Arkansas Insurance Department

Asa Hutchinson
Governor

Alan McClain
Commissioner

BULLETIN NO. 10-2021

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: PLAN YEAR 2022 REQUIREMENTS FOR CERTIFICATION OF QUALIFIED HEALTH PLANS, STAND-ALONE DENTAL PLANS AND REQUIREMENTS FOR ACA-COMPLIANT, OFF-MARKETPLACE HEALTH PLAN SUBMISSIONS

DATE: JUNE 23, 2021

The Affordable Care Act (ACA) requires that all Issuers and plans participating in a State-Based Marketplace-Federal Portal (SBM-FP) individual or Small Business Health Options Program (SHOP) meet State and Federal certification standards for Qualified Health Plans (QHPs) and Certified Stand-Alone Dental Plans (SADPs). The Arkansas Insurance Department (AID) will require QHP and SADP Issuers to meet all State licensure requirements and regulations, as well as State-specific QHP or SADP requirements and regulations. QHP and SADP Issuers will also be responsible for all other State and Federal regulations already prescribed for insurance companies in today's market.

The purpose of this Bulletin is to define Plan Year 2022 (PY2022) State and Federal requirements for QHP and SADP certification in the Arkansas individual and SHOP Marketplaces. Though this Bulletin attempts to provide a cohesive source of information for both the State and Federal requirements, Issuers are advised to consult Federal regulations, PY2022 Letter to Issuers, PY2022 HHS Notice of Benefit and Payment Parameters, and State law in conjunction with this Bulletin to ensure full compliance. Those companies issuing plans off the Marketplace (Off-Marketplace) will continue to be responsible for meeting State and Federal regulations and must adhere to the filing timeline made available through this Bulletin.

Health insurance Issuers wishing to sell major medical or dental policies in Arkansas should submit their applications to become QHPs or SADPs according to Appendix D. AID will review plans in the order received. Any plans not having undergone complete review and gaining State approval for QHP or SADP certification will be ineligible for offering a QHP or SADP through the Marketplace during the 2022 open enrollment period. If QHP or Off-Marketplace health

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. All such changes must be pre-approved by AID and CMS according to applicable guidelines. Issuers will return signed QHP agreements to CMS in September and AID will notify Issuers of the QHP or SADP certification decision in October.

QHP Certification and Recertification Overview

All plans offered on the Marketplace must be certified (or recertified) prior to open enrollment. Additionally, SADPs offered on or off the Marketplace as an option to satisfy a QHP's requirement to provide the pediatric dental Essential Health Benefit (EHB) must also seek certification (or recertification). AID will review plans for compliance with QHP or SADP certification requirements. All application materials are required for first-time certification applications as well as those plans currently offered on the Marketplace and 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. Further recertification guidelines can be found in the filing instructions attached to the Plan Management General Instructions tab in the System for Electronic Rate and Form Filing application (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 ARHOMES Program in accordance with 1115 CMS Waiver evaluation requirements. A sample MOU is available 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 DHS for PY2022.

State and Federal 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 State and Federal insurance rules and regulations and will certify plans.

AID has the final authority over approval of rates and will review the pricing of all QHP, Off-Marketplace, and individual SADP plans to ensure that they are adequately and appropriately priced. Certification will be valid for a period of one (1) plan year. If an Issuer wishes to

continue offering a certain QHP or SADP following that plan year, the Issuer must apply to have that QHP or SADP recertified. Specific State and Federal rate and form filing requirements for PY2022 submissions will be posted in SERFF.

Quality Improvement Strategy (QIS)

AID will continue to collect the QIS with the applications in SERFF. For PY2022, AID will not collect or review any other quality initiatives or incentives required by the ARHOMES program.

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 or not 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. State and Federal 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 *"PY2022 SERFF Network Adequacy Data Submission Instructions"* available in SERFF 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. For the purposes of SHOP, a service area is the geographic area where an individual is employed. 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 2022. 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). A service area cannot be less than a rating area, as defined in Appendix A.

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 (66 – 72% AV) and at least one Gold (76-82% AV) plan must be offered in the individual or SHOP markets for each service area in which the company is participating. Additionally, QHPs in the Arkansas individual market are required to include at least one Silver plan that contains only the EHBs included in the State Benchmark Plan and that utilizes the 94% cost-share variation meeting the parameters as described in Appendix C. Furthermore, As the result of the passage of ARHOMES Program, the Arkansas Department of Human Services (DHS) has introduced seven (7) Federal Poverty Level (FPL) cost share bands with different medical deductibles and maximum out of pocket (MOOP) levels. This creates an issue concerning reporting of AV variant types to CMS as they are not equipped to receive data for all seven (7) FPL bands as contemplated by DHS guidelines. The Plans and Benefits template allows for only one 94% AV variant per plan. For CMS reporting requirements, there can be only one 94% variant in the plans and benefit. Therefore, the 100% AV variant may be provided as usual, and the 94% variant presented with the deductible and MOOP tied to the highest FPL band (121%-140%). Issuers shall handle the remaining FPL bands internally within their systems with beneficiary income level data from Arkansas Department of Human Services (DHS).

