RULE 103

ESSENTIAL HEALTH BENEFITS BENCHMARK PLAN

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Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules and regulations necessary for the effective regulation of the business of insurance or as required for this State to be in compliance with federal laws. In addition, under Ark. Code Ann. § 23-61-108(b)(2), the Commissioner has authority to coordinate regulatory activities and administration with the federal government with respect to the regulation of insurance.

Section 2. Scope

This Rule applies to all non-grandfathered "qualified health plans" as defined by Section 1301 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act") as well as to, by virtue of Section 1201of the Affordable Care Act, which added Section 2707(a) to the Public Health Service Act, all non-grandfathered health plans offered in the individual and small group markets outside the Exchange in the State.

Section 3. Purpose & Background

The purpose of this Rule is to comply with requirements issued by the Department of Health and Human Services ("HHS") for states to select a benchmark health plan before September 30, 2012 to serve as the standard for providing essential health benefits (EHB) in non-grandfathered health plans offered through the Exchange operating in the State as well as to non-grandfathered plans offered in the individual and small group markets outside the Exchange in the State.

Section 1302(b) of the Affordable Care Act directs the Secretary of HHS ("Secretary") to define essential health benefits (EHB) for health plans subject to the Affordable Care Act. Under the Affordable Care Act, non-grandfathered plans in individual and small group markets both inside and outside of the Exchanges must provide EHB beginning in 2014. Section 1302(b) of the Affordable Care Act provides that EHB include items and services within the following ten (10) benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) prevent wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. Section 1302(b)(2) requires that the Secretary provide that the scope of EHB be equal to benefits provided under a "typical employer plan."

On December 16, 2011, HHS issued "Essential Health Benefits: HHS Informational Bulletin," and thereafter on January 25, 2012, "Essential Health Benefits: Illustrative List of the

Largest Three Small Group Products by State." These bulletins are the Secretary's implementation of Section 1302(b) of the Affordable Care Act.

Under the December 16, 2011 HHS bulletin, HHS requires that states choose in the third quarter of 2012 one of the following benchmark health insurance plans to serve as a reference for providing EHB in non-grandfathered health plans: (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national FEHBP plan options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State. HHS further provides that if a state does not exercise its option to select a benchmark health plan, the default benchmark health plan for that state is the largest plan by enrollment in the largest product in the state's small group market.

The purpose of this Rule is to provide guidance for selecting the benchmark plan for establishing EHB for non-grandfathered health plans offered through the Exchange operating in the State as well as for non-grandfathered plans offered in the individual and small group markets outside the Exchange in the State. In addition, this Rule shall define the criteria or standards which are the basis for the selection of the benchmark health plan.

Section 4. Standards Related to the Selection of a Benchmark Health Plan for this State

In selecting the benchmark plan for establishing EHB for non-grandfathered individual and small group health plans, the Commissioner shall take into consideration the following factors:

A. The federal requirement that the EHB package covers each of the following ten (10) statutory categories of EHB set out in Section 1302(b)(1) of the Affordable Care Act:

1) Ambulatory patient services;
2) Emergency services;
3) Hospitalization;
4) Maternity and newborn care;
5) Mental health and substance abuse disorder services, including behavioral health treatment;
6) Prescription drugs;
7) Rehabilitative and habilitative services and devices;
8) Laboratory services;
9) Preventive and wellness services and chronic disease management; and
10) Pediatric services, including oral and vision care.

B. The balance between comprehensiveness of benefits with plan affordability to promote optimal access to care for all residents of the State.

C. The extent to which supplements to the potential EHB benchmark must be made to be inclusive of the ten (10) statutory categories above.

D. The cost to the State of a potential EHB benchmark plan which may require the State to defray the costs of benefits mandated by State law in excess of the essential health benefits.

E. The appropriate balance of benefits among the ten (10) statutory categories so that benefits are not unduly weighted toward any category.

F. The health care needs of diverse segments of the Arkansas population, including women, children, persons with disabilities, and other groups.

G. The capacity of both individual and small group health plans in their ability to provide the potential EHB benchmark plan. Capacity should be assessed by considering: 1) Network adequacy in terms of the ability of plans to deliver the EHBs; and 2) whether the EHB package is too rich for plan sustainability and premium affordability in Arkansas' marketplace.

H. The advisory committee, public and healthcare industry comments and recommendations and actuarial studies for EHB benchmark plan options.

I. The extent to which the selection of a potential EHB benchmark plan may impact participation in the Exchange by consumers and health insurers in the market.

J. The extent to which the selection of the potential EHB benchmark plan provides and advances consumer protection interests to Arkansas participants in the health insurance marketplace.

The Commissioner shall maintain that the State benchmark plan shall be selected through an open, transparent and inclusive process.

The Commissioner shall evaluate the above considerations and select an initial EHB benchmark plan for coverage years 2014 and 2015 on or before September 30, 2012.

After selection of the EHB benchmark plan, the Commissioner shall issue his or her decision as to the EHB benchmark plan and the reasons therefore, through a publicly issued Directive or Bulletin within ten (10) days following submission of a report to the Commissioner from the Arkansas Health Benefits Exchange Partnership Division which shall include the data and recommendations related to the factors set out in Section Four (4) (A) through (J) of this Rule.

Section 5. Effective Date

The effective date of this Rule is September 1, 2012.

Jay Bradford

JAY BRADFORD
INSURANCE COMMISSIONER

August 1, 2012
DATE