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REGULATIONS COMPILER

1 Cabinet for Health and Family Services

2 Office of the Kentucky Health Benefit Exchange

3 (New Administrative Regulation)

4 900 KAR 10:010. Exchange Participation Requirements and Certification of Qualified

5 Health Plans and Qualified Dental Plans.

6 RELATES TO: KRS 194A.050(1), 42 U.S.C. Section 18031, 45 C.F.R. Parts 155 and

7 156.

8 STATUTORY AUTHORITY: KRS 194A.050(1)

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family

10 Services, Office of the Kentucky Health Benefit Exchange, has responsibility to

11 administer the state-based American Health Benefit Exchange. KRS 194A.050(1)

12 requires the secretary of the cabinet to promulgate administrative regulations necessary

13 to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency

14 of the individual citizens of the Commonwealth; to operate the programs and fulfill the

15 responsibilities vested in the cabinet, and to implement programs mandated by federal

16 law or to qualify for the receipt of federal funds. This administrative regulation

17 establishes the policies and procedures relating to the certification of a qualified health

18 plan to be offered on the Kentucky Health Benefit Exchange, pursuant to, and in

19 accordance with 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

20 Section 1. Definitions. (1) "Actuarial value" means the percentage of the total

21 allowed costs of benefits paid by a health plan.

1 (2) "Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care
2 Act, Public Law 111-148, enacted March 23, 2010 as amended by the Health Care and
3 Education Reconciliation Act, Public Law 111-152, enacted March 30, 2010.
4 (3) "Agent" is defined by KRS 304.9-020(1).
5 (4) "Annual open enrollment period" except for the initial open enrollment period, is
6 defined by 45 C.F.R. 155.410(e).
7 (5) "Benefit year" means a calendar year for which a health plan provides coverage
8 for health benefits.
9 (6) "Catastrophic plan" means a health plan that is described in and meets the
10 requirements of 45 C.F.R 156.155.
11 (7) "Certificate of authority" is defined by KRS 304.1-110.
12 (8) "Certification" means a determination by the Kentucky Health Benefit Exchange
13 that a health plan or a stand-alone dental plan has met the requirements in Sections 2
14 through 17 of this administrative regulation.
15 (9) "Child-only plan" means an individual health policy that provides coverage to an
16 individual under twenty-one (21) years of age and meets the requirements of 45 C.F.R
17 156.200(c)(2).
18 (10) "Consumer Operated and Oriented Plan" or "CO-OP" means a private, non-
19 profit health insurance issuer established in Section 1322 of the Affordable Care Act
20 that has a certificate of authority.
21 (11) "Dental Insurer" means an insurer defined by KRS 304.17C-010(4), which offers
22 a limited health service benefit plan for dental services.
23 (12) "Department of Health and Human Services" or "HHS" means the U.S.

1 Department of Health and Human Services.

2 (13) "Department of Insurance" or "DOI" is defined by KRS 304.1-050(2).

3 (14) "Enrollee" means an eligible individual enrolled in a qualified health plan.

4 (15) "Essential community provider" means a provider determined and approved by

5 HHS as an essential community provider for the Commonwealth of Kentucky.

6 (16) "Essential community provider category" means a provider as described in

7 "Chapter 7: Instructions for the Essential Community Providers Application Section", as

8 incorporated by reference in this administrative regulation.

9 (17) "Essential health benefits" means benefits as identified by 42 U.S.C. 18022 and

10 approved by the Secretary of HHS for the Commonwealth of Kentucky.

11 (18) "Health plan" is defined by 42 U.S.C. 18021(b)(1).

12 (19) "Indian" is defined by 25 U.S.C. 450b(d).

13 (20) "Issuer" is defined by 45 C.F.R. 144.103.

14 (21) "Health plan form" or "form" is defined by 806 KAR 14:007.

15 (22) "Individual exchange" means the Kentucky Health Benefit Exchange that serves

16 the individual health insurance market.

17 (23) "Individual market" is defined by KRS 304.17A-005(26).