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 (56-62% AV), or Platinum (86-92% AV) plans. However, QHP Issuers must offer matching child-only plans for each of the ACA metal level plans offered, excluding catastrophic plans, or attest that the plans are available to child-only members. See ACA Sec. 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 SHOP.

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 Benchmark Plan to set the EHBs for Arkansas. The 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 list of benefits included in the *PY2022 QHP & ACA Compliant Benchmark Checklist* can be found in SERFF.

Copies of the Benchmark Plans may be found at: https://insurance.arkansas.gov/pages/industry-regulation/regulatory-health-link/resources/.

Additional EHB

Because mandates applicable to the individual market prior to December 2011 continue to apply to individual plans even if the State Benchmark Plan is a small group plan, coverage for in-vitro fertilization and hearing aids are considered EHBs for all insurance companies. Coverage for renal dialysis is not identified as an EHB on the Benefits Package tab of the Plans and Benefits Template, but coverage should be provided by all plans. Please see the *PY2022QHP & ACA Compliant Benchmark Checklist* attached to the Plan Management General Instructions tab in SERFF for an all-inclusive list.

Benefits covered in addition to EHBs must be listed in the Actuarial Memorandum.

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 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.

One change may be made to the prescription drug formulary during a plan year if the change is approved by AID through the data change request process and does not exceed +/-2% of the adjusted rate index. A signed actuarial attestation stating the amount of change to the adjusted rate index must be included with the change request.

Non-Discrimination Standards and Marketing and Benefit Design

Issuers offering QHPs, Off-Marketplace plans, and SADPs must comply with State and Federal 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 and SADP Issuers may inform consumers in marketing materials that the plans are certified as a QHP or SADP after entering into a certification agreement with either CMS for individual plan offerings or AID for SHOP plan offerings. The Issuer cannot inform consumers that the certification of a QHP or SADP implies any form of further endorsement or support of the plans.

QHP, Off-Marketplace, and SADP marketing materials must be submitted in a searchable PDF format. The marketing materials shall comply with all Federal and State statutes, regulations, and guidance and are subject to review for compliance. 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 recommendation of the QHP or SADP for decertification.

Rate Filing

All rates filed for QHP, Off-Marketplace, and SADP 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 State and Federal 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 be 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 is an Effective Rate Review State and will review all rate filings and rate adjustments for prior approval. Rate filing information must be submitted to AID through SERFF 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.

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 who meet the federal definition of "tobacco use" set out in 45 C.F.R. § 147.102. Additionally, any premium amounts due to lack of Federal Cost-Sharing Reduction funding should be attributed to the Silver level variants for Marketplace filings, if allowed by CMS.

QHP and Off-Marketplace health insurance 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 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. All rate increase requests will be published for public comment on the Department's website.

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 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 off the Marketplace only to supplement the pediatric dental EHB for use with a QHP 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) 371-2755 or by email at: insurance.regulatory.health.link@arkansas.gov.

