

Arkansas Health Benefits Planning Exchange

Steering Committee Meeting	September 6, 2011	AR Health Benefits Exchange Planning AID- Hearing Room 1st Floor	3:00 PM – 5:00 PM
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<p><u>Members Present:</u> Fred Bean Elizabeth Burak Ed Choate Michael Crump-DHS for Marilyn Strickland David Deere Chad Harrison-OHIT for Ray Scott Rep. Barry Hyde Annabelle Imber Tuck Joni Jones Dr. Cal Kellogg Dr. Drew Kumpuris Tim Lampe Kevin Ryan Frank Scott Kenny Whitlock Dawn Zekis for John Selig</p> <p><u>Staff:</u> Cindy Crone Britton Kerr Craig Wilson-ACHI</p>	<p><u>Consultants:</u> Lars Powell-First Data Jason Scheel-AFMC Amy Schrader-AFMC David Sodergren-First Data</p> <p><u>Guests:</u> Deloris Chitwood-Chitwood Consultants Rhonda Cunningham-UAMS/Partners Vicki Farmer-AR Optometric Association Leo Hauser-Bi-Partisan Strategies Jim Johnson-Delta Dental Tricia Larson-Paschall Strategic Communications Melissa Masingill-Delta Dental Lisa Monk-Mitchell Williams Law Firm Joe Morgan-Group Insurance Consultants Carol Roddy-GetInsured.com Robert Sharum-Group Insurance Consultants Dean Ulmer-OHIT</p>	<p><u>Members Absent:</u> Patty Barker Deborah Bell Jim Glick Dr. John Wayne Rep. Jon Woods</p>
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Meeting Summary:

Items in Bold indicate “action item”.

- I. David Sodergren, First Data, opened the meeting. Steering Committee members and guests introduced themselves. This is the first meeting for Kevin Ryan, JD, MA, RN of ACHI and UAMS College of Public Health. He replaces David Boling on the Steering Committee. Cindy Crone announced that **Craig Wilson, JD, of ACHI will be providing research and consultation assistance to the Exchange planning effort at .20 FTE, funded by the CClO Planning Grant.** An experienced health attorney and policy adviser, Wilson replaces David Boling’s effort on this project.
- II. **The Steering Committee meeting summary from August 23 was approved** as circulated without corrections and will be posted as “final” on the HBE website.
- III. Updates
 - A. Community Meetings and Web-Based Survey – David Deere reported that the UAMS Partners for Inclusive Communities and COPH Stakeholder Inclusion Report summarizing findings from the 64 Community Meetings and Web-Based Survey will be delivered tomorrow. He reminded those in attendance that the web survey represents a convenience sample as opposed to the more scientific random sampling method used for the statewide

telephone survey work being commissioned by the Self-Chartered Health Care Reform Workgroup.

- B. First Data – David Sodergren reported that the IT Integration Plan, Marketplace Plan, and Operations Plan are nearing completion. Summaries of findings will be reported today. The First Data Bi-Weekly Progress report is available on the HBE Website and indicates planning milestones and deliverables are on time.
- C. Self-Chartered Health Care Reform Industry Workgroup – Dr. Cal Kellogg reported that results of the 600 household survey seeking to understand public opinion relative to an Arkansas vs. Federal Health Benefits Exchange are not yet available.
- D. CCIIO/Exchange Planning Grant Update – Cindy Crone provided an overview of written report (handout). There were no questions. She announced that Bruce Donaldson is in Baltimore at a CMS Eligibility/Enrollment Conference—along with leaders from Medicaid and DHS County Operations. Cindy and Bruce will both be in Arlington VA attending the CCIIO Grantee meeting on the date of the next Steering Committee meeting.

IV. Old Business

- A. Northwest Arkansas Agents Association Paper. Time was allowed for Steering Committee members to discuss points made in the paper. Bruce Donaldson had provided responses to the NWAAA paper outlining pertinent Proposed DHHS Regulations or ACA provisions. There were no specific comments from Steering Committee members. Cindy asked whether it was known if the Navigator comments might be changed in light of the recommendations discussed at the last Steering Committee meeting that defined the Navigator role as an educator/guide vs. enroller into health plans. Fred Bean stated that the NWAAA is comfortable with the Navigator role as proposed by AFMC and reported at the last meeting. A contact person is Cammie Scott. Guest Deloris Chitwood representing the NW Arkansas NAIFA Chapter clarified that the NWAAA group submitting the paper was not the official NWAR/NAIFA group.
- B. Relative to the Navigator Role, Exchange planners were reminded that one objective of the ACA is to lower health care costs. How would continued producer commissions and added costs of Navigators advance that goal? It was discussed that a major cost savings would result from residents having access to affordable, quality care. Getting everyone covered is a primary objective. The Navigators and producers would have complementary roles—and there would be some consumers who would use neither in their purchasing activities. Others might receive outreach/education services of Navigators and also consult a licensed producer to assist with complex enrollment issues. In that case the producer would receive a commission from the carrier.