18 (24) "Initial open enrollment period" means the period beginning October 1, 2013,

19 and extending through March 31, 2014, during which a qualified individual or qualified

20 employee may enroll in health coverage through an exchange for the 2014 benefit year.

21 (25) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-

22 based exchange conditionally approved by HHS pursuant to 45 C.F.R. 155.105 to offer

23 a QHP beginning January 1, 2014.

1 (26) "Metal level of coverage" means health care coverage provided within plus or
2 minus two (2) percentage points of the full actuarial value as follows:
3 (a) Bronze level with an actuarial value of 60 percent;
4 (b) Silver level with an actuarial value of 70 percent;
5 (c) Gold level with an actuarial value of 80 percent; and
6 (d) Platinum level with an actuarial value of 90 percent.
7 (27) "Multi-state plan" means a health plan that is offered under a contract with the
8 U.S. Office of Personnel Management in accordance with Section 1334 of the
9 Affordable Care Act.
10 (28) "Office of the Kentucky Health Benefit Exchange" or "Office" means the office
11 created to administer the Kentucky Health Benefit Exchange.
12 (29) "Participating agent" means an agent as defined by KRS 304.9-020(1) who has
13 been certified by the office to participate on the KHBE.
14 (30) "Participation agreement" means an agreement between the office and the
15 issuer to offer a QHP or qualified dental plan on the KHBE.
16 (31) "Pediatric dental essential health benefit" means a dental service to prevent
17 disease and promote oral health, restore an oral structure to health and function, and
18 treat an emergency condition provided to an individual under the age of twenty-one (21)
19 years that meets the requirements of 45 C.F.R. 156.110(a)(10).
20 (32) "Plan management data template" means the data collection templates used to
21 facilitate data submission for certification of qualified health plan issuers and qualified
22 health plans as established in CMS Form Number CMS-10433, as amended.
23 (33) "Plan year" means a consecutive twelve (12) month period during which a

1 health plan provides coverage for health benefits.

2 (34) "Premium" is defined by KRS 304.14-030.

3 (35) "Provider network" is defined by KRS 304.17A-005(35).

4 (36) "Qualified dental plan" means a dental plan certified by the KHBE that provides
5 a limited scope of dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), limited to a
6 pediatric dental essential health benefit which complies with the requirements of 45
7 C.F.R. 156.110(a)(10).

8 (37) "Qualified employee" means an individual employed by a qualified employer
9 who has been offered health insurance coverage by the qualified employer through the
10 SHOP.

11 (38) "Qualified employer" means an employer that elects to make, at a minimum, all
12 full-time employees of the employer eligible for one (1) or more QHPs in the small group
13 market offered through the SHOP.

14 (39) "Qualified health plan" or "QHP" means a health plan that meets the standards
15 described in 45 C.F.R. 156 Subpart C and that has in effect a certification issued by the
16 KHBE.

17 (40) "Qualified individual" means an individual who has been determined eligible to
18 enroll through the KHBE in a QHP in the individual market.

19 (41) "Service area" means a geographical area in which an issuer may offer a QHP.

20 (42) "SHOP" means a Small Business Health Options Program operated by the
21 KHBE through which a qualified employer can provide a qualified employee and their
22 dependents with access to one or more QHPs.

23 (43) "Small group" is defined by KRS 304.17A-005(42).

1 (44) "Stand-alone dental plan" means a dental plan as described by 45 C.F.R.
2 155.1065.
3 (45) "Summary of Benefits and Coverage" or "SBC" means a standard format,
4 created in accordance with 42 U.S.C. 300gg-15, for providing information to consumers
5 about a health plan's coverage and benefits.
6 (46) "System for Electronic Rate and Form Filing" or "SERFF" means an online
7 system established and maintained by the National Association of Insurance
8 Commissioners (NAIC) that enables an issuer to send and a state to receive, comment
9 on, and approve or reject rate and form filings.
10 Section 2. QHP Issuer General Requirements. In order for an issuer to participate in
11 the KHBE beginning January 1, 2014, the issuer shall:
12 (1) Hold a certificate of authority and be in good standing with the Kentucky
13 Department of Insurance;
14 (2) Be authorized by the office to participate on the KHBE;
15 (3) Enter into a participation agreement with the KHBE;
16 (4) Offer KHBE certified QHPs in the individual exchange or the SHOP exchange;
17 (5) Comply with benefit design standards as established in 45 C.F.R. 156.20;
18 (6) Provide coverage of the;
19 (a) Essential health benefits; or
20 (b) If stand-alone pediatric dental essential health benefit is offered in the KHBE in
21 accordance with 45 C.F.R 155.1065, essential health benefits excluding pediatric dental
22 essential health benefits;
23 (7) Implement and report on a quality improvement strategy or strategies consistent