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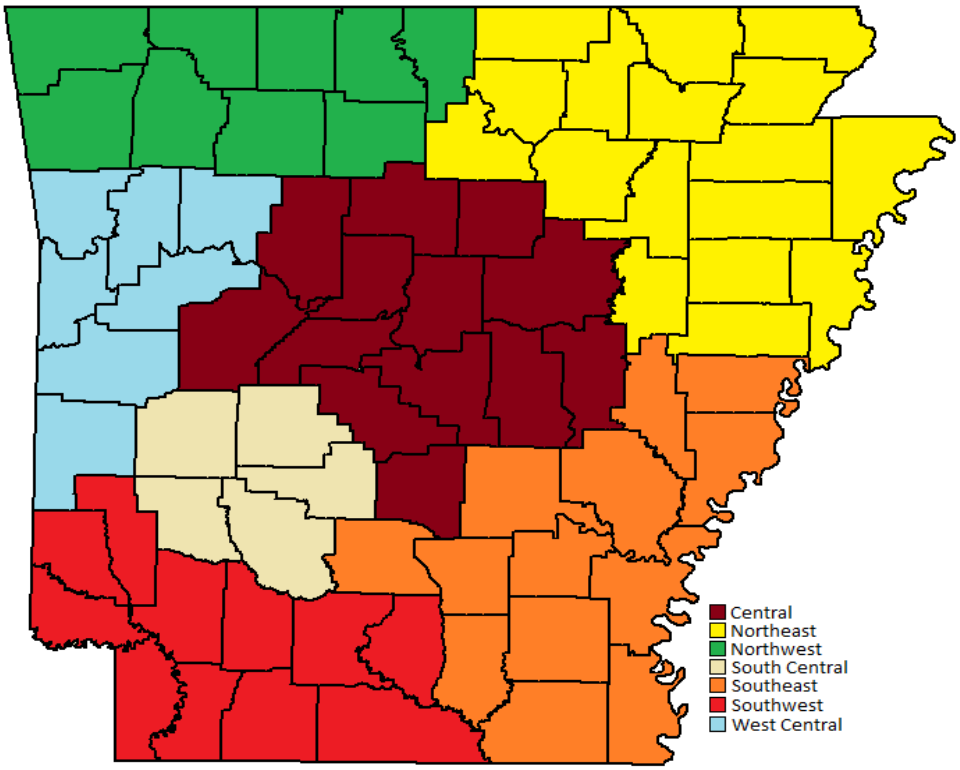
ALAN MCCLAIN DATE
INSURANCE COMMISSIONER
STATE OF ARKANSAS

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 the 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 known).

APPENDIX C-1

HIGH VALUE SILVER PLAN (100% A/V) VARIATION COST-SHARING REQUIREMENTS

High-Value Silver Plan 1
0% FPL – 20% FPL

Service Specific Deductibles:	
Medical	$1,300
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,300

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$-	100%
Behavioral Health Professional	Visit	$-	100%
Durable Medical Equipment	Service	$-	100%
Non-Emergency Use of the Emergency Department	Visit	$-	100%
X-rays and Diagnostic Imaging	Visit	$-	100%
Skilled Nursing Facility	Day	$-	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$-	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$-	100%
Specialist Visit	Visit	$-	100%
Generics	Prescription	$-	100%
Preferred Brand Drugs	Prescription	$-	100%
Non-Preferred Brand Drugs	Prescription	$-	100%
Specialty Drugs (i.e. High-Cost	Prescription	$-	100%
Imaging (CT/Pet Scans, MRIs	Visit	$-	100%
Speech Therapy	Visit	$-	100%
Occupational and Physical Therapy	Visit	$-	100%
Preventative Care/Screening/Immunizations	Visit	$-	
Laboratory Outpatient and Professional Services	Visit	$-	100%
Outpatient Surgery Physician/Surgical Services	Visit	$-	100%

APPENDIX C-2

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

High-Value Silver Plan 2
21% FPL – 40% FPL

Service Specific Deductibles:	
Medical	$1,316
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,400

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70	100%
Behavioral Health Professional	Visit	$4.70	100%
Durable Medical Equipment	Service	$4.70	100%
Non-Emergency Use of the Emergency Department	Visit	$9.40	100%
X-rays and Diagnostic Imaging	Visit	$4.70	100%
Skilled Nursing Facility	Day	$20.00	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70	100%
Specialist Visit	Visit	$4.70	100%
Generics	Prescription	$4.70	100%
Preferred Brand Drugs	Prescription	$4.70	100%
Non-Preferred Brand Drugs	Prescription	$9.40	100%
Specialty Drugs (i.e. High-Cost	Prescription	$9.40	100%
Imaging (CT/Pet Scans, MRIs	Visit	$4.70	100%
Speech Therapy	Visit	$4.70	100%
Occupational and Physical Therapy	Visit	$4.70	100%
Preventative Care/Screening/Immunizations	Visit	$ -	
Laboratory Outpatient and Professional Services	Visit	$4.70	100%
Outpatient Surgery Physician/Surgical Services	Visit	$4.70	100%

APPENDIX C-3

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

High-Value Silver Plan 3
41% FPL – 60% FPL

Service Specific Deductibles:	
Medical	$1,336
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,500