- C. Jason Scheel of AFMC provided an overview of the HBE Evaluation Plan drafted as part of the background research project. (PowerPoint Presentation attached; full draft was presented as handout at 8/23/11 meeting). He reported that requirements of the Exchange were considered in evaluation design as well as broader issues addressing “what’s good for Arkansas and Arkansans”. Some findings from the Massachusetts Exchange were considered. Discussion points/responses included:
- a. Primary care will be influenced by infrastructure changes as more people are insured.
 - b. Evaluation data will be considered for performance improvement? *Will reporting be in aggregate or by specific provider? Who will “fix any problems identified”? It’s important to not have “finger-pointing”.*
 - c. How will data be collected? *Some will be through existing population surveys. Others will be obtained through a mixed model (mail, phone) approach using standardized, qualified, literacy-tested questions. This has been successfully done by AFMC in the past. They have achieved a 30%-50% response rate. Consumers are eager to respond. There are follow-up attempts for non-responders.*
 - d. A future agenda item requested for discussion was “medical community supply and demand”. Review of emergency department data may be informative in this respect.
 - e. Costs of care vs. payment to providers needs to be considered in cost evaluations.
 - f. Data on utilization of care by provider(s) across multiple variables would be informative relative to tracking costs.
 - g. The Exchange needs to evaluate for fraud, waste, and abuse. It was asked how this would relate to the federal plan for adding FBI agents to monitor for F, W, & A. *Private plans must monitor funds now, but since federal funds (subsidies) will become part of the payer mix under ACA, how will monitoring change? New regulations are forthcoming.*
 - h. The need for data from a robust All Payer Claims Database (APCD) was highlighted. ACHI is planning development of an APCD relative to episodes of care associated with the Medicaid/Medicare/Private Plan payment reform. This could broaden to include the Exchange population. The question of whether or not the State could legally combine data from different sources (Medicaid, Medicare, private plans) was posed. *There may be hurdles, but this may be possible. Electronic Medical Records could help make this viable from a cost perspective. The group was reminded that Utah has had a successful APCD since 1993. Colorado is another state with an APCD. It was suggested that the APCD could help monitor for high utilization providers—including those with similar outcomes of care but at higher costs. It was suggested that high utilization will likely remain constant across payment reform (bundled payments) and the same quality issues would likely emerge to allow for focused improvements.*

V. Workgroup materials

- A. Exchange Legislation Review. Dr. Cal Kellogg prepared a document that outlined the Exchange Development portion of the Insurance Department House Bill that did not pass during the last legislative session (2011), identifying key questions/issues to be addressed. From this document, Exchange Planning Staff drafted a list of potential issues to be addressed (handout).
- B. At the last Steering Committee meeting it was determined that September (and subsequent) workgroup agendas would include time for addressing a “general” Exchange Development topic that all groups would discuss and “expertise specific” topic(s) that specific workgroups would address. Steering Committee Liaisons would facilitate agreed-upon Workgroup discussions that would lead to specific recommendations and rationale to be reported back to the Steering Committee. A handout prepared by Craig Wilson that outlined many of the key issues and pros/cons for considering each was distributed as a tool to assist with September workgroup discussions.
- C. **It was agreed that the “General topic” for September Workgroup meetings would be “Navigator Role and Plan”.** A summary handout was distributed for use in this discussion. **Each Workgroup will report back a recommendation and rationale for any changes relative to the Navigator role and program. The group agreed to add “governance board composition, conflict of interest, and length of terms” to the list of issues distributed.** *It was suggested that another issue for discussion would be whether the Exchange should be administered under the same umbrella as the Employee Benefits program. The Group determined that item should be tabled as it more addresses Exchange administration than design. Questions, however, like whether there should be an “inside” and “outside” Exchange marketplace should be addressed as they would impact underwriting decisions, influence carriers to participate or not, and eventually impact adverse selection. Members discussed the question: “Should the Exchange be able to impact costs?” If the Exchange has a role to lower costs, it would need tools to design a successful environment for competition—which could be achieved through active or passive purchasing.*

The Group next selected which topics each Workgroup would address as “expertise” items in September. Groups chose from 2-6 topics as below:

Community Leaders - Annabelle Imber Tuck and Kenny Whitlock

- Fees to support the Exchange: Should they be assessed on QHPs sold Inside and Outside the Exchange?
- Should we allow issuers to offer regional coverage, or statewide only?

Consumers – Elisabeth Burak and Deborah Bell

- Should Exchange be an Active, Passive or Hybrid purchaser?
- What criteria should we use to rate plans sold on the Exchange?
- Governance Board composition, conflict of interest policies, and length of term

Outreach/Education/Enrollment – *Fred Bean and Patty Barker*

- Should we have an Inside and Outside the Exchange marketplace?
- Governance Board composition, conflict of interest policies, and length of term

Providers (Carriers and Health Care Providers) – *Dr. Drew Kumpuris and Ed Choate*

- Should we have an Inside and Outside the Exchange marketplace?
- Should we allow groups to 50 or 100 employees in the Exchange in 2014-2016?
- Should Exchange be an Active, Passive or Hybrid purchaser?
- Fees to support the Exchange: Should they be assessed on QHPs sold Inside and Outside the Exchange?
- Should we allow issuers to offer regional coverage, or statewide only?
- Should we have two Exchanges or one (combined individual and SHOP)?