1 with the standards of 42 U.S.C. 18031(g);

2 (8) Comply with applicable standards described in 45 C.F.R. Part 153;

3 (9) For the individual exchange, offer at least a:

4 (a) QHP with a silver metal level of coverage;

5 (b) QHP with a gold metal level of coverage;

6 (c) Child-only plan; and

7 (d) Catastrophic plan.

8 (10) For the SHOP exchange, offer at least a:

9 (a) QHP with a silver metal level of coverage; and

10 (b) QHP with a gold metal level of coverage;

11 (11) For the individual and SHOP exchange, offer no more than four (4) QHPs within

12 a specified metal level of coverage. For the purposes of establishing the number of

13 QHPs offered in a metal level, the KHBE shall consider the same plan offered with

14 dental benefits and offered without dental benefits as one (1) QHP;

15 (12) Not discriminate, with respect to a QHP, on the basis of race, color, national

16 origin, disability, age, sex, gender identity or sexual orientation;

17 (13) Assure that the non-discrimination requirements in 42 U.S.C. 300gg-5 are met;

18 (14) If participating in the small group market, comply with KHBE processes,

19 procedures, and requirements established in accordance with 42 C.F.R. 155.705 for the

20 small group market;

21 (15) Allow a participating agent to:

22 (a) Enroll individuals, employers, and employees in QHPs offered on the exchange;

23 (b) Enroll qualified individuals in a QHP in a manner that constitutes enrollment

1 through the KHBE; and

2 (c) Assist individuals in applying for advance payments of premium tax credit and

3 cost sharing reductions; and

4 (16) (a) Offer a QHP in a statewide service area, except as allowed under paragraph

5 (b) of this subsection; or

6 (b) Offer a QHP in a service area less than statewide if:

7 1. A QHP is available statewide;

8 2. The issuer's service area includes one (1) or more counties;

9 3. The issuer's service area is approved by the DOI; and

10 4. The issuer's service area is established in a nondiscriminatory manner without

11 regard to:

12 a. Race;

13 b. Ethnicity;

14 c. Language;

15 d. Health status of an individual in a service area; or

16 e. A factor that excludes a high utilizing, high cost or medically-underserved

17 population.

18 Section 3. QHP Rate and Benefit Information.

19 (1) A QHP issuer shall:

20 (a) Comply with the provisions of 45 C.F.R. 156.210 and KRS 304.17A-095(4);

21 (b) Submit to DOI through the SERFF system:

22 1. Form filings in compliance with KRS 304.14-120 and applicable administrative

23 regulations promulgated thereunder;

1 2. Rate filings in compliance with KRS 304.17A-095 and applicable administrative
2 regulations promulgated thereunder;
3 3. Plan management data templates;
4 (c) Receive approval from DOI for a rate filing prior to implementation of the
5 approved rate; and
6 (d) For a rate increase, post the justification prominently on the QHP issuer's Web
7 site.
8 (2) A CO-OP, multi-state plan, and qualified dental plan shall comply with
9 requirements identified by subsection (1) of this section.
10 Section 4. QHP Certification and Recertification Timeframes.
11 (1) The KHBE will take final action on the request for certification or recertification of
12 QHPs no later than August 31 for the following plan year.
13 (2) A QHP not certified or recertified by August 31 may not be offered on the
14 exchange at any time during the following calendar year.
15 Section 5. Transparency in Coverage.
16 (1) A QHP issuer shall provide the following information to the office in accordance
17 with the standards established by subsection (2) of this section:
18 (a) Claims payment policies and practices;
19 (b) Periodic financial disclosures;
20 (c) Data on enrollment;
21 (d) Data on disenrollment;
22 (e) Data on the number of denied claims;
23 (f) Data on rating practices;

1 (g) SBC;

2 (h) Information on cost-sharing and payments for out-of-network coverage; and

3 (i) Information on enrollee rights under Title I of the Affordable Care Act.