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70	100%
Behavioral Health Professional	Visit	$4.70	100%
Durable Medical Equipment	Service	$4.70	100%
Non-Emergency Use of the Emergency Department	Visit	$9.40	100%
X-rays and Diagnostic Imaging	Visit	$4.70	100%
Skilled Nursing Facility	Day	$20.00	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70	100%
Specialist Visit	Visit	$4.70	100%
Generics	Prescription	$4.70	100%
Preferred Brand Drugs	Prescription	$4.70	100%
Non-Preferred Brand Drugs	Prescription	$9.40	100%
Specialty Drugs (i.e. High-Cost	Prescription	$9.40	100%
Imaging (CT/Pet Scans, MRIs	Visit	$4.70	100%
Speech Therapy	Visit	$4.70	100%
Occupational and Physical Therapy	Visit	$4.70	100%
Preventative Care/Screening/Immunizations	Visit	$ -	
Laboratory Outpatient and Professional Services	Visit	$4.70	100%
Outpatient Surgery Physician/Surgical Services	Visit	$4.70	100%

APPENDIX C-4

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

High-Value Silver Plan 4
61% FPL – 80% FPL

Service Specific Deductibles:	
Medical	$1,356
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,600

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70	100%
Behavioral Health Professional	Visit	$4.70	100%
Durable Medical Equipment	Service	$4.70	100%
Non-Emergency Use of the Emergency Department	Visit	$9.40	100%
X-rays and Diagnostic Imaging	Visit	$4.70	100%
Skilled Nursing Facility	Day	$20.00	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70	100%
Specialist Visit	Visit	$4.70	100%
Generics	Prescription	$4.70	100%
Preferred Brand Drugs	Prescription	$4.70	100%
Non-Preferred Brand Drugs	Prescription	$9.40	100%
Specialty Drugs (i.e. High-Cost	Prescription	$9.40	100%
Imaging (CT/Pet Scans, MRIs	Visit	$4.70	100%
Speech Therapy	Visit	$4.70	100%
Occupational and Physical Therapy	Visit	$4.70	100%
Preventative Care/Screening/Immunizations	Visit	$ -	
Laboratory Outpatient and Professional Services	Visit	$4.70	100%
Outpatient Surgery Physician/Surgical Services	Visit	$4.70	100%

APPENDIX C-5

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

High-Value Silver Plan 5
81% FPL – 100% FPL

Service Specific Deductibles:	
Medical	$1,377
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,700

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70	100%
Behavioral Health Professional	Visit	$4.70	100%
Durable Medical Equipment	Service	$4.70	100%
Non-Emergency Use of the Emergency Department	Visit	$9.40	100%
X-rays and Diagnostic Imaging	Visit	$4.70	100%
Skilled Nursing Facility	Day	$20.00	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70	100%
Specialist Visit	Visit	$4.70	100%
Generics	Prescription	$4.70	100%
Preferred Brand Drugs	Prescription	$4.70	100%
Non-Preferred Brand Drugs	Prescription	$9.40	100%
Specialty Drugs (i.e. High-Cost	Prescription	$9.40	100%
Imaging (CT/Pet Scans, MRIs	Visit	$4.70	100%
Speech Therapy	Visit	$4.70	100%
Occupational and Physical Therapy	Visit	$4.70	100%
Preventative Care/Screening/Immunizations	Visit	$ -	
Laboratory Outpatient and Professional Services	Visit	$4.70	100%
Outpatient Surgery Physician/Surgical Services	Visit	$4.70	100%

APPENDIX C-6

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

High-Value Silver Plan 6
101% FPL – 120% FPL

Service Specific Deductibles:	
Medical	$1,419
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,800

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70	100%
Behavioral Health Professional	Visit	$4.70	100%
Durable Medical Equipment	Service	$4.70	100%
Non-Emergency Use of the Emergency Department	Visit	$9.40	100%
X-rays and Diagnostic Imaging	Visit	$4.70	100%
Skilled Nursing Facility	Day	$20.00	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70	100%
Specialist Visit	Visit	$4.70	100%
Generics	Prescription	$4.70	100%
Preferred Brand Drugs	Prescription	$4.70	100%
Non-Preferred Brand Drugs	Prescription	$9.40	100%
Specialty Drugs (i.e. High-Cost	Prescription	$9.40	100%
Imaging (CT/Pet Scans, MRIs	Visit	$4.70	100%
Speech Therapy	Visit	$4.70	100%
Occupational and Physical Therapy	Visit	$4.70	100%
Preventative Care/Screening/Immunizations	Visit	$ -	
Laboratory Outpatient and Professional Services	Visit	$4.70	100%
Outpatient Surgery Physician/Surgical Services	Visit	$4.70	100%

APPENDIX C-7

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

High-Value Silver Plan 7
121% FPL – 138% FPL

Service Specific Deductibles:	
Medical	$1,443
Pharmacy	$0
Member Out-of-Pocket Max (all services combined):	$1,900