State Agencies – *Joni Jones and Ray Scott*

- Should Exchange be an Active, Passive or Hybrid purchaser?
- Should we have two Exchanges or one (combined individual and SHOP)?

We did not assign IT Workgroup as it is not scheduled to meet in September. Liaisons are Ray Scott and Tim Lampe.

VI. **New Business**

- A. IT Integration Plan – Dave Sodergren provided a PowerPoint Presentation (handout) and distributed a draft planning document. He provided a list of identified IT assets and emphasized that coordinated, effective planning *now* is critical to overall project success. It is important to maximize federal support in order to minimize state resource requirements for maintenance costs. Discussion points included:
- a. Need for an overall Enterprise Manager as well as Project Managers to coordinate and manage interagency design and detailed planning analysis, workplans, and deliverables.
 - b. Department of Information Services may have resources to help with the need for project managers.
 - c. It was suggested that ACHI APCD be added as an asset (McKenzie, Private Plans, Medicaid and Medicare are working on short term project).
 - d. It was asked whether COTS and SAAS had been considered in cost estimates. *The answer was that COTS and third party assets are planned to be assessed in a later RFI process.*

B. Marketplace Report - Dr. Lars Powell (on-site – PowerPoint-attached), Mark Howland and Tom Messer from SCIOInspire presented updated financial models that included assumptions, inputs, trends, national, and Arkansas figures. These were reviewed and discussed. Discussion points:

- a. Some of the inputs were questioned. For example, the PMPM costs may not be accurate for Exchange projections for Medicaid costs as those costs were not divided by different eligibility populations such as SSI, current non-disabled population, MAGI, long-term care, etc.
- b. The narrative report was not yet available for distribution; however, it is expected in the next day or so. Embedded in it are Excel tables which are configured in a way that preserves the ability to re-calculate uptake and PMPM cost projections with changes in input numbers. Cindy will send this report to Steering Committee members electronically.

C. Operations Report – was not presented due to time of day. It will be presented next meeting.

VII. Next Meeting is September 20, 2011, 3:00 – 5:00 AID Hearing Room. Operations model and Level One Funding Application will be discussed.

DRAFT

Steering Committee

Areas of

Discussion for Work Groups

A- **Main Topic** for all work groups to discuss:

Navigator Program- certified, licensed; educator vs. enroller?

B- **Work Group Specific Topics** to consider:

- 1) Should we have In and Out of Exchange marketplace?
- 2) Should we allow groups 50 – 100 employees in the exchange 2014-2016?
- 3) Should Exchange be an Active, Passive or Hybrid purchaser?
- 4) Fees to support the Exchange- Assessed on QHP plans In and Out of the Exchange?
- 5) Should we allow issuers to offer regional coverage or state wide?
- 6) What criteria should we use to rate plans sold on the Exchange?
- 7) Should we have two exchanges or one (combined individual and SHOP)?
- 8) Governance Board Composition, Conflict of Interest & Length of Term

Exchange Issues Pros/Cons & State Breakdown

Potential Governance Structures

State-agency	Non-Profit	Quasi-governmental
Pro: <ul style="list-style-type: none"> • Accountable and transparent • Can be embedded within existing state agency (AID) • May have easier access to and communication with other agencies 	Pro: <ul style="list-style-type: none"> • Greater operational flexibility • Ability to pay higher salaries • Insulation from political infighting and change • Greater access to business expertise 	Pro: <ul style="list-style-type: none"> • More flexibility for hiring and recruitment and access to state agency resources • Because of alignment with agency, easier to negotiate and procure health plans and IT
Con: <ul style="list-style-type: none"> • Vulnerable to political infighting • Increases bureaucracy • Ability of government to process private market transactions • Affected by political change 	Con: <ul style="list-style-type: none"> • Requires development of a new entity • May not be easy to exchange info with state agencies • Less public accountability given administration of subsidies and regulatory requirements 	Con: <ul style="list-style-type: none"> • Leadership and staff salaries could become excessive • Start from scratch with infrastructure, such as office space and staff

As of July 2011, most exchanges had been created with some independence from state government. **Twenty-nine states had chosen quasi-governmental structures, and **four** others had opted for a non-profit corporation. Exchanges in **three states** are housed within state agencies but have independent governing boards.

Board Compositions

Proposed regulations require exchanges established as quasi-governmental and non-profit entities to have clearly-defined governing boards overseen by the state. Of the states that have defined their board structures, all have independent boards of directors ranging in size from five to 15 members. Members often represent stakeholders and subject matter experts in an attempt to balance political interests and management skills. Some of the legislatively-defined boards require certain numbers of consumer or other stakeholder representation. States that do not require consumer or stakeholder representation have sometimes included advisory groups to facilitate feedback from those groups. Governors are often responsible for appointing members of the boards.

