State of Arkansas

Arkansas Insurance Department

Arkansas Health Benefits Exchange Planning Project

Evaluation Plan

Version 2.0

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Document History

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Date	Version	Responsible	Reason for Revision
August 18, 2011	1.0	Amy Schrader/Debbie Hopkins	Initial Submission
August 19, 2011	2.0	Amy Schrader/Debbie Hopkins	Comments from Cindy Crone

Table 1: Document History

1 Introduction

In developing this evaluation plan, we have tried to simultaneously take two perspectives. Our first perspective is that of the policy maker who wants to know whether the Exchange, as established in Arkansas, satisfactorily performs what lawmakers have termed "essential functions." The second perspective is broader. We sought to also develop an evaluation plan that would address whether the Exchange was able to meet its public policy goals and whether any publicly anticipated or feared consequences were observed.

This proposed evaluation plan is designed to be a comprehensive assessment of Arkansas's new health insurance exchange. Evaluation is focused on three primary components: implementation, outcomes, and efficiency. Implementation evaluation focuses on the process of Exchange introduction to the public. A solid implementation evaluation serves as the foundation for outcomes and efficiency evaluations since the latter depend on successful implementation.

However, as a policy instrument, the Exchange is expected to have far-reaching consequences on the broader health care system. An outcomes evaluation centers on the policy objectives of the Exchange. Thus, this evaluation plan also aims to address various policy-relevant potential effects of the new Exchange.

Finally, in a time of constrained resources, efficiency is the critical third pillar of comprehensive evaluation. Efficiency evaluations identify whether the Exchange was implemented with minimal waste and whether the health outcomes were achieved in the most cost-effective manner.

It is essential that cooperative partnerships occur in the measurement of the implementation, outcomes and efficiency of the Exchange in order for the impact to be successful and for the Exchange to experience the most in cost-effectiveness. The measures presented in this evaluation plan are designed to track many aspects of health care, including satisfaction with care, quality of care, access to care, utilization of care, and cost of care. Although funding for an evaluation requires a financial commitment upfront, the benefits result in health improvement for Arkansans and a cost-effective and efficient health system which lead to potentially greater cost savings long-term.

To measure the HBE implementation effectiveness, we **recommend** conducting a population-wide survey of all Arkansas residents to capture awareness and use of the HBE as well as calculating enrollment and re-enrollment, tracking disenrollment and gaps in coverage.

To ensure that enrollees are satisfied with their healthcare coverage purchased through the HBE, we **recommend** conducting the CAHPS Health Plan survey to measure enrollee satisfaction. Since Navigators and licensed insurance producers are predicted to play an instrumental role in consumers accessing the HBE, we **recommend** surveying consumers at the time of enrollment to capture whether they used a Navigator or licensed producer and how satisfied they were with their Navigator or producer.

With a predicted increase in consumers accessing care, we **recommend** surveying providers to see if they feel they can adequately meet the needs of their existing patients and deliver care to new patients.

Tracking the number of uninsured Arkansans as well as crowd-out will be one aspect of measuring the success of the HBE. Also, the calculation of quality measures will measure whether enrollees' are receiving quality and timely care. We also recommend measuring access to care to determine if problems arise after more people access healthcare services as well as measuring utilization of care to determine if enrollees are accessing preventive services, not accessing the emergency department for non-urgent care and are not being readmitted to the hospital. Tracking the costs of care by plan and issuer will help identify any outlier expenditures.

1.1 Abbreviations and Definitions

ACA	The Affordable Care Act, which refers collectively to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act
AHRQ	Agency for Healthcare Research and Quality
AID	Arkansas Insurance Department
Applicant	An individual who is seeking an eligibility determination to enroll in a health plan through the Exchange, to receive advance payments of the tax credit, or to receive other State benefits per *§1312(f)(1)*
CCIIO	Center for Consumer Information and Insurance Oversight
CAHPS	The Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
CPM	Committee on Performance Measurement
Enrollee	A qualified individual or qualified employee who has enrolled in a qualified health plan, per *ACA §1312(f)(1)*
HBE	Health Benefits Exchange
Health Plan	A discrete combination of benefits and cost-sharing, also known as a "qualified health plan" or "QHP" per *ACA §1312(f)(1)*
HEDIS®	Healthcare Effectiveness Data Information Set, a set of standardized performance measures developed and maintained by NCQA
Issuer	ACA & the CCIIO use the term "issuer", not "carrier" to refer to "the entity offering coverage". For the sake of consistency, we adopt the same term throughout this proposal for Exchange evaluation.
MCPSS	Medicare Contractor Provider Satisfaction Survey
NCQA	National Committee for Quality Assurance, a not-for-profit organization committed to assessing, reporting on and improving the quality of health care
NQMC	National Quality Measures Clearinghouse
Qualified Individual	One who is already determined eligible to participate in an Exchange, per *ACA §1312(f)(1)*

Table 2: Abbreviations and Definitions

2 Approach

In developing the evaluation plan, we have relied upon the cause-and-effect logic implicit in ACA and subsequent rules and proposed rules. We have proposed measures that are directly tied to one or more of the stated objectives of ACA or to one of the mechanisms by which ACA is believed to achieve its policy goals. When a measure is required or proposed to be required, we have noted that in the text.

Our evaluation secondarily draws on a review of the experiences of early adopters of Exchanges, a review of existing evaluation plans for current or planned Exchanges and other changes to health insurance programs, and conventional measures of health system effectiveness. Our intent with this approach was to identify objectives and methods that were relevant to Arkansas and its unique population needs rather than imposing federal or non-comparable state standards.

2.1 Review of Other State Exchanges

Currently, only two states (Massachusetts and Utah) have functional state Exchanges. Both states require legislative revision to their existing state exchange authorization to be in compliance with the Patient Protection and Affordable Care Act (ACA). During the 2011 legislative session, ten states passed laws to establish Exchanges. Several other states either passed legislation or had executive orders signed that expressed the intent to develop a state-run Exchange .

Table 3 shows the status of Exchange development in states that have taken action to developing their own exchanges.

Type of Action	States
Existing Exchange	Massachusetts, Utah
Authorizing Legislation	California, Colorado, Connecticut, Hawaii, Maryland, Nevada, Oregon, Vermont, Washington, West Virginia
Intent-to-Establish Legislation	Illinois, Indiana, North Dakota, Virginia
Feasibility Study	Alabama, Mississippi, Wyoming

Table 3: Progress Toward Creating Exchanges

Source: Adapted from Table 1 of "Establishing Health Insurance Exchanges: An Update on State Efforts." (http://www.kff.org/healthreform/upload/8213.pdf)

Of the states listed, legislative review focused on West Virginia because it is the most similar to Arkansas in terms of rural composition and socioeconomic variables. More of West Virginia's population (54%) resides in rural areas than Arkansas (47%). However, with exception of Vermont, it is the only heavily rural state to adopt Exchange legislation. There is no statistical difference in educational attainment or median household income between West Virginia and Arkansas.

The objectives of feasibility studies for Alabama and Mississippi were examined for guidance on evaluation topics, again because of their similarity to Arkansas in rural composition and socioeconomics. Alabama's rural population is 45%, while Mississippi's is 51% (2000 US Census). Socioeconomic profiles focused on educational attainment and income. Arkansas's percent of high school graduates (82.4%) has a statistically equal proportion to Alabama's 82.1% and Mississippi's 80.4%. Mississippi has a median household income that is about $1,200 less than Arkansas's. Alabama incomes are about $2,700 higher. Both differences are significant.

Most early-adopting states have a high urban population, are relatively affluent, and have a low uninsured population relative to the US as a whole. However, where these states are similar to Arkansas on key health system features, their enabling legislation and statements by policy-makers were reviewed in a highly focused manner.

2.2 Review of Existing Evaluation Plans and Related Literature

State-developed plans for Exchange evaluations were difficult to find. This is not surprising given that most states are only in the early phases of Exchange development.

Most information about evaluation exists for the Massachusetts exchange. As the first of the states to attempt universal coverage through the private insurance market, Massachusetts attracted a great deal of outside research interest. Thus, a large proportion of the evaluation of the Massachusetts exchange have been conducted by non-state entities with little state oversight or input.

A secondary area of interest is the evaluations that have been conducted of other programs to expand health insurance coverage. The programs have focused mainly on Medicaid and its various State waiver programs. We reviewed the funded evaluation programs for coverage expansion programs identified by the State Health Access Data Assistance Center (SHADAC), an initiative of the Robert Wood Johnson Foundation.

The most common concerns in existing evaluations are the degree of enrollment change and especially barriers to enrollment. Other areas of interest are changes in the cost of care specifically as they relate to reimbursement for newly covered services.

2.3 Sources of Established Measures

In many cases, there are established methods for capturing the measures we propose in this evaluation. We **recommend** relying on these measures when possible because they have been previously validated and are generally well-accepted in the industry.

Most validated measures of health system quality and efficiency are publicized through the National Quality Measures Clearinghouse (NQMC). Our measures rely upon two main measurement sets, Healthcare Effectiveness Data Information Set® (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Most commercial

issuers have experience with these measures, so their collection should not represent a new administrative burden.

The HEDIS® is a set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS® is one of the most widely used set of health care performance measures used in the United States. HEDIS measures, while inclusive of some outcomes, generally are focused on the process of care. For example, the Breast Cancer Screening measure reports the percentage of women 40 to 69 years of age who had a mammogram to screen for breast cancer.

NCQA's Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, health care providers and policy makers, oversees the evolutions of the measurement set. Several Measurement Advisory Panels (MAPs) provide clinical and technical knowledge required to develop the measures. Additional HEDIS® Expert Panels and the Technical Advisory Group (TAG) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

The CAHPS program is overseen by the United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ) and includes a myriad of survey products designed to capture consumer and patient perspectives on health care quality.