4 (2) A QHP issuer shall:

5 (a) Submit, in an accurate and timely manner, to be determined by HHS, the

6 information described in subsection (1) of this section to the KHBE, HHS, and DOI; and

7 (b) Provide public access to the information described in subsection (1) of this

8 section.

9 (3) A QHP issuer shall ensure that the information submitted under subsection (1) of

10 this section is provided in plain language as the term is defined by 45 C.F.R. 155.20.

11 (4) (a) A QHP issuer shall make available, in a timely manner, information about the

12 amount of enrollee cost-sharing under the enrollee's plan or coverage relating to

13 provision of a specific item or service by a participating provider upon the request of the

14 enrollee.

15 (b) The information shall be made available to an enrollee through;

16 1. An Internet Web site; and

17 2. Other means if the enrollee does not have access to the Internet.

18 Section 6. Marketing and Benefit Design of QHPs. A QHP issuer and its officials,

19 employees, agents, and representatives shall:

20 (1) Comply with issuer marketing practices provided under KRS 304.17A and 806

21 KAR 12:010; and

22 (2) Not employ marketing practices or benefit designs that will have the effect of

23 discouraging the enrollment of individuals with complex health care needs in QHPs.

1 Section 7. Network Adequacy Standards.

2 (1) A QHP issuer shall ensure that the provider network of a QHP is available to all
3 enrollees within the QHP service area, and:

4 (a) Includes essential community providers in the QHP provider network in
5 accordance with 45 C.F.R. 156.235 and meets the network adequacy standards for
6 essential community providers as established in section 8 of this administrative
7 regulation;

8 (b) Maintains a network that is sufficient in number and types of providers, including
9 providers that specialize in mental health and substance abuse services, to assure that
10 all services will be provided in a timely manner; and

11 (c) Meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and
12 KRS 304.17A-515.

13 (2) A QHP issuer shall make its provider directory for a QHP available:

14 (a) To the KHBE for online publication;

15 (b) To potential enrollees in hard copy upon request; and

16 (c) In accordance with KRS 304.17A-590.

17 (3) A QHP issuer shall identify in the QHP provider directory a provider that is not
18 accepting new patients.

19 Section 8. Network Adequacy Standards for Essential Community Providers for
20 Coverage Year 2014. A QHP issuer shall:

21 (1) (a) Demonstrate a provider network, which includes at least twenty (20) percent
22 of available essential community providers in the QHP service area participate in the
23 issuers provider network; and

1 (b) Offer a contract to:

2 1. At least one (1) essential community provider in each essential community

3 provider category in each county in the service area where an essential community

4 provider in that category is available; and

5 2. Available Indian providers in the service area, using the Model Indian Addendum

6 as developed by The Centers for Medicare and Medicaid Services and identified in the

7 "Supplementary Response: Inclusion of Essential Community Providers" form

8 incorporated by reference in this administrative regulation; or

9 (2) If unable to comply with the requirements in subsection (1) of this section,

10 (a) Demonstrate a provider network which includes at least ten (10) percent of

11 available essential community providers in the QHP service area; and

12 (b) Submit a supplementary response as identified in "Supplementary Response:

13 Inclusion of Essential Community Providers" as incorporated by reference in this

14 administrative regulation.

15 Section 9. Health Plan Applications and Notices. A QHP issuer shall provide an

16 application, including the streamlined application designated by the office, and notices

17 to enrollees pursuant to standards described in 45 C.F.R. 155.230.

18 Section 10. Consistency of Premium Rates Inside and Outside the KHBE for the

19 Same QHP. A QHP issuer shall charge the same premium rate without regard to

20 whether the plan is offered:

21 (1) Through the KHBE;

22 (2) By an issuer outside the KHBE; or

23 (3) Through a participating agent.