Exchange Issues

Pros/Cons & State Breakdown

Conflict of Interest policies

In addition to variation in terms of board composition, legislation also varies with respect to eliminating or limiting conflicts of interest among board members by prohibiting certain board members (such as brokers or insurers). **Twenty states** have bills prohibiting insurers, agents/brokers and or other conflicted parties from service on the board. **Eleven states** have bills that require at least one board member to be an insurer, and **nine** also reserve a board position for an agent or broker. Two states require an insurer but not an agent/broker to be on the board. In eight states, legislation is silent on the issue. (Arkansas's bill permits, but does not require, insurers and/or brokers/agents to serve on the board.)

Exchange Structure

Single Statewide	Regional	Small Subsidiary Exchanges (either within a region or state)
Pro: <ul style="list-style-type: none"> • More streamlined regulation of plans • State can experiment with new models • Easier to integrate other social program eligibility and enrollment 	Pro: <ul style="list-style-type: none"> • Shared administrative costs • Creates larger markets • Enables greater risk pooling • May create greater efficiencies 	Pro: <ul style="list-style-type: none"> • Greater responsiveness to local needs • Plan pricing can more easily reflect geographic variation • Maximizes consumer choice • Encourages entry into the market
Con: <ul style="list-style-type: none"> • May inhibit consumer choice depending on insurer participation • May be more costly to administer 	Con: <ul style="list-style-type: none"> • Varying regulatory environments • Complicated risk adjustment • Difficult to integrate other state programs • Difficult to share responsibilities 	Con: <ul style="list-style-type: none"> • May be costly to administer and regulate • May inhibit greater risk pooling • Risk of adverse selection • May create volatility in the market

Exchange Issues Pros/Cons & State Breakdown

Separate or Combined Individual and Group

Separate Individual	Separate SHOP	Combined
Pro: <ul style="list-style-type: none"> • Allows specific focus on lower-income individuals • May be easier to administer subsidies 	Pro: <ul style="list-style-type: none"> • More streamlined billing for enrollee premiums • Allows focus on meeting needs of small businesses 	Pro: <ul style="list-style-type: none"> • Could offer more choices to all enrollees • Creates single risk pool, less volatility • May create greater efficiencies
Con: <ul style="list-style-type: none"> • Creates higher risk pool • May increase costs for enrollees 	Con: <ul style="list-style-type: none"> • May be more costly to administer 	Con: <ul style="list-style-type: none"> • Risk profiles of group and non-group may vary significantly • Combined risk pools may create market instability • May create regulatory complexity • Marketing complexity

Exchange Purchasing Power

Active Purchaser	Passive Purchaser	Hybrid
Pro: <ul style="list-style-type: none"> • Greater potential to drive down cost and improve quality • Could simplify decision-making for consumers • Could provide for long-term cost containment 	Pro: <ul style="list-style-type: none"> • Provides more choice among plans • Minimizes bureaucracy • May attract new insurers into the market 	Pro: <ul style="list-style-type: none"> • Potential to maintain cost and quality without direct negotiation • Transparent process for defining cost and quality • Simplifies decision-making for consumers • Flexibility to contract selectively
Con: <ul style="list-style-type: none"> • Could limit choice • Disruption for consumer if their plan is dropped • Could make one insurer commercially non-viable if unable to meet contracting requirement • Heavy regulation • Limited in concentrated market 	Con: <ul style="list-style-type: none"> • Complicates decision-making • Lessens ability to contract for cost and quality 	Con: <ul style="list-style-type: none"> • Limits choice by defining additional cost and quality indicators • Increases bureaucracy, to the extent of defining additional indicators for participation or attempting to enhance market by selectively contracting

Exchange Issues

Pros/Cons & State Breakdown

As of July 2011, of the 12 states with established exchanges, including Massachusetts and Utah, **five states had exchanges acting as active purchasers, while **three others** served simply as clearinghouses. **Four states** did not address the topic or charged the board with making the decision. Smaller states' exchanges tended to have a more passive role because of concentrated markets.

HEALTH CARE REFORM - EXCHANGE MODEL - INPUTS

STARTING VALUES - 2013

	NATIONAL		ARKANSAS	
	# (000'S)	\$ PMPM	# (000'S)	\$ PMPM
Medicaid & CHIP Enrolled	56,300	666.40	682	522.07
Uninsured - Medicaid Eligible	19,300	599.76	234	540.00
Uninsured - Group Eligible	4,000	450.00	80	405.00
Uninsured - Other	26,500	390.00	273	351.00
Uninsured Total	49,800	476.11	587	433.70
Insured - Individual	14,766	435.00	136	391.50
Insured - Group <51	36,300	370.00	289	333.00
Insured - Group 51-100	9,600	390.00	75	351.00
Insured - Group 101+	121,400	420.00	950	378.00
Medicare Enrolled	42,500	770.00	420	693.00
Medicare Advantage	13,500	745.00	130	670.50
Total Population*	344,166	518.93	3,269	466.13