3 Evaluation Measures and Methods

3.1 Implementation Effectiveness

"Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each state has the opportunity to establish an Exchange(s) that: (1) facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other requirements specified in the Affordable Care Act."

Implementation evaluation focuses on the process of Exchange introduction to the target population. Outcomes and efficiency evaluations must be interpreted in the context of how successfully implementation occurred. Therefore, a solid implementation evaluation serves as the foundation for all subsequent evaluations. The key measures by which the Exchange implementation process will be judged are its adoption by consumers and the continued use of the exchange.

Table 4 summarizes suggested measures of implementation effectiveness and potential sources. This list may be expanded later to comply with federal rules that are not yet finalized.

Potential Data Sources						
	Survey	Website	Call Center	Insurance Issuers	Medicaid Data	Exchange
Use of the Exchange	X	X	X			
Enrollment	X			X	X	X
Re-enrollment				X	X	X
Disenrollment				X	X	X
Gaps in Coverage	X			X	X	X

Table 4: Summary of Implementation Measures

3.1.1 Use of the Exchange

Use of the Exchange reflects two components: consumer awareness of the HBE as an option for purchasing health insurance and the ease with which the various HBE interfaces may be used. To date, discussions with the Arkansas Insurance Department and the Exchange workgroups have indicated that consumers will have multiple ways to accessing the HBE. There are multiple ways to access the Exchange including a federally-mandated call center and website as well as walk-in and by mail.

We **recommend** a population-wide survey of all Arkansas residents. This data collection method enables evaluators to ask residents specifically whether they are aware of the Exchange and separately whether they have tried to use it. Because the HBEs are new, no national survey tools are currently available to measure awareness and use. While this may change between now and when the HBE is implemented in Arkansas, we **recommend** that plans for evaluating awareness and use include development of a new survey tool designed

specifically to capture awareness and use. We **further recommend** that an updated review of tools be made before developing a new statewide survey tool since significant time and expense is involved in this process.

An **alternative recommendation** is to use relatively easy to capture statistics that are specific to the method of contact and established within that industry. An example of a use measure is the "bounce rate" or the number of times a consumer visits a website but leaves without visiting a threshold number of pages on that site. We **recommend** that no measures be finalized until authorizing legislation has passed and AID has set up appropriate administrative structures.

3.1.2 Enrollment and Re-enrollment through the Exchange

An Exchange is intended to be a method by which consumers can access Medicaid or health insurance they otherwise could not have purchased. Enrollment through the exchange is arguably one of the most important measurements of implementation success. Just because insurance is available through the Exchange, it is not guaranteed that all individuals who are eligible for Medicaid or subsidized premiums will elect to enroll or purchase coverage.

Currently, 47.1% of employers in Arkansas offer health insurance to at least some of their employees. In general, about 83.6% of employees at firms that offer insurance are eligible for coverage. The "take-up" rate, or the percentage of eligible employees actually electing to enroll in the company's plan, is 77% in Arkansas. We believe that 77% should be viewed as a baseline "take-up" measure before implementation of the Exchange. Therefore, with additional outreach efforts, we believe 90% should be the minimum threshold for enrollment of qualified individuals in the Exchange.

The premium subsidies for insurance coverage through the Exchange will be substantial relative to what many employers offer, especially for family coverage. For example, the average Arkansan with employer-based coverage pays about 20.2% of the total cost of the premium for employee-only coverage and 26.6% of the premium for family coverage (analogous to a subsidy of 79.8% and 73.4%, respectively). Exchange premium subsidies for families making less than 400% of FPL will range from 35% to 96%, depending on income.

There are additional incentives to purchase insurance through the exchange. First, lower income families will also be eligible for cost-sharing subsidies that may not be available through an employer, thus the total premium + cost-sharing cost of health insurance may be lower through the exchange. Second, most (66%) of the projected enrollment for the exchange will come from people who are currently uninsured and may not have access to insurance, but would like to purchase it. Finally, there will be individual fines for not maintaining health insurance coverage. All of these factors may contribute to a higher take-up rate than is currently observed for employer-offered insurance in Arkansas.

Among states that already have an insurance exchange or have passed authorizing legislation, Arkansas has no peers in take-up rate. Indeed, in states with similar employer

subsidies to Arkansas, the take-up rate is generally lower than that observed in Arkansas. This may indicate that people in Arkansas may be more likely to respond to premium subsidies. The many unknowns surrounding this issue underscore the importance of studying the enrollment rate.

We **recommend** measuring enrollment as the number of enrollees divided by the number of qualified individuals, expressed as a percentage. Because not all potential qualified individuals will actually apply for coverage through the HBE, we **further recommend** measuring enrollment as the percentage of potentially eligible individuals.

Re-enrollment is defined as maintaining QHP coverage through the HBE from one benefit year to the next. Re-enrollment is an important measure of effectiveness because it indirectly captures the value consumers place on the HBE. We **recommend** measuring re-enrollment as the number of enrollees in the current benefit year who have had any previous enrollment through the HBE divided by all current enrollees, expressed as a percentage.

3.1.3 Disenrollment and Gaps in Coverage

For the purposes of this evaluation proposal, disenrollment is any enrollee-driven termination of coverage through HBE. Under the 45 CFR §155.430, there are six reasons for termination of coverage. Since we are looking at disenrollment categories that would cause an enrollee to leave the Exchange, we are interested in the following four categories of reasons for termination of coverage: (1) voluntary termination, (2) loss of eligibility, (3) failure to pay premiums, and (4) rescission. Under current proposed rules, HBEs must "establish maintenance of records procedures for termination of coverage, track the number of individuals for whom coverage has been terminated and submit that information to HHS on a monthly basis" (45 CFR §155.430, proposed). The remaining two disenrollment categories include: the QHP terminates or is decertified by the HBE and the enrollee changes from one QHP to another. For the purpose of this evaluation, we do not recommend tracking these reasons since these categories of termination do not involve the enrollee leaving the HBE, but simply switching to other plans within the HBE.

We **recommend** that the HBE track reasons for termination of coverage over time with particular attention paid to whether there is a trend in the percentage of enrollees voluntarily terminating or failing to pay their premiums. We **further recommend** that this analysis be carried out with respect to subsidy and benefit level. Because the proposed rules will require the HBE to maintain termination records, we **do not anticipate new data collection or surveys for this measure**.

A gap in coverage occurs when an enrollee moves from one class of coverage to another (e.g. a Medicaid to QHP) and this move results in a period of uninsurance for at least one day. If proposed rules are finalized, gaps in coverage should be rare because of a provision that allows for special enrollment periods of 60 days when an individual has a loss of coverage and a provision for continued Medicaid until the private plan assumes coverage. Specifically, the regulations state that individuals "will not be required to be uninsured

prior to receiving a determination of eligibility for a special enrollment period." ACA§9801(f), 45 CFR§155.420.

However, it is likely that many individuals losing coverage will not take advantage of the ability to obtain an eligibility determination before losing their current coverage. Therefore, we **recommend** that the HBE monitor the actual time elapsed between when an individual loses the current type of coverage they have (employer, QHP, or Medicaid) and when they subsequently gain coverage through the HBE (in a QHP or Medicaid).

The date of lost coverage will be known to the HBE because of the 60-day enrollment period. The date of enrollment in a QHP or Medicaid will also be part of the HBEs standard record-keeping process. Therefore, this recommendation **does not represent new data collection, but rather analysis of what will be existing administrative data.**

Finally, we **specifically recommend** that analysis of gaps in coverage focus on QHP enrollees and Medicaid beneficiaries who are close to the Medicaid threshold since these individuals may be especially prone to changes in eligibility. The HBE should determine whether individuals with one or the other type of coverage delays switching to the other type for close to the 60 day limit. Additional clarity within federal regulations will further define how to handle QHP enrollees switching to Medicaid and Medicaid beneficiaries gaining coverage through a QHP to accommodate gaps.

3.1.4 Navigator Education

Given the central role envisioned for Navigators, we **recommend** assessing whether they feel they received appropriate and sufficient training and had sufficient technical assistance to be able to answer consumer questions. We **additionally recommend** that Navigators be asked whether they feel the HBE is supporting the role of a Navigator and whether the HBE could make administrative changes that would enable Navigators to more effectively serve consumers.

We **recommend** that these surveys take place each six months in the first and second year of implementation, with possible subsequent surveys if identified issues are not resolved. We **further recommend** that, given the nature of the domains of interest, the surveys should be qualitative and open-ended rather than guided response.

3.1.5 Federally-Required Measures

Planning for and development for Exchanges is in its early days. To date, the CCIIO has focused its efforts on disseminating information about goals and objectives for Exchanges and the appropriate functions and governance thereof. CCIIO has not published any guidelines for measuring Exchange effectiveness. This is subject to change.

We **recommend** regularly reviewing the guidance, proposed rules, and final rules published in the *Federal Register* for updated information on standards for Exchange evaluation. In the interim, related proposed and final rules should be reviewed to determine the potential direction CCIIO may take in establishing any rules for evaluation.

Specifically, **we recommend** reviewing all materials released relating to Exchange implementation, Qualified Health Plan (QHP) standards, and risk adjustment.

At a minimum, a review of existing federal rules should be made before any evaluation is undertaken to ensure that compliance is maintained. This in no way precludes evaluation if no federal rules are in existence. The recommended clearinghouse for this information is the Regulations & Guidance webpage of the Implementation Center, currently accessible through http://www.healthcare.gov/center/.

3.2 Enrollee Satisfaction

We **recommend** the HBE or a designated contractor administer CAHPS Health Plan surveys to measure enrollee satisfaction in the following areas: Navigators, HBE website, health plan, issuer, medical provider, and agent. The surveys should be administered to a random sample. When selecting the random sample of enrollees for the CAHPS survey, **we recommend** following current CAHPS sampling methodology to ensure that the sample size is sufficient to draw conclusions about relevant groups and subgroups.