1 Section 11. Enrollment Periods for Qualified Individuals.

2 (1) A QHP issuer participating in the individual market shall:

3 (a) Enroll a qualified individual during the initial and annual open enrollment periods

4 described in 45 C.F.R 155.410(b) and (e) and comply with the effective dates of

5 coverage established by the KHBE in accordance with 45 C.F.R. 155.410(c)(1) and (f);

6 and

7 (b) Make available, at a minimum, special enrollment periods described in 45 C.F.R.

8 155.420(d), for QHPs and comply with the effective dates of coverage established by

9 the KHBE in accordance with 45 C.F.R 155.420(b).

10 (2) A QHP issuer shall notify a qualified individual of the effective date of coverage.

11 (3) Notwithstanding the requirements of this section, coverage shall not be effective

12 until premium payment is submitted by the individual.

13 Section 12. Enrollment Process for Qualified Individuals.

14 (1) A QHP issuer shall process enrollment of an individual in accordance with this

15 section.

16 (2) A QHP issuer participating in the individual market shall enroll a qualified

17 individual if the KHBE:

18 (a) Notifies the QHP issuer that the individual is a qualified individual; and

19 (b) Transmits information to the QHP issuer in accordance with 45 C.F.R.

20 155.400(a).

21 (3) If an applicant initiates enrollment directly with the QHP issuer for enrollment in a

22 plan offered through the KHBE, the QHP issuer shall either:

23 (a) Direct the individual to file an application with the KHBE in accordance with 45

1 C.F.R. 155.310; or

2 (b) Ensure the applicant received an eligibility determination for coverage through

3 the KHBE through the KHBE Internet Web site.

4 (4) A QHP issuer shall accept enrollment information in accordance with the privacy

5 and security requirements established by the KHBE pursuant to 45 C.F.R. 155.260 and

6 in an electronic format pursuant to with 45 C.F.R. 155.270.

7 (5) A QHP issuer shall follow the premium payment process established by the

8 KHBE in accordance with 45 C.F.R. 155.240.

9 (6) A QHP issuer shall provide new enrollees with an enrollment information package

10 that complies with the accessibility and readability requirements established by 45

11 C.F.R. 155.230(b).

12 (7) A QHP issuer shall reconcile enrollment files with the KHBE no less than once a

13 month in accordance with 45 C.F.R. 155.400(d).

14 (8) A QHP issuer shall acknowledge receipt of enrollment information transmitted

15 from the KHBE in accordance with KHBE requirements established by 45 C.F.R.

16 155.400(b)(2).

17 Section 13. Termination of Coverage for Qualified Individuals.

18 (1) A QHP issuer may terminate coverage of an enrollee in accordance with 45

19 C.F.R. 155.430(b)(2).

20 (2) If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer

21 shall:

22 (a) Provide the enrollee with a notice of termination of coverage that includes the

23 reason for termination at least thirty (30) days prior to the final day of coverage, in

1 accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

2 (b) Notify the KHBE of the termination effective date and reason for termination; and

3 (c) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

4 (3) Termination of coverage of enrollees due to non-payment of premium in

5 accordance with 45 C.F.R. 155.430(b)(2)(ii) shall:

6 (a) Include the grace period for enrollees receiving advance payments of the

7 premium tax credits as described in 45 C.F.R. 156.270 (d); and

8 (b) Be applied uniformly to enrollees in similar circumstances.

9 (4) A QHP issuer shall provide a grace period of three (3) consecutive months if an

10 enrollee receiving advance payments of the premium tax credit has previously paid at

11 least one (1) full month's premium during the benefit year. During the grace period, the

12 QHP issuer:

13 (a) 1. Shall pay claims for services provided to the enrollee in the first month of the

14 grace period; and

15 2. May suspend payment of claims for services provided to the enrollee in the

16 second and third months of the grace period;

17 (b) Shall notify HHS of the non-payment of the premium due; and

18 (c) Shall notify providers of the possibility for denied claims for services provided to

19 an enrollee in the second and third months of the grace period.