*Certain members have dual coverage, hence the sum exceeds the census population

HEALTH CARE REFORM - EXCHANGE MODEL - ASSUMPTIONS

MIGRATIONS AND RELATIVE COSTS				
MIGRATION PATH	NATIONAL		ARKANSAS	
	%	Rel Risk	%	Rel Risk
Medicaid/CHIP to Medicaid/CHIP	100%	1.000	100.0%	1.000
Uninsured Medicaid Eligible to Medicaid	71%	0.970	71.0%	0.970
Uninsured Medicaid Eligible to Uninsured	29%	1.073	29.0%	1.073
Uninsured - Group Eligible to Uninsured	60%	1.020	58.2%	1.020
Uninsured - Group Eligible to Groups Exchange	40%	0.970	41.8%	0.972
Uninsured - Other to Individuals Exchange	25%	1.000	31.8%	1.000
Uninsured - Other to Uninsured	75%	1.000	68.2%	1.000
Insured - Individual to Individuals Exchange	10%	1.000	16.2%	1.000
Insured - Individual to Insured Individual	90%	1.000	83.8%	1.000
Insured - Group <51 to Individuals Exchange	6%	1.100	1.3%	1.100
Insured - Group <51 to Groups Exchange	20%	1.030	16.9%	1.030
Insured - Group <51 to Insured - Group <51	74%	0.984	81.8%	0.992
Insured - Group 51-100 to Individuals Exchange	3%	1.100	0.0%	1.100
Insured - Group 51-100 to Groups Exchange	12%	1.030	16.9%	1.030
Insured - Group 51-100 to Insured - Group 51-100	85%	0.992	83.1%	0.99
Assumed Cost Increase for Uninsureds Obtaining Insurance	8%		8%	

HEALTH CARE REFORM - EXCHANGE MODEL - Trend

Membership Trend

	2014	2015	2016	2017	2018	2019
Medicare	2.9%	2.9%	2.8%	3.1%	3.0%	2.9%
Medicaid/CHIP	1.0%	1.5%	5.0%	-2.3%	0.4%	0.5%
Employer-sponsored Private Health Insurance	-0.4%	0.6%	-1.4%	-1.1%	-0.6%	0.5%
Individual (Exchange)	0.0%	14.4%	18.2%	21.3%	7.0%	0.8%
Individual (Grandfathered)	-8.0%	-8.9%	-10.0%	-11.3%	-13.0%	-15.2%
Uninsured	0.0%	-6.0%	-3.4%	3.1%	0.8%	-1.5%

Cost Trend

	2014	2015	2016	2017	2018	2019
Medicare	3.1%	1.9%	2.9%	3.2%	3.6%	3.9%
Medicaid/CHIP	6.0%	6.0%	2.9%	8.2%	6.4%	6.7%
Employer-sponsored Private Health Insurance	4.9%	5.5%	6.1%	3.5%	3.9%	5.3%
Individual	4.9%	5.5%	6.1%	3.5%	3.9%	5.3%
Uninsured	4.9%	5.5%	6.1%	3.5%	3.9%	5.3%

HEALTH CARE REFORM - EXCHANGE MODEL - NATIONAL FIGURES

2013	2014	2015	2016	2017	2018	2019
MEDICAID/CHIP # 56,300 pmpm 666.40	MEDICAID/CHIP # 70,705 pmpm 691.80	MEDICAID/CHIP # 71,759 pmpm 733.64	MEDICAID/CHIP # 75,360 pmpm 754.56	MEDICAID/CHIP # 73,603 pmpm 816.65	MEDICAID/CHIP # 73,867 pmpm 868.64	MEDICAID/CHIP # 74,218 pmpm 926.83
UNINSURED INDIVIDUALS # 45,800 pmpm 478.39	INDIVIDUALS EXCHANGE # 10,568 pmpm 440.83	INDIVIDUALS EXCHANGE # 12,088 pmpm 465.11	INDIVIDUALS EXCHANGE # 14,293 pmpm 493.54	INDIVIDUALS EXCHANGE # 17,334 pmpm 510.65	INDIVIDUALS EXCHANGE # 18,550 pmpm 530.64	INDIVIDUALS EXCHANGE # 18,702 pmpm 558.62
UNINSURED IN GROUPS # 4,000 pmpm 450.00	GROUPS EXCHANGE # 9,973 pmpm 418.85	GROUPS EXCHANGE # 10,032 pmpm 441.92	GROUPS EXCHANGE # 9,891 pmpm 468.93	GROUPS EXCHANGE # 9,786 pmpm 485.19	GROUPS EXCHANGE # 9,727 pmpm 504.18	GROUPS EXCHANGE # 9,780 pmpm 530.77
	UNINSURED OTHER # 25,528 pmpm 511.63	UNINSURED OTHER # 24,000 pmpm 539.82	UNINSURED OTHER # 23,191 pmpm 572.82	UNINSURED OTHER # 23,910 pmpm 592.68	UNINSURED OTHER # 24,090 pmpm 615.88	UNINSURED OTHER # 23,730 pmpm 648.35
INSURED INDIVIDUALS # 14,766 pmpm 435.00	INSURED INDIVIDUALS # 13,289 pmpm 456.12	INSURED INDIVIDUALS # 12,104 pmpm 481.25	INSURED INDIVIDUALS # 10,896 pmpm 510.67	INSURED INDIVIDUALS # 9,665 pmpm 528.37	INSURED INDIVIDUALS # 8,412 pmpm 549.05	INSURED INDIVIDUALS # 7,136 pmpm 578.00
INSURED IN GROUPS <51 # 36,300 pmpm 370.00	INSURED IN GROUPS <51 # 26,758 pmpm 381.67	INSURED IN GROUPS <51 # 26,915 pmpm 402.70	INSURED IN GROUPS <51 # 26,538 pmpm 427.32	INSURED IN GROUPS <51 # 26,255 pmpm 442.13	INSURED IN GROUPS <51 # 26,098 pmpm 459.44	INSURED IN GROUPS <51 # 26,239 pmpm 483.66
INSURED IN GROUPS 51-100 # 9,600 pmpm 390.00	INSURED IN GROUPS 51-100 # 8,128 pmpm 405.76	INSURED IN GROUPS 51-100 # 8,176 pmpm 428.11	INSURED IN GROUPS 51-100 # 8,062 pmpm 454.28	INSURED IN GROUPS 51-100 # 7,976 pmpm 470.03	INSURED IN GROUPS 51-100 # 7,928 pmpm 488.43	INSURED IN GROUPS 51-100 # 7,971 pmpm 514.19