Although not all of the measures below are currently captured on the CAHPS 4.0 Health Plan surveys, supplemental questions will be designed to measure enrollee satisfaction in the areas listed in Table 5. For questions that are captured on the national CAHPS Health Plan survey, national benchmarks will be available for comparison.

	National Survey	Custom Questions	Benchmark Available?
With Navigators		X	
With Exchange Website		X	
With Health Plan	X		X
With Issuer	X		X
With Provider	X		X
With Agent		X	

Table 5: Summary of Enrollee Satisfaction Measures

3.2.1 Navigators

There is no current national survey tool to measure satisfaction with a Navigator. We **conditionally recommend** that if a national Navigator-specific survey tool is developed and validated before HBE implementation such a tool should be used. However, at this time, **we recommend** that the HBE or a designated contractor develop a new survey tool that measures (1) ease of access to a Navigator, (2) how often the navigator gives the enrollee the information or help they need, (3) how often the navigator treats the enrollee with courtesy and respect, and (4) how often the enrollee rates the navigator an 8 or above on a 0 to 10 scale where 0 represents the worst navigator possible and 10 represents the best navigator possible. These proposed dimensions are patterned after the CAHPS survey.

To capture enrollees' satisfaction with a Navigator when they are most likely to recall the experience, we **recommend** asking these questions within six months of their enrollment. A follow-up survey could also be conducted at re-enrollment to determine if there were any changes in the enrollee's satisfaction with the Navigator. We **further recommend** that applicants be pre-screened for inclusion in the Navigator survey at the time of benefit eligibility determination so that only applicants who used a Navigator are selected for this survey.

3.2.2 Exchange Website

Using the CAHPS Health Plan survey tools as a model, we **recommend** that questions be developed to evaluate the Health Exchange Website to measure how often a consumer has utilized the website within a specified timeframe, how often the website provided information the consumer needed about how their health plan works and how the consumer rates the Health Exchange Website on a 0 to 10 scale where 0 represents the worst website possible and 10 represents the best website possible.

3.2.3 Issuer

Enrollee satisfaction surveys are mandated under ACA §1311(c)(4). Proposed federal rules are that the HBE must maintain a website that provides enrollees with up-to-date information about satisfaction survey results. At this time, no federal guidelines give the nature and content of these enrollee satisfaction surveys. However, the proposed 45 CFR Part 155 states specifically that HHS will be issuing further rules with respect to this topic. We make several recommendations below that we believe will likely be compliant with eventual guidance. However, **we caution that all recommendations of specific enrollee satisfaction measures are subject to change** pending eventual federal regulations.

The proposed 45 CFR Part 155 suggests that an insurance issuer or the HBE may be the entity which conducts the enrollee satisfaction survey. This is one of the areas subject to additional clarification. Therefore, Table 6 lists the potential entities that may have collection responsibility.

Measure	Potential Data Sources			Suggested Benchmark(s)
	Insurance Issuer	Outside Evaluator	State or Exchange	
Overall Rating	X	X	X	National average Exchange average
Information on Costs	X	X	X	Exchange average
Claims Processing	X	X	X	Exchange average
Customer Service	X	X	X	National average Exchange average

Table 6: Measures of Enrollee Satisfaction and Collecting Entities

Because of the ACA collection requirement, we do not envision the need to conduct additional surveys explicitly for evaluation, as long as sufficient sample sizes were collected when the regulatory requirement to conduct a survey was met. For this reason, **we recommend** close cooperation between survey operations for the Exchange's consumer information piece and the evaluation piece. Indeed, having one entity responsible for both may be the most cost-efficient way to meet the regulatory requirements and conduct a strong evaluation.

We **recommend** using existing national measures to capture an enrollee's satisfaction with their health plan collected through CAHPS Health Plan surveys which include: Rating of Health Plan, Plan Information on Costs, Claims Processing and Customer Service. It is worth noting here that the CAHPS use of "health plan" refers to that entity which is defined as an "issuer" in this text and by ACA and CCIIO.

The Rating of Health Plan measure asks the enrollee to rate their health plan on a scale from 0 to 10 where 0 represents the worst health plan possible and 10 represents the best health plan possible. Ratings of 8 and above will be calculated out of all ratings for comparison as well as each health plan's average rating.

The Plan Information on Costs measures how often the enrollee is able to find out from their health plan how much they will have to pay for a health care service or equipment as well as prescription medicines. This measure is calculated by taking the percent of consumers who responded "Always" or "Usually" out of all responses: "Never", "Sometimes", "Usually" and "Always".

The Claims Processing measures how often the enrollees' claims are handled quickly and correctly by the health plan. This measure is calculated by taking the percent of enrollees who responded "Always" or "Usually" out of all responses: "Never", "Sometimes", "Usually" and "Always".

The Customer Service measures how often the health plan's customer service gave the enrollee information or help they needed and treated them with courtesy and respect. This measure is calculated by taking the percent of enrollees who responded "Always" or "Usually" out of all responses: "Never", "Sometimes", "Usually" and "Always".

3.2.4 Health Plan

It is envisioned that ACA will provide consumers with choice of health plans to fit their needs. Under ACA, a health plan "is defined as a discrete combination of benefits and cost-sharing that is offered by a health insurance issuer and in which an individual or group can enroll." All health plans sold through the Exchange must be "qualified health plans" (QHPs). Each issuer may offer multiple QHPs.

This proposed section of the evaluation will determine whether there are systematic differences in enrollee satisfaction across issuers by benefit levels. Benefit levels are classified under ACA as bronze, silver, gold, and platinum. Catastrophic coverage is available to those 30 or younger, provided certain conditions are met. Since it is not known

whether there will be sufficient numbers of enrollees in the catastrophic QHPs, we do not recommend analysis at this benefit level without statistical assessment of sample size first.

We **recommend** measuring enrollee satisfaction with QHPs by the same measures as those collected under the issuer survey. This prevents the need to conduct a separate survey, which should additionally moderate evaluation costs.

We recommend comparing QHP satisfaction between those enrollees with and without a Navigator or Agent. We recommend capturing this measure by stratified analysis of CAHPS survey results based on a gateway question "Did you use a Navigator to select your QHP?" and "Did you use an Agent to select your QHP?" within the questionnaire. Therfore, the Exchange will be able to measure the effectiveness of the Navigator or Agent by comparing satisfaction scores between groups of enrollees who used and did not use a Navigator or Agent.

It is well-known that enrollee satisfaction varies with health status. Because of the potential for healthier enrollees to self-select into different levels of coverage than sicker enrollees, risk-adjustment is critical before statistically valid comparisons can be made across benefit levels. Therefore, we **recommend** that the Exchange choose one of the federally-mandated risk-adjustment measures as a tool for calibration in order to ~~when the final regulations are published in the Federal Register. The relevant rule is 45 CFR Part 153 Subpart D. This calibration will~~ provide a fair assessment of satisfaction and ~~will~~ allow for comparison between the QHPs. ~~when the final regulations are published in the Federal Register.~~ The relevant rule is 45 CFR Part 153 Subpart D. ~~This calibration will~~

3.2.5 Provider

We **recommend** using the CAHPS 4.0 Health Plan survey tools to also measure four components related to the enrollees' medical providers. Specifically we recommend the following CAHPS composites and ratings be used: How Well Doctors Communicate, Shared Decision Making, Rating of Personal Doctor and Rating of Specialist.

The How Well Doctors Communicate measures how often doctors listen, explain things, spend enough time with and show respect for what the enrollees have to say. The Shared Decision Making measures how often enrollees are included in their health care decisions by their providers. Standardized responses are "Never'', "Sometimes", "Usually", and "Always". We **recommend** that the evaluation follow CAHPS protocol and use a combination of the "Always" and "Usually" responses as a gauge of success.

The Rating of Personal Doctor measure asks the enrollee to rate their personal doctor for a specific timeframe on a scale from 0 to 10 where 0 represents the worst personal doctor possible and 10 represents the best personal doctor possible. The Rating of Specialist measure asks the enrollee to rate the specialist they saw most often for a specific timeframe on a scale from 0 to 10 where 0 represents the worst specialist possible and 10 represents the best specialist possible. We **recommend** that the evaluation follow CAHPS protocol and calculate the percent of enrollees who rated the item an 8 or higher.

3.2.6 Agent

There is no current national measure for an agent, however, we **recommend** that the state measures (1) ease of access to an agent, (2) how often the agent gives the consumer the information or help they need, (3) how often the agent treats the consumer with courtesy and respect, and (4) how the consumer rates their agent on a 0 to 10 scale where 0 represents the worst agent possible and 10 represents the best agent possible.

3.3 Provider Perceptions

With an expected increase of consumers accessing care, it is important to measure if providers' still feel they can adequately meet the needs of their existing patients and deliver care to new patients. These surveys are not intended to compare carriers or health plans or judge providers' opinion of ACA. The goal of this measure is to determine whether the provider has noticed an increase in patients and an increase in health care service utilization with a specific focus on whether either of these has impacted care delivery. In essence we are measuring access to care from the providers' perspective.

At this point, we cannot predict whether the QHPs will be existing plans or will be new plans developed under the HBE. If specially developed QHPs are designed so that providers can recognize that these plans were purchased through the HBE, then we **recommend** measuring provider satisfaction by plan and issuer for QHPs purchased through the HBE.

We **recommend** using questions from a national survey tool in order to measure provider satisfaction. Provider surveys should be short in length and straightforward in order to engage the provider quickly.

3.4 Insurance Coverage

One of the stated goals of ACA is to achieve universal health insurance coverage through a mix of market-based reforms. As a federal priority, measurement of increased insurance coverage will likely be a necessity in the future. However, it should be a priority for the state as well.

