Rating and Service Areas

Q4: How will the Commissioner determine price "outliers" while ensuring statewide QHP consumer choice?

A4: The Commissioner will work with issuers to certify all appropriately and competitively priced QHPs to ensure statewide consumer choice through the Arkansas Marketplace.

Q5: 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?

A5: AID's intent is to establish issuer service areas prior to June 30.

Q6: Does AID have a target date in mind for concluding service area reviews?

A6: 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.

Q7: 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?

A7: 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

Q8: 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?

A8: 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.

Q9: 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.

A9: 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.

Q10: 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?

A10: 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.

Q11: Did CMS clarify whether or not risk corridors will apply for the Private Option?

A11: HHS confirmed that risk corridors, in addition to risk adjustment and reinsurance programs, apply to the Private Option.

Q12: If one parent loses a job, but the other continues to work, can both parents change insurance plans?

A12: 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.

Q13: For how long must rate filings be posted to company web site?

A13: One year, unless federal law dictates otherwise.

Q14: Is there a definition of "emergency" for purposes of the 72-hour emergency supply?

A14: 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.

Q15: 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?

A15: 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.

Q16: 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?

A16: 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.

Q17: Please provide additional guidance (or examples) of requirements of QHPs to submit marketing materials for approval.

A17: 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.

Q18: 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?

A18: No, the State will not prepare a SBC for these plans. The health plan issuers are responsible for the SBCs.

EHB

Q19: 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?

A19: The individual will be responsible for premium payment for these products. These products are not eligible for subsidy payments.

Definitions

Q20: Family deductible

A20: 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."

Q21: Definition/determination of plan versus calendar year benefits for small group.

A21: 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.

Q22: Family Out-of-Pocket Maximum

A22: 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

Q23: How will Private Option eligible individuals be enrolled into QHPs?

A23: 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.

Q24: How will QHP auto-assignment work in the Private Option?

A24: 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.

Q25: Given that issuers have had no experience with or premium exposure to the Private Option participants, how will State achieve cost-effective purchasing?

A25: 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.

Q26: 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?

A26: 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.

Q27: What are the data reporting requirements for QHP issuers in 2014?

A27: 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.