2013	2014	2015	2016	2017	2018	2019
MEDICAID/CHIP						
# 682	# 857	# 869	# 913	# 892	# 895	# 899
pmpm 522.07	pmpm 557.08	pmpm 590.77	pmpm 607.61	pmpm 657.61	pmpm 699.48	pmpm 746.34
UNINSURED INDIVIDUALS	INDIVIDUALS EXCHANGE					
# 507	# 113	# 129	# 152	# 185	# 198	# 199
pmpm 438.23	pmpm 399.59	pmpm 421.60	pmpm 447.37	pmpm 462.88	pmpm 481.00	pmpm 506.36
UNINSURED IN GROUPS	GROUPS EXCHANGE					
# 80	# 95	# 95	# 94	# 93	# 92	# 93
pmpm 405.00	pmpm 394.13	pmpm 415.84	pmpm 441.26	pmpm 456.56	pmpm 474.43	pmpm 499.45
	UNINSURED OTHER					
	# 301	# 283	# 274	# 282	# 284	# 280
	pmpm 431.54	pmpm 455.31	pmpm 483.14	pmpm 499.89	pmpm 519.46	pmpm 546.85
INSURED INDIVIDUALS						
# 136	# 114	# 104	# 93	# 83	# 72	# 61
pmpm 391.50	pmpm 410.51	pmpm 433.12	pmpm 459.60	pmpm 475.53	pmpm 494.15	pmpm 520.20
INSURED IN GROUPS <51						
# 289	# 235	# 237	# 234	# 231	# 230	# 231
pmpm 333.00	pmpm 346.45	pmpm 365.53	pmpm 387.88	pmpm 401.33	pmpm 417.04	pmpm 439.03
INSURED IN GROUPS 51-100						
# 75	# 62	# 62	# 62	# 61	# 61	# 61
pmpm 351.00	pmpm 365.80	pmpm 385.95	pmpm 409.54	pmpm 423.74	pmpm 440.33	pmpm 463.54

The purpose section describes the Exchange as a supplement not a replacement to the current individual and small group insurance marketplace—established to facilitate purchase and sale of qualified health plans in the state. This implies that a marketplace will be allowed to continue to exist outside the exchange and the exchange will be designed to expand the availability of coverage supplied. Exchange is the mechanism to enroll traditionally uninsured via expanded Medicaid or by determining eligibility for advance premium tax credit subsidies or other cost reductions that will help make qualified health plan coverage more affordable. Qualified health plans must meet minimum essential benefits packages, quality and reporting standards, and follow all state and federal insurance laws and regulations. Tax subsidies may only be accessed for plans sold through the Exchange.

Issues for Discussion: Role of the exchange

- Does it replace the non-exchange market by design?
- Does it replace the non-exchange market by normal market forces if it is better?
- Does it supplement or complement the existing market and exist with the existing market?

23-104-102. Purpose.

The purpose of this chapter is to provide for the establishment of a second insurance marketplace called the "Arkansas Health Benefits Exchange" to supplement the current insurance marketplace and to facilitate the purchase and sale of qualified health plans in the individual market in the State of Arkansas and to provide for the establishment of a Small Business Health Options Program to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered through the exchange in the small group market.

Definitions section provides definitions required by the ACA. Key definitions are what constitutes health insurance, what is not covered by the exchange rules, qualified health plans, qualified employers, qualified individuals. Much of this language is drawn from the NAIC model legislation and the specific requirements and definitions in the Affordable Care Act.

Issues for discussion:

- Are the definitions too narrow or broad? ACA sets the minimum, but some definitions can be modified, for example the definition of principle place of business.

23-104-103. Definitions.