Most people recognize the financial burden the uninsured place on the healthcare system. For a poor state like Arkansas, this burden is particularly difficult to pay. Nationally, the number of physicians providing charity care fell to 68% in 2004-2005 from 76% in 1996-1997. Arkansas faces a restricted supply of physicians and safety-net clinics. This means that care is shifted to hospitals' emergency departments or inpatient facilities if the uninsured delays care long enough. This may help explain Arkansas's higher-than-average supply of hospital beds.

Lacking health insurance also places individual Arkansans and their families at substantial health and financial risk. Because uninsured Arkansans often forego preventive care, they may miss out on screenings and hence be diagnosed in later stages of diseases, including

cancer, and die earlier than those with insurance. Medical bills can keep the uninsured from being able to pay for basic necessities such as housing or food.

Of the currently uninsured, more than 75% are either employed or the children of employed parents. Amongst this group, the majority (90%) will qualify for some sort of subsidy of insurance premiums through the exchange. However, it is possible that the exchange will not completely eliminate the number of uninsured in Arkansas due to lack of enrollment and employer crowd-out (when private industry quits providing a service once government assumes that function).

Table 7 shows what data sources we **recommend** HBE to use in order to measure the number of uninsured Arkansans and, the state's crowd-out rate.

	Proposed Data Source		
	Survey of Arkansans	**Survey of Business**	**National Data**
Number of Uninsured • By Income • By Age	 X X		 X X
Crowd-Out		X	X

Table 7: Summary of Insurance Measures

3.4.1 Reducing Number of Uninsured Arkansans

In 2009, the most recent year with data available, 82.9% of Arkansans had health insurance. This was below the national rate of 84.6%. This reflects the effect of Medicare coverage in the elderly population though. Amongst the non-elderly population, 80.4% had insurance and amongst non-elderly adults, the percent with coverage falls still further to 74.8%. This places Arkansas amongst the list of states with the lowest insurance coverage for adults under the age of 64.

There has been a national trend toward declining insurance coverage in recent years. It is likely that this trend is reflected in Arkansas as well. To control for trends outside of policy changes related to ACA, we **recommend** that state-level measurement of insurance coverage for the specified groups below begin as soon as possible. When possible, these groups are constructed to reflect current national measurement, which will allow for meaningful benchmarking.

In some cases, no national benchmark exists. For example, the Marshallese minority group has a significant presence in Arkansas, but their experience is not tracked nationally. Another exception is geographic areas within Arkansas, which are defined by Arkansas's Department of Health public health regions. The counties within each region are defined in Table 8. Measurement can still take place and be tracked over time without a benchmark.

Domain	Sub-Group	National Benchmark Exists?
Household Income	<100% of Federal Poverty Level 138% of FPL and less (newly Medicaid eligible) 139% to 250% of FPL (premium subsidy + cost-sharing subsidy) 251% to 399% of FPL (premium subsidy only)	✓ ✓ ✓ ✓
Race and Ethnicity	White, Non-Hispanic Black, Non-Hispanic Hispanic Asian/South Pacific Islander Multi-racial American Indian/Alaska Native Marshallese	✓ ✓ ✓ ✓ ✓ ✓
Age	0 to 18 years 19 to 44 years 45 to 64 years 0 to 64 years. Should we also add 19-64? 65 years and older	✓ ✓ ✓ ✓ ✓
Geographic Area	**Central:** Faulkner, Garland, Grant, Lonoke, Perry, Pulaski and Saline counties. **Northeast:** Clay, Cleburne, Craighead, Crittenden, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, Stone, White and Woodruff counties. **Northwest:** Baxter, Benton, Boone, Carroll, Conway, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Pope, Scott, Searcy, Sebastian, Van Buren, Washington and Yell counties. **Southeast:** Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Jefferson, Lee, Lincoln, Monroe, Phillips, Prairie and St. Francis counties. **Southwest:** Calhoun, Clark, Columbia, Dallas, Hempstead, Hot Spring, Howard, Lafayette, Little River, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier and Union counties.	

Table 8: Proposed Sub-Group Analyses

In the absence of a State-level survey, measures of insurance cannot be reliably obtained in a timely fashion. Therefore, we **strongly recommend** that the State conduct or obtain through contract a state-wide annual survey of insurance following nationally-recognized and statistically valid methods for measuring insurance enrollment.

3.4.2 Crowd-Out

"Crowd-out" is an economic term that refers to the phenomenon of private industry ceasing to provide a service or produce a good once government assumes that function. In the context of the new Exchange, there is the potential that some small employers who currently offer insurance coverage will cease to provide health insurance. If this happens, their low-wage employees will be shifted to Medicaid. Mid-wage employees will qualify for insurance subsidies and can purchase through the Exchange. High-income employees however may be left to purchase insurance in the traditional individual market or may become uninsured. Nationally, there is little evidence for an extensive crowd-out effect amongst low-income adults who newly qualify for Medicaid. For example, a report by the Center for Budget and Policy Priorities found that "in the 12 states that have expanded Medicaid to cover adults with incomes at or above the poverty line, an average of 23 percent of individuals with incomes eligible for Medicaid have private coverage. In the states that haven't expanded Medicaid, a nearly identical share — 22 percent — of the same population has private coverage." This is because such a small proportion of low-income families have access to private insurance. Given Arkansas's economic profile, this may mean that the Medicaid expansion would have little effect here. There is more evidence of switching to subsidized insurance when it is offered. For example, when CHIP was expanded to include children beyond the poverty level, the CBO found that up to 50% of children had previously had private insurance. Information on whether this was employer-provided or purchased on the individual market by parents was not available.

The extent to which crowd-out will occur in Arkansas is unknown. Because there has never been a program exactly like this before, projections rely heavily on state expansions of Medicaid eligibility and CHIP. We were not able to identify any such studies that looked at Arkansas specifically. Table 9 shows our recommended measures of crowd-out effects.

Measure	Enrollment Documents	Enrollee Survey	Employer Survey	National Benchmark
Ceasing insurance offer			X	
Switching		X		
• To Medicaid	X			✓
• To private exchange plan	X			
• By health plan	X			
• By subsidy level	X			
Reason for switching				
• More affordable		X		
• Better coverage		X		
• Employer no longer offered		X		

Table 9: Measures of Crowd-Out

As of 2009, 47.1% of employers in Arkansas offered some form of health insurance to their employees. These appear to be primarily large employers because 83.3% of employed Arkansans work at companies that offer health insurance. However, a sizable portion,

16.4%, of employees at Arkansas firms that offer health insurance are not eligible for the insurance offered.

When the fine for having an employee purchase through the exchange is less than the amount the employer contributes to the health insurance premium, employers have an incentive to cease offering insurance. Due to the already sub-average number of firms and employees with employer-provided private insurance in Arkansas, we **strongly recommend** that this number be closely tracked on an annual basis through an employer survey. Surveys should begin before the Exchange becomes an option to control for any trend due to changing economic conditions.

Where offered, Arkansas employees generally paid about 20% of the premiums for their health insurance for single coverage and about 27% of premiums for family coverage. Where subsidies for the purchase of insurance exceed current employer coverage, there is the potential for switching. Therefore, we **also recommend** a survey of enrollees in the exchange to ascertain whether they are switching and the reason why. This should be analyzed by the level of subsidy and type of health plan purchased. Variables for sub-group analysis can be obtained by enrollee survey or from enrollment documents, the latter likely being the more reliable source. Analysis should be conducted using statistically-robust methods that adjust for exogenous trends, such as changes in economic conditions.

3.5 Quality of Care

If a large percentage of consumers is not receiving a treatment or preventive service that national guidelines call for, this tells us – medical professionals, payers and the general public – that something needs to change. This may mean: changing the way care is delivered, establishing or refining processes so that critical steps are not missed, helping healthcare providers stay current on the latest guidelines, educating Arkansans about the importance of preventive healthcare, improving access to healthcare providers in medically underserved areas, and helping doctors and patients communicate effectively.

Table 10 shows the data sources for quality measures that we recommend. These quality measures are described in their sections below

	Survey	Chart Review	Claims Data	Statistical Analysis
Technical and Process Measures • Comprehensive Diabetes Care • Cardiovascular Conditions		X	X X	
Health Outcome Measures	X	X	X	X
Variation in Measures • by Health Plan • by Issuer				X X

Table 10: Summary of Quality of Care Measures

3.5.1 Technical and Process Measures

While there are over seventy HEDIS® measures, we **recommend** that the Health Exchange focus on areas of greatest need within Arkansas as well as the demographics of the consumers. HEDIS® measures are often reviewed, edited, retired and created by NCQA's CPM to ensure that all measures accurately reflect current medical practices, codes and technologies. Therefore, the list of measures are recommended, but not limited to, the measures below:

Comprehensive Diabetes Care: For the more than 212,000 Arkansans who have diabetes, preventive care is critical for preventing complications such as kidney disease, blindness and amputations. Regular hemoglobin A1c testing can indicate a need for better blood-sugar control. Annual fasting lipid profiles track control of cholesterol and triglyceride levels, which are important in preventing diabetes-relate vascular disease. Annual dilated eye exams can identify early signs of diabetic retinopathy, and early detection followed by laser treatments can dramatically reduce the risk of blindness. For the Arkansas Medicaid population, the rates of Hemoglobin A1c testing, LDL-C screening and Dilated eye exams were consistently lower than the national Medicaid rates from SFY2003 to SFY 2007.

Cardiovascular Conditions: Heart disease and stroke, the first and third leading causes of death in the United States, are the most common cardiovascular diseases. Heart disease accounted for 27 percent of deaths in Arkansas in 2005, while stroke caused 7 percent of deaths. In 2007, 31 percent of adults in Arkansas reported having high blood pressure (hypertension) and 40 percent of those screened reported having high blood cholesterol, which puts them at greater risk for developing heart disease and stroke. Currently, there are three HEDIS® measures that focus on Cardiovascular conditions: Cholesterol Management for Patients with Cardiovascular Conditions, Controlling High Blood Pressure, and Persistence of Beta-Blocker Treatment After a Heart Attack.