	Unit of Service	Copays	Coinsurance
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -	100%
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70	100%
Behavioral Health Professional	Visit	$4.70	100%
Durable Medical Equipment	Service	$4.70	100%
Non-Emergency Use of the Emergency Department	Visit	$9.40	100%
X-rays and Diagnostic Imaging	Visit	$4.70	100%
Skilled Nursing Facility	Day	$20.00	100%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70	100%
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70	100%
Specialist Visit	Visit	$4.70	100%
Generics	Prescription	$4.70	100%
Preferred Brand Drugs	Prescription	$4.70	100%
Non-Preferred Brand Drugs	Prescription	$9.40	100%
Specialty Drugs (i.e. High-Cost	Prescription	$9.40	100%
Imaging (CT/Pet Scans, MRIs	Visit	$4.70	100%
Speech Therapy	Visit	$4.70	100%
Occupational and Physical Therapy	Visit	$4.70	100%
Preventative Care/Screening/Immunizations	Visit	$ -	
Laboratory Outpatient and Professional Services	Visit	$4.70	100%
Outpatient Surgery Physician/Surgical Services	Visit	$4.70	100%

APPENDIX D-1

The timeline

Abbreviation	Description
Off-Marketplace	Individual/Small Group ACA-Compliant major medical plan sold only Off the Marketplace.
QHP	Individual/Small Group Qualified Health Plan sold On the Marketplace.
SADP	1. Individual/Small Group Certified dental plan sold On the Marketplace; **or** 2. Individual/Small Group Certified dental plan sold Off the Marketplace to supplement the pediatric dental benefit of a QHP.

Key Dates	Description
5/17	All Federal and State Network Adequacy Templates for **QHPs/SADPs** to AID.
5/17	All Federal and State Network Adequacy Templates for ACA-Compliant (**Off-Marketplace)** medical plans to AID.
5/17	**QHP/SADP** application templates, Rating Business Rules Templates, and all Binder Supporting Documentation to AID, excluding the QHP *PY2022 Plans and Benefits Template Attestation,* Rate Data Templates, and URRTs.
5/17– 6/11	AID **QHP/SADP** Application/Template Review Period.
6/14	AID to submit 1st SERFF Data Transfer of Individual Plans to CMS.
6/18	**QHP** Form Filings, excluding the Schedules of Benefits (Schedules) and *PY2022 Plans and Benefits Template Attestation,* to AID. Associate Forms to Binders.
6/18	**QHP** and **Off-Marketplace** medical Rate Filings to AID and HIOS. Associate Rate Filings to Binders and initial Rate Data Template and URRT due.
7/2	Proposed **QHP** and **Off-Marketplace** medical rate adjustments published on AID website.
7/16	**QHP/SADP** Final Rate Data Templates and **QHP** URRTs due in Binders.
7/20	**SADP** Form Filings to AID. Associate Form Filings to Binders.
7/30	Target date on which CMS will post proposed rate changes.
8/2	Service area data change request deadline to AID.
8/2	Final changes to **QHP/SADP** Applications to AID.
8/3	Individual **SADP** Rate Filings to AID. Associate Rate Filings to Binders. (Group Dental Rates are not reviewed through a Rate Filing submission. Do not submit.)
8/11	**QHP/SADP** Issuers submit final Plan ID Crosswalk Templates in the Binder.

8/11 – 8/25	**QHP/SADP** Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates in the PM Community.
8/16	AID transfers final changes to the **QHP/SADP** Applications to CMS.
8/17	**Off-Marketplace** medical Form Filings, excluding Schedules and *PY2022 Plans and Benefits Template Attestation*, to AID. Associate Form Filings to Binders
8/17	Any remaining **Off-Marketplace** medical Binder data to AID, excluding Schedules and *PY2022 Plans and Benefits Template Attestation.*
8/18	Target date for all final rates to be published on AID website. Deadline for QHPs to be finalized in URR module of HIOS.
8/19 – 9/13	CMS reviews initial **QHP** applications and releases results in PM Community.
8/24	**QHP** Schedules due to AID. Schedules must match benefits in the Plans and Benefits Templates. *PY2022 Plans and Benefits Template Attestation* must be attached to the Form Filings and Binders. Associate Schedules to the Binders.
8/24	**Off Marketplace** medical Schedules due to AID. Schedules must match benefits in the Plans and Benefits Templates. *PY2022 Plans and Benefits Template Attestation* must be attached to the Form Filings and Binders. Associate Schedules to Binders.
9/10	Data change requests due to AID
9/16 – 9/17	CMS limited data correction window
10/2	AID releases certification notices to issuers.
11/1	Open Enrollment Begins.