20 (5) For the three (3) months grace period described in subsection (4) of this section,

21 a QHP issuer shall:

22 (a) Continue to collect advance payments of the premium tax credit on behalf of the

23 enrollee from the U.S. Department of the Treasury; and

1 (b) Return advance payments of the premium tax credit paid on behalf of the
2 enrollee for the second and third months of the grace period if the enrollee exhausts the
3 grace period as described in subsection (7) of this section.
4 (6) If an enrollee is delinquent on premium payment, the QHP issuer shall provide
5 the enrollee with a notice of the payment delinquency.
6 (7) If an enrollee receiving advance payments of the premium tax credit exhausts the
7 three (3) months grace period in subsection (4) of this section without paying the
8 outstanding premiums, the QHP issuer shall terminate the enrollee's coverage on the
9 effective date of termination described in 45 C.F.R. 155.430(d)(4) if the QHP issuer
10 meets the notice requirement specified in subsection (2) of this section.
11 (8) A QHP issuer shall maintain records in accordance with KHBE requirements
12 established pursuant to 45 C.F.R. 155.430(c).
13 (9) A QHP issuer shall comply with the termination of coverage effective dates as
14 described in 45 C.F.R. 155.430(d).
15 Section 14. Accreditation of QHP Issuers.
16 (1) A QHP issuer shall:
17 (a) Be accredited on the basis of local performance of a QHP by an accrediting entity
18 recognized by HHS in categories identified by 45 C.F.R. 156.275(a)(1); and
19 (b) Pursuant to 45 C.F.R. 156.275(a)(2) authorize the accrediting entity that accredits
20 the QHP issuer to release to the KHBE and HHS;
21 1. A copy of the most recent accreditation survey, and
22 2. Accreditation survey-related information that HHS may require, including
23 corrective action plans and summaries of findings.

1 (2) A QHP issuer shall be accredited within three (3) years of initial QHP certification
2 in accordance with requirements identified by 45 C.F.R. 155.1045.
3 (3) The QHP issuer shall maintain accreditation so long as the QHP issuer offers
4 QHPs.
5 Section 15. Recertification, Non-renewal, and Decertification of QHPs.
6 (1) A QHP shall be recertified in accordance with the requirements of this
7 administrative regulation every two (2) years no later than August 31 for the following
8 plan year.
9 (2) An issuer shall submit to the Exchange a request for recertification of a QHP at
10 least ninety (90) days prior to an expiration of a certification.
11 (3) If a QHP issuer elects not to seek recertification with the KHBE, the QHP issuer,
12 at a minimum, shall:
13 (a) Notify the KHBE of its decision prior to the beginning of the recertification process
14 and follow the procedures adopted by the KHBE in accordance with 45 C.F.R.
15 155.1075;
16 (b) Provide benefits for enrollees through the final day of the plan or benefit year;
17 (c) Submit reports as required by the KHBE for the final plan or benefit year of the
18 certification;
19 (d) Provide notices to enrollees in accordance with Section 13 of this administrative
20 regulation;
21 (e) Terminate coverage of enrollees in the QHP in accordance with 45 C.F.R.
22 156.270, as applicable; and
23 (f) Comply with requirements of KRS 304.17A-240 and 304.17A-245;

1 (2) If a QHP is decertified by the KHBE pursuant to 45 C.F.R. 155.1080, the QHP
2 issuer shall terminate coverage of enrollees only after:
3 (a) The KHBE has provided notification as required by 45 C.F.R 155.1080(e);
4 (b) Enrollees have an opportunity to enroll in other coverage; and
5 (c) The QHP issuer has complied with the requirements of KRS 304.17A-240 and
6 304.17A-245.
7 Section 16. General Requirements for a Stand-alone Dental Plan.
8 (1) In order for a dental insurer to participate in the KHBE beginning January 1, 2014
9 and offer a stand-alone dental plan, the dental insurer shall:
10 (a) Hold a certificate of authority to offer dental plans and be in good standing with
11 the Kentucky Department of Insurance;
12 (b) Be authorized by the Office to participate on the KHBE;
13 (c) Enter into a participation agreement with the KHBE;
14 (d) Offer a pediatric dental plan certified by the KHBE in accordance with this
15 administrative regulation in the individual exchange or SHOP exchange that shall:
16 1. Comply with the requirements of KRS Chapter 304 Subtitle17C;
17 2. Submit to DOI through the SERFF system:
18 a. Form and rate filings in compliance with KRS Chapter 304; and
19 b. Dental plan management data templates;
20 (d) Offer a stand-alone dental plan that shall:
21 1. Be limited to a pediatric dental essential health benefit required by 42 U.S.C.
22 Section 18022(b)(J) for individuals up to twenty-one (21) years of age; and
23 2. Pursuant to 45 C.F.R. 156.150, provide within a variation of plus or minus two (2)