3.5.2 Outcome Measures

Over 600 evidence-based quality measures exist through the NQMC, a database sponsored by AHRQ to promote widespread access to quality measures by the health care community.

Due to the large number of quality measures, we **recommend** that the Exchange commission a needs assessment and meet with key stakeholders, agencies and leaders to determine which areas of health outcomes should be the primary focus for the HBE and which data elements are currenly collected or required under ACA. After determining which outcome measures are most relevant for Arkansas and existing data sources and gaps,, the Exchange in consultation with key stakeholders can choose the desired outcomes measures accordingly and adapt the evaluation plan at that time.

Data collection methods will vary depending upon which measures are chosen by the Exchange. Some measures require claims data, a survey, chart review, or a combination of data collection methods. Valid statistical methods should be used to compare trends or to test for differences between health plans.

3.5.3 Variation by Plan and Issuer

One of the explicit goals of the ACA is to provide consumers with information to make informed decisions about the best private health insurance options for them and their families. Specifically, consumers will be able to "directly compare available private health insurance options on the basis of price, quality, and other factors." Quality ratings assigned to QHPs described in section 1311(c)(3) of the Affordable Care Act (pg 42).

Selected quality of care measures should be calculated annually for each health plan and issuer. Reports should highlight where significant differences exist between health plans and issuers in order to ensure consumers are accessing quality health care.

3.6 Access to Care

One focus of the health benefits exchange is to improve a consumer's access to health care. Since many of the consumers likely to join the health exchange will have not been previously covered by a health plan or had minimal coverage through a health plan, they will have access to health care they previously would not have had.

To measure the consumer's access to health care, we **recommend** a CAHPS-like survey be administered to capture the following measures: perceived access to services, wait time for primary care visit, miles traveled for primary care, affordability of insurance, affordability of care and affordability of prescriptions.

	Custom Survey	Existing Survey	GIS Software
Perceived Access to Services • Enrollees • Arkansans		X	
Wait Time for Primary Care Visit		X	
Miles Traveled for Primary Care	X		X
Referrals to Specialists	X	X	
Affordability of Insurance	X		
Affordability of Care	X	X	
Affordability of Prescriptions	X	X	

Table 11: Summary of Access Measures

3.6.1 Perceived Access to Services

The objective of this measure is to learn the extent to which the Health Exchange has had a positive impact on the consumer's ability to obtain health care services. We **recommend** the survey ask about the consumer's experiences before enrolling in the Health Exchange and their experience since enrolling in the Health Exchange. The survey should not be

conducted for consumers who have been enrolled less than six months. The following measures will, but are not limited to, compare a consumer's access to health care services: improved access to a primary care provider, prescription medication and emergency or urgent care.

- To measure improved access to a consumer's primary care provider, the survey should determine the level of problem accessing a primary care provider prior to enrollment and compared to at least six months post enrollment.
- To measure improved access to urgent care from a doctor's office or the emergency room, the survey should determine the level of problem accessing urgent care from a doctor's office or the emergency room prior to enrollment and compared to at least six months post enrollment.
- To measure improved access to a consumer's prescription medication, the survey should determine the level of problem accessing prescription medication prior to enrollment and compared to at least six months post enrollment.

Although these measures are not nationally available, the measures could be compared by health plan to determine where consumers are experiencing the greatest improvement in access to health care services. Statistical tests should be conducted to determine whether the changes in access to health care prior to enrollment and post enrollment are significant.

3.6.2 Wait Time for Primary Care Visits

Access to health care is multi-dimensional. There is the access to the system that insurance grants a person. As noted before, only about 68% of physicians will see patients who are uninsured. However, it is equally important to measure another dimension of access — timeliness of care.

As previously mentioned, Arkansas's supply of active physicians is far below the national average. Each active physician in Arkansas serves an average of 581 Arkansans. Nationally, physicians serve about 455 U.S. residents. Numbers that apply specifically to primary care doctors in Arkansas were not available, but it is reasonable to expect that they generally serve more patients than their peers in other states. There is also a relative shortage of safety-net clinics in Arkansas. There are only 4 FQHCs per 100,000 Arkansans living below 200% of the FPL. The national average is 7 FQHCs per 100,000 people below 200% of the FPL.

Of the states with existing Exchanges or with legislation authorizing an Exchange, Utah and Nevada are most like Arkansas with respect to physician supply. Three states currently studying the feasibility of operating a state-run Exchange (Alabama, Mississippi, and Wyoming) also have similar physician supply profiles to Arkansas.

We **recommend** measuring wait time for primary care visits on two dimensions: (1) how often the consumer gets care as soon as they thought they needed it and (2) how often the consumer sees a primary care provider within 15 minutes of their appointment time.

Table 121 shows entities that might collect the information on primary care access. ACA section 1311(c)(1)(D)(i) requires that all QHPs be accredited with an outside accrediting organization (e.g., NCQA), which HHS is interpreting, per 45 CFR §156.275 (proposed), to mean QHP issuers must be accredited. If the accreditation organization requires some form of timeliness measurement, the State could simply require that each QHP issuer submit this information annually during its recertification process. A method for doing so is outlined in the proposed rule. However, from an evaluation perspective, all accreditation organizations would have to use the same measures of timeliness. As HHS has not yet released final regulations on which organizations may accredit QHP issuers, we cannot offer guidance on whether this is a feasible strategy.

As an alternative, we **recommend** using two validated measures of timeliness, available through NCQA. The "Getting Care Quickly" measure is captured through the CAHPS 4.0 survey and measures the consumer's access to timely urgent and non-urgent care. "Wait time" includes time spent in the waiting room and exam room. This measure captures how often consumers see a primary care provider within 15 minutes of their appointment time and is captured through the Clinician and Group CAHPS survey.

	Data Sources		
Dimension	Insurance Issuer	Outside Evaluator	State or Exchange
Getting Care Quickly (CAHPS for consumers)	X	X	X
Time in Waiting Room (Clinician & Group CAHPS)	X	X	X

Table 12: Collection of Primary Care Access Data

The measures for timely access to needed care are well-established, so the primary concern with this area is who will collect and analyze the data. Many QHP issuers will likely already conduct the CAHPS survey. Given this, the State could require CAHPS survey data to be submitted to the Exchange or a designated contractor for statistical analysis of differences by issuer and for meta-analysis to determine aggregate effects. The strength of this approach is that the State will know how the existence of the exchange has affected care for those in and outside its operation. There is the added benefit of reduced data-collection costs.

Alternately the State could take a more restricted view and the State, the Exchange, or a designated contractor with strong survey experience could conduct a CAHPS survey of just Exchange enrollees.

Regardless, we believe that given the sensitive nature of this topic and ACA more generally, an outside evaluator should play a central role. While issuer-level data may be submitted by the QHP issuer or its accreditor, at a minimum we advise that a broad benchmark survey be conducted by an outside evaluator so any outlier issuers can be identified. This is a critical quality-control tool.

3.6.3 Travelling for Primary Care

Apart from being able to get an appointment with a primary care doctor, Arkansans also need to be able to reach their doctors. One concern that has been raised is that increased access to coverage will cause additional caseload burdens to be placed on physicians who may subsequently decide to stop providing care. While there is no compelling evidence to support the link between the Exchanges and the number of physicians practicing, we believe that the evaluation should address some of the concerns of critics.

If the supply of physicians declines, we expect that Arkansans will have to travel further than they do now for care. Long travel times can discourage people from seeking primary care as much as long wait times. In a rural state, such as Arkansas, monitoring travel distance and time is particularly important.

We **recommend** one of two measurement methods. We believe both methods of measurement are valid; the preferred method will depend largely on the Exchange's ability to secure data-sharing agreements and willingness to make long-term financial commitments.

Option 1 for measuring travel distance and time is a consumer survey. Because there is no currently validated question or set of questions to assess this, the Exchange would need to contract with an outside agency that is experienced with developing and testing new survey questions to create a question that accurately captures this data. Through the consumer survey tool, a supplemental question will be developed to measure the one way distance or miles the consumer travels to visit their primary care provider. The new question(s) could then be added to an existing survey and administered annually.

Option 2 is to use consumer and provider ZIP codes to approximate travel distance and time. Commercially available software, such as GeoAccess-GeoNetworks, has been widely used by health insurance companies to calculate distances and approximate travel times when assessing network adequacy. While we do not endorse a particular software program, GeoAccess is one of the most well-known programs in this class of software and is used by the GSA (Contract #GS-35F-0027W). Using this approach would require obtaining 5-digit enrollee ZIP codes and the ZIP code of the enrollee's primary care provider. 5-digit ZIP codes are HIPAA protected and would require a formal data-sharing agreement with each issuer authorized to sell through the new Exchange. Specific primary care provider IDs would not need to be disclosed for this method.

3.6.4 Referrals to Specialists

Another aspect in measuring satisfaction of care involves measuring whether consumers are receiving care from specialists in a timely matter and how difficult it was to get an appointment with a specialist. The CAHPS 4.0 Health Plan survey tools have a section designed to measure the specialist that the consumer saw most often in a specific timeframe. These measures are nationally recognized and provide a means of comparison against national benchmarks. Such questions include whether the consumer tried to make

an appointment to see a specialist, how often it was easy to get appointments with specialists, and how many specialists the consumer saw. Although the CAHPS 4.0 Health Plan survey tools do not contain questions about referrals, supplemental questions could be developed to measure if the consumer needed a referral in a specified timeframe and how often they got a referral to see a specialist as soon as they needed.