As used in this chapter:

- (1) "Educated health care consumer" means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters;
- (2)(A) Health benefit plan means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse the costs of health care services.
- (B) Health benefit plan does not include:
 - (i) Coverage for accident-only or disability income insurance or any combination of accident-only or disability income insurance;
 - (ii) Coverage issued as a supplement to liability
 - (iii) Liability insurance, including general liability and automobile liability insurance;
 - (iv) Workers' compensation or similar insurance;
 - (v) Automobile medical payment insurance;
 - (vi) Credit-only insurance;
 - (vii) Coverage for on-site medical clinics; or
 - (viii) Other similar insurance coverage specified in federal regulations issued under the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, under which the benefits for health care services are secondary or incidental to other insurance benefits.
- (C) If the benefits are provided under a separate policy, certificate, or contract of insurance or otherwise are not an integral part of the plan, "health benefit plan" does not include:
 - (i) Limited dental or vision benefits;

- (ii) Benefits for long-term care, nursing-home care, home-health care, community-based care, or any combination thereof; or
 - (iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191.
- (D) If the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the benefits and an exclusion of benefits under a group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under a group health plan maintained by the same plan sponsor, "health benefit plan" does not include:
- (i) Coverage for only a specified disease or illness; or
 - (ii) Hospital indemnity or other fixed indemnity insurance.
- (E) If offered as a separate policy, certificate, or contract of insurance, "health benefit plan" does not include:
- (i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, as it existed on 35 January 1, 2011;
 - (ii) Supplemental coverage provided under 10 U.S.C. 1 Chapter 55, the Civilian Health and Medical Program of the Uniformed Services; or
 - (iii) Similar supplemental coverage provided under a group health plan;
- (3) Health carrier means an entity subject to the insurance laws of this state or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, including:
- (A) An accident and health insurance company;
 - (B) A health maintenance organization;
 - (C) A nonprofit hospital and medical service corporation; or
 - (D) Any other entity providing a plan of health insurance, health benefits, or health services;
- (4) "Principal place of business" means the location in a state where an employer has its headquarters or significant place of business and where the persons with direction and control authority over the business are employed;
- (5) "Qualified dental plan" means a limited-scope dental plan that has been certified in accordance with § 23-104-107;
- (6) "Qualified employer" means a small employer that elects to make its full-time employees and some or all of its part-time employees eligible for one (1) or more qualified health plans offered through the Small Business Health Options Program if the employer:
- (A) Has its principal place of business in this state and elects to provide coverage through the Small Business Health Options Program to all of its eligible employees, wherever employed; or
 - (B) Elects to provide coverage through the Small Business Health Options Program to its eligible employees who are principally employed in this state;
- (7) Qualified health plan means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107;
- (8) Qualified individual means an individual, including a minor, who:
- (A) Is seeking to enroll in a qualified health benefit plan offered through the Arkansas Health Benefits Exchange;
 - (B) Resides in this state;
 - (C) At the time of enrollment is not incarcerated other than incarceration pending the disposition of charges; and
 - (D) Is a citizen or national of the United States or an alien lawfully present in the United States; and

This definition begins with 50 as a small employer, but provides the commissioner the latitude to expand to 100 at any time up to the date (2016) when the ACA requires that states include groups up to 100 in the small group definition.

Issue: Does starting at 50 limit the potential size of the SHOP exchange?

- (9)(A) Small employer means an employer that employed an average of at least two (2) but not more than fifty (50) employees during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year unless the commissioner determines that the purposes or administration of this chapter is better served by an increase in the maximum average number of employees during the preceding calendar year not to exceed one hundred (100).
- (B) For purposes of this subdivision (9):
- (i) A person treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, as it existed on January 1, 2011, shall be treated as a single employer;
 - (ii) An employer and any predecessor employer shall be treated as a single employer; and
 - (iii) Each employee shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.
- (C) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected the employer will employ on business days in the current calendar year.
- (D) An employer that makes enrollment in qualified health plans available to its employees through the Small Business Health Options Program and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the Small Business Health Options Program available to its employees.

This section establishes the exchange governance entity and structure of the Board. Wording was designed to allow the exchange to operate outside specific procurement, personnel and administrative laws, but still operate as a state based entity. Board was established with seven voting non-governmental members and five non-voting ex officio governmental agency members. Defined terms of three years, required at least three members shall have experience related to health insurance. Also delineated that at least one consumer, small employer, hospital, and health care provider be included. Commissioner appoints the Board rather than the Governor. This was done with the understanding that the Governor's office did not wish to appoint the Board. Staggered terms were devised to create continuity for the Board.

Note: under recently released NPRM from Health and Human Services, no more than three members of the Board could be employees of insurance companies or agents/brokers.

Issues for Discussion: Size of board, conflict of interest issues, representation on board, any limits on consecutive terms. etc.

23-104-104. Establishment of Arkansas Health Benefits Exchange.

- (a) There is created a nonprofit legal entity to be known as the Arkansas Health Benefits Exchange the purpose of which will be to increase the access to quality and affordable health care coverage, reduce

the number of uninsured persons in Arkansas, and increase availability and consumer choice of health care coverage through the exchange to qualified individuals and small employers.