1 percentage points:

2 a. A low level of coverage with an actuarial value of 70 percent; and

3 b. A high level of coverage with an actuarial value of 85 percent, and

4 3 Have an annual limitation on cost-sharing at or below:

5 a. $1,000 for a plan with one (1) child enrollee; or

6 b. $2,000 for a plan with two (2) or more child enrollees;

7 (e) Comply with the:

8 1. Provider network adequacy requirements identified by KRS 304.17C-040 and

9 maintain a network that is sufficient in number and types of dental providers to assure

10 that all dental services will be accessible without unreasonable delay in accordance with

11 45 C.F.R. 156.230;

12 2. Requirements for stand-alone dental plans referenced in 45 C.F.R. 156 Subpart E;

13 and

14 3. Essential community provider requirement in 45 C.F.R. 156.235; and

15 (f) Not discriminate, with respect to a pediatric dental plan, on the basis of race,

16 color, national origin, disability, age, sex, gender identity, or sexual orientation; and

17 (2) The dental insurer offering a stand-alone dental plan participating in the KHBE

18 beginning January 1, 2014:

19 (a) May offer a stand-alone dental plan which includes coverage for individuals

20 regardless of age which includes at a minimum a pediatric dental essential health

21 benefit required by 42 U.S.C. Section 18022(b)(J) coverage for individuals up to twenty-

22 one (21) years of age; and

23 (b) If electing to offer the plan specified in paragraph (a), shall comply with the

1 requirements of subsection one (1) of this section.

2 Section 17. Essential health benefits for individuals up to twenty-one (21) years of
3 age. The KHBE shall ensure that an individual up to age twenty-one (21) years of age
4 eligible to enroll in a QHP shall obtain coverage for pediatric dental coverage.

5 Section 18. Enforcement. The DOI shall be responsible for enforcing the
6 requirements of KRS Chapter 304 and any administrative regulations promulgated
7 thereunder against any issuer.

8 Section 19. Issuer Appeals.

9 (1) An issuer may appeal the office's decision to:

10 (a) Deny certification of a QHP;

11 (b) Deny recertification of a QHP; or

12 (c) Decertify a QHP.

13 (2) An issuer appeal identified in subsection (1) of this section shall be made to the
14 office in accordance with KRS Chapter 13B.

15 Section 20. Material Incorporated by Reference.

16 (1) The following material is incorporated by reference:

17 (a) "Chapter 7: Instructions for the Essential Community Providers Application
18 Section", April, 2013 version; and

19 (b) "Supplementary Response: Inclusion of Essential Community Providers", April,
20 2013 version.

21 (2) This material may be inspected, copied, or obtained, subject to applicable
22 copyright law, at the Office of the Kentucky Health Benefit Exchange, 12 Mill Creek
23 Park, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or from

1 its Web site at www.healthbenefitexchange.ky.gov.

900 KAR 10:010

APPROVED:

Carrie Banahan
Executive Director
Office of the Kentucky Health Benefit Exchange

5/9/13
Date

APPROVED:

Audrey Tayse Haynes
Secretary
Cabinet for Health and Family Services

5/10/13
Date

900 KAR 10:010

PUBLIC HEARING AND COMMENTS:

A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the Public Health Auditorium located on the First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by June 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40621, (502) 564-7905, Fax: (502) 564-7573

REGULATORY IMPACT ANALYSIS AND TEIRING STATEMENT

Administrative Regulation Number: 900 KAR 10:010
Contact Person: Carrie Banahan (502) 564-7940

1. Provide a brief summary of:

   (a) What this administrative regulation does: This administrative regulation establishes the criteria for certification as a qualified health plan or a qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156.