3.6.5 Affordability

We **recommend** measuring affordability across three dimensions: insurance premiums, cost-sharing for medical care, and prescription drug costs. While not exhaustive, we believe that this list will present an accurate picture of how costs to the consumer are changing over time in Arkansas. Monitoring the affordability of healthcare is vital to ensuring that consumers are accessing needed care and preventive screenings to prevent higher costs and chronic illness later.

One supposition of the ACA is that "companies will compete for business on a level playing field, driving down costs." It is believed by the authors of the ACA that this will occur through many mechanisms. For example, "Exchanges will give individuals and small businesses the same purchasing clout as big businesses."

The Exchange evaluation should determine the extent to which premium reductions for individual and small business purchasers actually occurs. Ideally, this includes a baseline assessment of what the average cost of coverage for different family configurations in the individual and small business market pre-Exchange implementation.

Further, the evaluation should determine whether premiums are declining overall, or whether coverage is simply more affordable to enrollees due to the presence of subsidies. This latter investigation necessitates the need for analysis by subsidy tier and by benefit level (i.e., bronze, silver, gold, or platinum).

Affordability also covers whether insured persons can pay for the medical treatment that they need. There is currently evidence that the cost of medical care is a substantial barrier to access. Nationally, of those reporting difficulty accessing care, 44.7% cited cost as the main reason they did not get treatment. Insurance does not immediately remove this barrier. Amongst the non-elderly with private insurance, 29% cited cost as a barrier and amongst the publicly insured, 42.1%. Lower income households will qualify for reductions in cost-sharing if they purchase insurance through the Exchange. It is therefore logical that the Exchange monitor the extent to which cost-sharing subsidies are effective at keeping medical care affordable.

While national surveys exist that measure these important domains, the data are generally only available on a substantial lag and cannot be analyzed at the granular level required for state policymaking. Therefore, we **recommend** the evaluation of the Exchange include the development of a new consumer survey tool.

Questions for the new consumer survey tool should be developed to assess the level of financial burden placed on the enrollee by (1) the monthly insurance premium and (2) any

relevant cost-sharing relative to their annual household income. We further propose that this new survey tool assess (1) whether the enrollee chose to delay care due to out-of-pocket costs, (2) not access care due to the out-of-pocket costs, and (3) go without any prescription medication due to the out-of-pocket cost of the medicine.

3.7 Utilization of Care

As a large number of Arkansans gain access to health insurance and are able to access the health system in new ways, we expect that patterns of health care use will change. National studies indicate that most enrollees in the Exchange will have been uninsured and that there is substantial pent-up demand for health care services.

For example, it is projected that more than one third of Exchange enrollees will have gone two or more years since their last preventive check-up. Further, over 25% of enrollees will have had no interaction with the health system at all in the year before their enrollment. Given this, it is logical to expect immediate and dramatic differences in utilization of some health care services (preventive care and non-urgent emergency department) and long-term declines in others as chronic health conditions are diagnosed earlier and better managed over the course of the disease (certain hospitalizations).

	Hospital Data	Claims Analysis	Issuers	Survey
Preventive Services		X	X	X
Emergency Department	X	X	X	X
Hospitalizations	X	X	X	X

Table 13: Data Sources for Utilization of Care

3.7.1 Preventive Services

We **recommend that** receipt of a specific set of evidence-based preventive services should be measured annually due to high economic value. Also, ACA regulations expanded prevention coverage for women's health, immunizations, aspirin use to prevent cardiovascular disease and smoking cessation. Women's health preventive services include breast cancer screening, Chlamydia screening, and cervical cancer screening. Since ACA is recommending specific preventive services to be covered under the Exchange, we recommend at least measuring these preventive services to determine if enrollees through the Exchange are being screened in order to prevent the onset of further complicated conditions or health deterioration.

Other important preventive measures include access to dental care, adult BMI assessment, and adults' access to preventive/ambulatory health services. We **recommend** that these measures should be calculated for each health plan and by issuer. We **recommend** these rates should be compared to the national benchmark to determine whether the plans and/or issuers exceed or need improvement within these areas.

Women's Health: Preventive care for women – mammograms, cervical cancer testing and Chlamydia screening – is in need of increased attention and focus. Mammogram rates are falling nationally and here in Arkansas. Screening for Chlamydia – one of the most common and easily cured sexually transmitted diseases – has fallen in recent years in Arkansas, even as national rates have climbed. The percentage of women receiving Pap tests, which can detect precancerous changes in cervical cells, has also fallen in Arkansas while national rates have risen slightly.

Colorectal Cancer Screenings: Although the colorectal cancer screening is likely to affect a small subset of older adults, colorectal cancer is the third most common type of non-skin cancer in men and in women and it is the second leading cause of cancer death in the U.S. after lung cancer.

Medical Assistance with Cessation Smoking: This measure is captured in the CAHPS 4.0 Health Plan survey. It measures the percentage of smokers and tobacco users who were advised by their provider to quit smoking or using tobacco, recommended cessation medications and provided cessation methods or strategies.

Flu Shots for Adults Ages 50-64: This measure is captured in the CAHPS 4.0 Health Plan survey. It measures the percentage of adults' age 50 to 64 who receives an influenza vaccination during a specific timeframe.

Aspirin Use: The CAHPS 4.0 Health Plan survey also includes a subset of questions on the adult survey that is used to measure the percentage of adults who are currently taking aspirin.

Discussing Aspirin Risks and Benefits: Within the subset of questions mentioned above, the survey also measures the percentage of adults who discussed the risks and benefits of using aspirin with a doctor or other health provider within a specified timeframe.

Annual Dental Visit: This HEDIS® measure calculates the percentage of enrollees who had at least one dental visit during a specific timeframe.

Adult BMI Assessment: This HEDIS® measure calculates the percentage of enrollees who had an outpatient visit and who had their body mass index (BMI) documented within a specific timeframe.

Adults' Access to Preventive/Ambulatory Health Services: This HEDIS® measure calculates the percentage of enrollees who had an ambulatory or preventive care visit within a specific timeframe.

The preventive services listed as examples here are targeted toward adults. We have selected them because current projections are that adults aged 19 to 64 years will account for about 80% of Exchange enrollees. We **recommend** strong Exchange involvement in the choice of which preventive care measures will ultimately be used.

3.7.2 Emergency Department for Non-Urgent Care

Use of the emergency department (ED) for non-urgent care may be an inefficient use of health system resources. Specifically, if care provided in the ED could be provided in primary care clinics, it is generally less expensive for treatment to be provided outside of the ED. More troubling, high use of the ED for non-urgent care may indicate lack of access to primary care, especially in medically underserved areas and populations.

We **recommend** that the Exchange evaluate whether non-urgent ED use changes over time and whether there is a different pattern of non-urgent ED use amongst different benefit levels and in different regions of the state. As part of this evaluation, the Exchange should determine a valid method for measuring non-urgent ED care. Our assessment is that any method will be claims or electronic medical record (EMR)-based and therefore will require the Exchange to enter into a data-sharing agreement with the QHP issuers or with the various hospitals in the state.

Each data source has its own strengths and weaknesses. Relying on claims data from the QHPs only provides information about Exchange enrollees, with no ability to benchmark to a broader population. Additionally, claims data is generally only available on a lag and is restrictive in the amount of clinical information available. However, the use of claims data allows for standardization (since a fixed set of fields are collected for all claims).

EMR data is more immediate and allows for a greater set of clinical adjustments. Additionally, the Exchange would be able to capture data from a broad range of patients, rather than just enrollees. However, it is not clear how feasible separating out the Exchange enrollees from others would be. Also, given the number of hospitals in the state, there is a potential large number of different EMR systems. Also, the required number of technical support personnel to ensure smooth transitions of data from various hospital systems into one central analysis location is likely to be substantial.

3.7.3 Hospitalizations

Two classes of hospitalizations should be examined to judge the long-term effectiveness of insurance expansion through the Exchange. The first is a measure of whether enrollees are able to access the care they need for follow-up treatment after an initial hospitalization. The second is a measure of whether enrollees are getting better care for chronic health conditions.

There is evidence that the uninsured are more likely to be readmitted to the hospital because they have greater difficulty getting needed follow-up care. We **recommend** monitoring 30-day readmission rates for Exchange enrollees to help assess whether they are able to get all required post-hospitalization care.

While the adults who are expected to enroll in the Exchanges have significantly lower self-assessed physical health status than those who currently have private health insurance, they paradoxically have fewer diagnosed chronic health conditions. This can be explained

by the lack of contact with primary care providers who perform regular screenings for chronic health conditions. Without regular contact with primary care, a person may not find out he or she has a chronic condition until a complication arises and hospitalization occurs.

These types of hospitalizations belong to a class called hospitalizations for "ambulatory care sensitive conditions" (ACSCs) and are generally thought to be avoidable with adequate management. The Agency for Healthcare Research and Quality (AHRQ) has developed a validated algorithm for tracking hospitalizations for ACSCs. The Prevention Quality Indicators (PQIs) have a component that focuses specifically on chronic conditions. W**e recommend** using the Chronic PQI composite rate to track long-term changes in care for chronic conditions. As a nationally developed and tracked measure, a benchmark is available to judge performance.

Data for these measures will be derived from claims and may be reported by the issuers if supplied with appropriate guidelines. The AHRQ software runs on SAS, a statistical package for which not all health insurance companies will have a license. Issuers likewise may not have the in-house expertise working with these measures to regularly report on them. Therefore, we strongly recommend that discussion of data sharing take place so that the Exchange or a qualified contractor could perform calculations.

At a minimum, we believe analysis by health plan is necessary. However, statistical validity is of paramount concern with single-year rates because they may be highly volatile in small populations. It is highly recommended that, if rates are issuer-reported, a trained statistician will review calculations to determine reliability.

3.8 Cost of Care

Our proposed affordability measures were targeted to the enrollee. The measures of cost take a system-wide perspective. In this measurement area, health care costs are relevant, regardless of who pays them. Data on the cost of care is vital to an understanding of health system efficiency.

It is no secret that health care costs in the U.S. are rising and healthcare costs in the U.S. are significantly higher compared to other developed countries. Currently, the U.S. spends about $7,400 per person on healthcare each year. One of the goals of ACA is to reduce the cost of health care. The rationale for how this will happen is not as clearly delineated as it is for other goals of the law. Additionally, the public does not have much confidence that this will be the ultimate outcome of the new reforms; 28% of the public overall believes that costs will "get better". Amongst independents and Republicans, the belief that costs will decrease is even lower, 19% and 9% respectively.

We **recommend** that the Exchange calculate the cost per enrollee for each health plan and issuer annually. The data necessary for this analysis is already mandated as reportable to the Exchange and HHS under 45 CFR §153.520. Data will be submitted by QHP issuers in a standardized HHS-mandated format. Under 45 CFR §153.510, HBEs are required to make

transfer payments from issuers with the lowest risk pools to the highest risk pools through a risk corridor beginning 2014. The amounts due to or from each issuer will be determined based on the aggregate allowed amounts. We **recommend** using these allowed amounts as a proxy for expenditures.

3.8.1 Expenditures by Plan

Examination of expenditures by health plan is intended to identify systematic differences in the cost of health care across benefit levels (i.e. bronze, silver, gold, platinum). Due to the reporting structure mandated by HHS, it will be possible to stratify each issuer's expenditures by benefit level. We **recommend** that the HBE calculate the costs per enrollee annually for the different benefit tiers across issuers. Because healthier individuals may select plans with higher cost-sharing requirements to get the benefit of a lower premium, valid actuarial risk-adjustment methods **are required**, consistent with 45 CFR §153.320.

We **recommend** that this analysis be conducted by a healthcare economist, or other individual similarly trained, with the goal of identifying expenditure-benefit pairings that could indicate large numbers of enrollees are selecting coverage that does not sufficiently meet their needs.

3.8.2 Expenditures by Issuer

The HBE should calculate the risk-adjusted expenditures per enrollee for each issuer annually and compare to the all-issuer average expenditure per enrollee to determine if one issuer is significantly more or less that other issuers. Issuers with lower than average costs and higher satisfaction or quality scores should be identified and may serve as a learning model for other plans.

3.8.3 Trends in Health Expenditures

It is hypothesized that aggregate health expenditures may potentially decrease because insurers will face greater competition and hence exert more pressure on providers for cost-efficient care as a means to lower the premiums they are able to charge.

We **recommend** examining statewide trends in health expenditures as a measure of the effect, if any, that expanded insurance coverage through the HBE has on aggregate health expenditures. We emphasize that while trends analysis may be used to supplement annual health plan or issuer analyses, the trend analysis proposed here specifically takes a macro view, **including those insured through sources outside the HBE and those who remain uninsured**.

We **recommend** that this analysis be conducted by a health economist, or other individual similarly trained to conduct statistically valid observational studies that can control for the myriad other causes of changes in expenditures (e.g. an aging population).

3.8.4 Contrast Between Private Issuers and Medicaid

We anticipate that there will be different health cost experiences between those who enroll in private QHPs and those who access Medicaid through the Exchange. Additionally, we expect that the trends in health expenditures will vary over time across the two sources of insurance coverage (private and Medicaid). Therefore, we propose that the evaluation include an assessment of the degree to which costs differ in the base-year (2013) and how costs change over time between private issuers, as a group, and Medicaid.

We **do not advise** singling out any particular QHP, benefit level, or issuer for direct Medicaid comparison. However, it will likely be instructive to divide the private QHP enrollees by income. For all analysis, we **recommend** valid risk-adjustment measures be used, as established by regulation.

3.9 Summary of Evaluation Measures

Note: No measures should be considered final until appropriate administrative structures are set up.

The "X" in the columns of Table 14 designate whether the recommendation is a measure of implementation, outcomes, or efficiency or whether the recommendation refers to methodology.

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
3.1.1	Population-wide survey of all Arkansas residents on awareness of HBE	X			
3.1.1	Survey will be custom tool to capture awareness and use	X			
3.1.1	Review available tools before design in case one exists at time of implementation Or capture bounce rate on HBE website	X			
3.1.2	Measure enrollment and re-enrollment as defined	X			
3.1.3	Track reasons for termination of coverage at subsidy and benefit level.	X			
3.1.4	Analysis of gaps in coverage focus on QHP enrollees and Medicaid beneficiaries	X			

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
3.1.4	Assess Navigator satisfaction with their training and support from the HBE	X			
3.1.5	Regularly review proposed rules in Federal Register and all materials released relating to Exchange implementation	X	X	X	
3.2	Administer CAHPS surveys to measure enrollee satisfaction and follow CAHPS protocol and methodology		X	X	
3.2.1	Develop new survey tool to capture enrollee satisfaction with Navigator at time of enrollment	X	X	X	
3.2.1	Applicants should be pre-screened for inclusion in survey				X
3.2.1	Compare QHP satisfaction between enrollees with and without a Navigator, conduct stratified analysis of CAHPS survey results based on if enrollee had a Navigator.		X		
3.2.2	Use CAHPS questions as model to measure Exchange website satisfaction		X		
3.2.3	Use of existing national measures to capture enrollee's satisfaction		X		
3.2.4	Measure enrollee satisfaction with QHPs by same measures collected in issuer survey		X	X	
3.2.4	Choose one of the federally-approved risk-adjustment measures published in Federal Register for OHP satisfaction		X	X	
3.2.5	Use CAHPS composites		X		

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
	and ratings to measure enrollee satisfaction with providers; follow CAHPS protocol				
3.2.6	Measure enrollee satisfaction with their Agent	X			
3.3	Measure provider perceptions since HBE implementation	X			
3.4	Measure number of uninsured Arkansans and state's crowd-out rate				X
3.4.1	Begin state-level measurement of insurance coverage as soon as possible	X	X		
3.4.1	Collect level of insurance coverage through survey				X
3.4.2	Track state crowd-out measure annually through employer survey		X		
3.4.2	Survey enrollees to determine whether they are switching coverage and why		X		
3.5.1	Calculate HEDIS measures that focus on greatest need within Arkansas		X	X	
3.5.2	Commission a needs assessment to decide areas of health outcomes to measure		X		
3.5.3	Calculate quality of care measures annually for each health plan and issuer		X	X	
3.6	Conduct CAHPS-like survey to capture enrollee access to care		X		
3.6.1	Questions asking enrollee about access to care prior to coverage through HBE and since acquiring coverage through HBE		X		X
3.6.2	Measure wait time for PCP		X		X

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
	through CAHPS survey measures				
3.6.3	Recommend two methods for enrollee's traveling for primary care: 1) through survey measure 2) approximate travel distance through zip code analysis		X		X
3.6.4	Measure access to specialist through CAHPS survey		X		X
3.6.5	Measure affordability through three dimensions as defined in text		X	X	X
3.6.5	Measure affordability through new consumer survey tool		X		X
3.7.1	Calculate HEDIS measures for preventive services by health plan and issuer and compare to national benchmarks		X		
3.7.2	Evaluate whether non-urgent ED use changes over time and track patterns among different benefit levels and geographic regions		X	X	
3.7.3	Monitor 30-day readmission rates for enrollees to ensure that they are able to get all required post-hospitalization care.		X	X	
3.7.3	Use Chronic PQI composite to track long-term changes in care or chronic conditions		X	X	
3.8	Calculate cost per enrollee for each health plan and issuer annually			X	
3.8	Use allowed amounts as proxy for expenditures				X
3.8.1	Calculate cost per enrollee annually for different benefit tiers across issuers				X

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
	and analysis should be conducted by healthcare economist				
3.8.2	Calculated risk-adjusted expenditures per enrollee for each issuer annually and compare to all-issuer average expenditure per enrollee			X	X
3.8.3	Examine trends in heath expenditures including those insured outside of HBE and the remaining uninsured; Analysis should be conducted by a health economist to control for myriad causes of changes in expenditures				X
3.8.4	Valid risk-adjustment measures be used for all analyse~~i~~s as established by regulations				X

Table 14: Summary of Evaluation Measures

4 Estimated Budget

After accounting for all measures required through the Department of Health and Human Services regulations and all recommended measures as defined in this evaluation plan, we propose the following amounts as an estimated budget for this evaluation.

Evaluation Component	HHS Required	Estimated Sample Size	Estimated Amount	Recurring Expenses
Annual Enrollee Satisfaction Surveys	Yes	22,000	$240,000	$240,000
Annual Provider Satisfaction Surveys	No	2,000	$46,000	$46,000
Measurement of Enrollment and Re-enrollment	No	N/A	See staff time	Recurring staff expense
Measurement of Disenrollment and Gaps	No	N/A	See staff time	Recurring staff expense
Annual HBE Website Survey and Analysis	Yes (proposed)	N/A	$18,000	$18,000
Conducting Annual Navigator Education Survey	No	750	$23,000	$23,000
Enrollee Navigator Satisfaction Survey and Analysis (includes development)	No	Unknown	$36,000	$25,000
Qualitative Navigator Interviews	No	5 focus groups	$5,000	$0
Staff Time (data entry, analysis and reporting)	N/A	N/A	$365,000	$365,000

Table 15: Estimated Budget

Additionally, staff time will be required to complete data entry, conduct all analyses and reporting related to implementation effectiveness, access to care, utilization of care, and costs. We estimate the annual expense for this component to be $365,000. Therefore, total estimated costs to effectively implement the proposed evaluation plan are projected to be $733,000.

5 Required Tasks and Timeline

In this section, we outline required tasks for evaluation and when they should occur in order to meet deadlines set by HHS or to best facilitate evaluation. Unless otherwise noted, the time indicated in the timeline is simply our recommendation to facilitate evaluation. Additionally, some tasks in the timeline below are not evaluation tasks, but are present to provide some reference to other major HBE events that are evaluation-related.