   (b) The necessity of this administrative regulation: This administrative regulation is necessary to inform issuers of the requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

   (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that issuers are aware of the requirements for certification of a health plan as a qualified health plan or dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange as required by 45 C.F.R. Parts 155 and 156.

   (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed requirements for certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange to comply with the statute.

2. If this is an amendment to an existing administrative regulation, provide a brief summary of:

   (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

   (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

   (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

   (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect approximately 15 issuers that may request certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit Exchange.

4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

   (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will submit information electronically through the SERFF system related to rate and form filings to the Department of Insurance for review by DOI and KHBE.

   (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): $1,000.

   (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation will benefit each issuer that may request certification of a health plan as a qualified health plan or certification of a dental plan as a qualified dental plan to be offered on the Kentucky Health Benefit by providing detailed instructions regarding certification of Qualified Health Plans.

5. Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

   (a) Initially: No additional costs will be incurred to implement this administrative regulation.

   (b) On a continuing basis: No additional costs will be incurred.

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding to be used for the implementation and enforcement of this administrative regulation will be from Kentucky Office of Health Benefit Exchange existing budget. No new funding will be needed to implement the provisions of this regulation.

7. Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary.

8. State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees and does not increase any fees either directly or indirectly.

9. TIERING: Is tiering applied? (Explain why or why not)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 900 KAR 10:010
Contact Person: Carrie Banahan
Phone number: 502-564-7940

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation affects the Office of the Kentucky Health Benefit Exchange within the Cabinet for Health and Family Services.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.050(1), 42 U.S.C. § 18031, and 45 C.F.R. Parts 155 and 156.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate any revenue.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

(c) How much will it cost to administer this program for the first year? No additional costs will be incurred to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? No additional costs will be incurred to implement this administrative regulation on a continuing basis.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 900 KAR 10:010
Contact Person: Carrie Banahan, 564-7940

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

2. State compliance standards. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet, and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Kentucky Health Benefit Exchange, pursuant to, and in accordance with 42 U.S.C. Section 18031 and 45 C.F.R. Parts 155 and 156.

3. Minimum or uniform standards contained in the federal mandate. The Affordable Care Act establishes the creation of the American Health Benefit Exchange as identified in Section 1311(a) of the Affordable Care Act. The "Kentucky Health Benefit Exchange" (KHBE) is the Kentucky state-based exchange conditionally approved by HHS established by 45 C.F.R. 155.105 to offer a QHP in Kentucky beginning January 1, 2014. An Exchange must make qualified health plans available to qualified individuals and qualified employers.
   At a minimum, an Exchange must implement procedures for the certification, recertification, and decertification of health plans as qualified health plans. The Affordable Care Act allows for Exchanges to certify health plans as qualified health plans. This certification may be done if:
   - the health plan meets the rules for certification by the U. S. Department of Health and Human Services; and
   - the Exchange determines that making such health plan available through the Exchange is in the interests of qualified individuals and qualified employers in the state or states in which the Exchange operates.

   The Exchange must require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. These plans must prominently post such information on their websites.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter requirements than those required by the federal mandate.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Office of Kentucky Health Benefit Exchange

900 KAR 10:010 Exchange Participation Requirements and Certification of Qualified Health Plans and Qualified Dental Plans.

Summary of Material Incorporated by Reference

1. "Chapter 7: Instructions for the Essential Community Providers Application Section" is used by issuers to identify the types of facilities that are essential community providers. The form contains 11 pages.

2. "Form KHBE-C1, Issuer Participation Intent Form" is used by issuers to express a nonbinding notice of intent to participate in the Health Benefit Exchange for plan year 2014. The form contains 2 pages.

3. "Supplementary Response: Inclusion of Essential Community Providers" is used by issuers to obtain information related to Indians. The form contains 4 pages

The total number of pages incorporated by reference is 17 pages.