Our timeline is presented as a series of calendar year tables divided by quarters. An "X" in a quarter column indicates that the task is ongoing through that quarter. If a quarter column is the final one marked, the task must be complete by the end of that quarter. **If a specific date applies, the column contains a number in parentheses** that refers to a list directly below the table.

5.1 For Calendar Year 2012

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
Data Warehouse Development (supports HBE tracking of enrollment, QHP choice, issuer choice, and termination reason)	Yes	Related				(1)
Measurement of Enrollment and Re-enrollment • Determine if measurement will be internal to HBE or contracted o If contracted, select contractor and sign security agreements that meet federal standards	Yes	Evaluation				(2)
Measurement of Disenrollment and Gaps • Determine if measurement will be internal to HBE or contracted o If contracted, select contractor and sign security agreements that meet federal standards						(2)
Survey Question Development • Development of Navigator and agent satisfaction questions • Validation of questions		Evaluation		X X	X X	X (3)
Website Development	Yes	Related				(2)

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Select federally-approved risk-adjustment method	Yes	Both				(2)
HBE Awareness and Use Measurement • Determine whether awareness and use will be assessed jointly or if use only will be measured through HBE website • If awareness and use o Review available tools and proceed to next steps if unavailable o Obtain contract for survey question development o Develop awareness and use questions o Validate awareness and use questions o Administer awareness survey o Analyze awareness results o Present awareness results to HBE board o Administer use survey o Analyze use results o Present use results to HBE board • If use only o Select contractor to measure appropriate metrics for website usefulness (e.g. bounce rate, industry standard web-based survey) o Administer survey via HBE website o Analyze use results o Present use results to HBE board		Evaluation	X	X X		X X
Assessment of Insurance Coverage • Select vendor if not conducted by HBE • Conduct baseline pre-HBE survey of coverage and employer-offer					X	X
Enrollee Satisfaction Survey • Verify CAHPS is acceptable tool • Select and contract with CAHPS administrator	Yes	Evaluation	X	X	X	X X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Quality of care measurement • Select contractor, if used, for quality assessment and analysis	Yes	Evaluation				X
Measure Navigator and agent satisfaction • Select vendor if not conducted by HBE o If contracted, select contractor and sign security agreements that meet federal standards						X X
Enrollee Satisfaction Survey • Verify CAHPS is acceptable tool • Select and contract with CAHPS administrator	Yes	Evaluation	X	X	X	X X
Assessment of access to care • Select vendor if not conducted by HBE o If contracted, select contractor and sign security agreements that meet federal standards	Yes	Evaluation				X X
Assessment of Insurance Coverage • Select vendor if not conducted by HBE • Conduct baseline pre-HBE survey of coverage and employer-offer					X	X
Assessment of expenditures • Select vendor if not conducted by HBE o If contracted, select contractor and sign security agreements that meet federal standards • Secure data use agreement with data providers	Yes					X X X
Assessment of affordability • Select vendor if not conducted by HBE o If contracted, select contractor and sign security agreements that meet federal standards		Evaluation				X X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Assessment of expenditures • Select vendor if not conducted by HBE o If contracted, select contractor and sign security agreements that meet federal standards • Secure data use agreement with data providers	Yes					X X X
Assessment of use of services • Select vendor if not conducted by HBE o If contracted, select contractor and sign security agreements that meet federal standards • Secure data use agreement with data providers	Part Yes Yes	Evaluation				X X X

Table 16: HBE Evaluation and Related Tasks - 2012

2012 Notes:

1. This is an information technology (IT) task. Because it supports an essential function of the HBE, we anticipate that having a data warehouse in place will be required in order to secure HHS approval of the Arkansas HBE. This approval must be given, by statute, "no later than January 1, 2013". We have therefore marked Q4 as the completion time. Detailed information should be sought from IT.
2. This component should be completed no later than December 31, 2012 to ensure that agreements are in place before approval is required.
3. October 31, 2012 so that the entities conducting the new survey have sufficient time to train their staff with the new questions.

5.2 For Calendar Year 2013

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
First annual enrollment period	Yes	Related				X

HBE Awareness and Use Measurement • If awareness and use o Administer awareness survey o Analyze awareness results o Present awareness results to HBE board • If use only o Administer survey via HBE website o Analyze use results o Present use results to HBE board		Evaluation			X X X X X X	X X X X X X
Measure Navigator and agent satisfaction • Administer questions						X
Website Satisfaction Survey • Conduct • Analysis		Evaluation			X X	X X
Quality of care measurement • Conduct baseline needs assessment • Convene stakeholder panels • HBE board selects annual quality priorities	Yes	Evaluation	 X	X X	X	 X
Assessment of access to care • Conduct a survey to measure baseline access to care (previous year)	Yes	Evaluation	X			
Assessment of Insurance Coverage • Conduct baseline pre-HBE survey of coverage and employer-offer						X

Table 17: Evaluation and Related Tasks – 2013

5.3 For Calendar Year 2014

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
First annual enrollment period	Yes	Related	(1)			
Measurement of Enrollment and Re-enrollment • Open enrollment report provided to HBE board • Special enrollment report provided to	Yes	Evaluation		X		

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
HBE board • Re-enrollment report provided to HBE board				X		X
Measure Navigator and agent satisfaction • Administer questions • Conduct analysis and report results to HBE board		Evaluation	X	X		
Enrollee satisfaction survey • Conduct CAHPS • Analyze CAHPS results and report to HBE board • CAHPS results published to HBE website	Yes	Evaluation		X	X	(1)
Measurement of disenrollment and gaps • Disenrollment report provided to HBE board (for previous year)	Yes	Evaluation	X			
HBE Awareness and Use Measurement • If awareness and use o Analyze awareness results o Present awareness results to HBE board o Administer use survey o Analyze use results o Present use results to HBE board • If use only o Analyze use results o Present use results to HBE board		Evaluation	X X	X X X X X		
Website Satisfaction Survey • Conduct • Analysis		Evaluation	X	X		
Quality of care measurement • Measure quality of care by HEDIS® measures or other appropriate sources • Conduct analysis of variation in quality by health plan and issuer	Yes	Evaluation				X X
Assessment of access to care • Conduct annual post-HBE implementation access to care survey • Analyze and report results of access survey to HBE board	Yes	Evaluation	X	X		
Assessment of Insurance Coverage • Conduct annual post-HBE survey of coverage and employer-offer • Provide annual coverage report (previous year) • Provide 5-year trend report to HBE board (early years will include pre-HBE		Evaluation	X X			X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
trends)						
Assessment of expenditures • Perform analysis of annual expenditures by health plan and issuer (for previous year) • Report results of annual expenditures analysis to HHS and HBE board • Perform 3-year trend analysis and report to HBE board	Yes	Evaluation			X X X	
Assessment of affordability • Conduct annual post-HBE implementation assessment of health insurance premiums and cost-sharing as a percentage of income • Analyze and report previous year's results to HBE board		Evaluation	X			X

Table 18: Evaluation and Related Tasks - 2014

2014 Notes:

1. Annual enrollment for the initial period will extend through February 28, 2014 under the current proposed rule from HHS.

5.4 For Calendar Year 2015

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
First annual enrollment period	Yes	Related	(1)			
Measurement of Enrollment and Re-enrollment • Open enrollment report provided to HBE board • Special enrollment report provided to HBE board • Re-enrollment report provided to HBE board	Yes	Evaluation		X X		X
Measure Navigator and agent satisfaction • Administer questions • Conduct analysis and report results to HBE board		Evaluation	X	X		
Enrollee satisfaction survey • Conduct CAHPS • Analyze CAHPS results and report to HBE board • CAHPS results published to HBE website	Yes	Evaluation		X	X	(1)

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Measurement of disenrollment and gaps • Disenrollment report provided to HBE board (for previous year)	Yes	Evaluation	X			
HBE Awareness and Use Measurement • If awareness and use o Analyze awareness results o Present awareness results to HBE board o Administer use survey o Analyze use results o Present use results to HBE board • If use only o Analyze use results o Present use results to HBE board		Evaluation	X X	 X X X X X		
Website Satisfaction Survey • Conduct • Analysis		Evaluation	X	 X		
Quality of care measurement • Measure quality of care by HEDIS® measures or other appropriate sources • Conduct analysis of variation in quality by health plan and issuer	Yes	Evaluation				X X
Assessment of access to care • Conduct annual post-HBE implementation access to care survey • Analyze and report results of access survey to HBE board	Yes	Evaluation	X	 X		
Assessment of Insurance Coverage • Conduct annual post-HBE survey of coverage and employer-offer • Provide annual coverage report (previous year) • Provide 5-year trend report to HBE board (early years will include pre-HBE trends)		Evaluation	 X X			X
Assessment of expenditures • Perform analysis of annual expenditures by health plan and issuer (for previous year) • Report results of annual expenditures analysis to HHS and HBE board • Perform 3-year trend analysis and report to HBE board	Yes	Evaluation			X X X	
Assessment of affordability • Conduct annual post-HBE implementation assessment of health insurance premiums and cost-sharing as		Evaluation				X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
a percentage of income • Analyze and report previous year's results to HBE board			X			

Table 19: Evaluation and Related Tasks - 2015 and ongoing

2015 Notes:

1. Should be available October 1 of each year in time for open enrollment of the next year.

In general, analyses that are based on claims or will be claims-derived are done on a retrospective basis. These analyses are performed in the 3rd calendar year quarter each year, beginning in 2015, for use and expenditures in the previous year. This allows for a 180 day claim lag between the time service occurs, the provider submits the claim, and the issuer processes the claim. While this does not preclude skewed results due to the use of claims, it does substantially reduce the risk.

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