- (b) All health carriers licensed to sell accident and health insurance or health maintenance organization contracts may participate in the exchange.
 - (c)(1) (A) The exchange shall operate subject to the supervision and control of the Board of Directors of the Arkansas Health Benefits Exchange.
(B) The exchange is created as a political subdivision, instrumentality, and body politic of the State of Arkansas, and as such, is not a state agency.
 - (2) Except to the extent provided in this chapter, the exchange shall be exempt from:
 - (A) All state, county, and local taxes;
 - (B) The Arkansas Procurement Law, § 19-11-201 et seq.;
 - (C) The Arkansas Public Officers and Employees Law, § 21-21 1-101 et seq.; and
 - (D) The Arkansas Administrative Procedure Act, § 25-15-201 et seq.
 - (3) (A) The board shall consist of seven (7) voting members appointed by the Insurance Commissioner.
(B) At least three (3) of the seven (7) voting board members shall have experience in health care benefits administration, health care economics, or health insurance or health-insurance-related actuarial principles.
(C) One (1) of the voting board members shall represent the interests of health-benefit-plan consumers in this state.
(D) One (1) of the voting board members shall represent the interests of small employers in this state.
(E) One (1) of the voting board members shall be a representative of a hospital located in Arkansas.
(F) One (1) of the voting board members shall be a health care provider licensed to practice in Arkansas.
 - (4) The commissioner or his or her representative, the Director of the Department of Human Services or his or her representative, the Director of the Office of Health Information Technology or his or her representative, the Director of the Department of Health, and the Director of the Arkansas Center for Health Improvement or his or her representative shall be nonvoting ex officio members of the board.
 - (5) (A) The voting members of the board shall serve staggered three-year terms.
(B) The initial term of two (2) of the voting members shall be one (1) year, the initial term of two (2) of the voting members shall be two (2) years, and the initial term of the remaining three (3) voting members shall be three (3) years to allow for continuity.
(C) The voting members shall draw lots to determine the lengths of their initial terms.
(D) Voting members may be reappointed for additional terms.
 - (6) The chair of the board shall be elected annually from the voting members of the board by the voting members of the board.
 - (7) Any vacancy among the voting members of the board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.
 - (8) Voting members of the board may be reimbursed from moneys of the exchange for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be compensated for their services.
- (d) The board may provide in its bylaws or rules for indemnification of, and legal representation for, the board members and employees.

This section clarifies the exchange is to offer qualified health plans to qualified individuals and employers and indicates that non-qualified health plans cannot be offered on the exchange. It clarifies that limited scope dental plans can be offered as required by ACA. Exchange cannot penalize a person for dropping off the exchange and going into new coverage.

23-104-105. General requirements.

- (a) The Arkansas Health Benefits Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.
- (b)(1) The exchange shall not make available a health benefit plan that is not a qualified health plan.
- (2) The exchange shall allow a health carrier to offer a plan through the exchange that provides limited-scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as it existed on January 1, 2011, separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.
- (c) The exchange or a health carrier offering qualified health benefit plans through the exchange shall not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as it existed on January 1, 2011.

This section mirrors the language in ACA related to the duties of the exchange. The duties used in this legislation are taken from the NAIC Model Exchange Language. That language conforms with specific ACA minimum requirements of an exchange and this language is designed to meet those requirements. Please note that Item (16) should be stricken since the free choice vouchers were removed from the bill by amendment in later legislation. If duties beyond those required by PPACA are envisioned, they should be enumerated here.

Issues for discussion:

- This would be the section where duties of the exchange would be expanded if the group believes the Exchange should be an active purchaser.

23-104-106. Duties of Arkansas Health Benefits Exchange.

The Arkansas Health Benefits Exchange shall:

- (1) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary of the United States Department of Health and Human Services under section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107 of health benefit plans as qualified health plans;
- (2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- (3) Provide for enrollment periods, under section 1311(c)(6) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-12 152;

(4) Maintain a website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on plans;

(5) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary of the United States Department of Health and Human Services under section 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary of the United States Department of Health and Human Services under section 1302(d)(2)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(6) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act, 42 U.S.C. § 201 et seq. as it existed on January 1, 2011;

(7)(A) In accordance with section 1413 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, or any applicable state or local public program.

(B) If through screening of the application by the exchange the exchange determines that an individual is eligible for a program, enroll that individual in that program;

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of a premium tax credit under section 36B of the Internal Revenue Code of 1986, as it existed on January 1, 2011, and any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

(9) Establish a Small Business Health Options Program through which qualified employers may access coverage for their employees that shall enable a qualified employer to specify a level of coverage among those offered on the exchange so its employees may enroll in a qualified health plan offered through the Small Business Health Options Program at the specified level of coverage;

(10) Subject to section 1411 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, as it existed on January 1, 2011, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(A) There is not an affordable qualified health plan available through the exchange or through the individual's employer to cover the individual; or

(B) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

(11) Transfer to the Secretary of the United States Department of the Treasury the following:

(A) A list of the individuals who are issued a certification under subdivision (10) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986, as it existed on January 1, 2011, because:

(i) The employer did not provide minimum essential coverage; or

(ii) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as it existed on January 1, 2011, to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

- (i) Each individual who notifies the exchange under section 1411(b)(4) of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act 12 of 2010, Pub. L. No. 111-152, that he or she has changed employers; and
- (ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(12) Provide to each employer the name of each employee of the employer described in subdivision (11)(B) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(13) Perform duties required of the exchange by the Secretary of the United States Department of Health and Human Services or the Secretary of the United States Department of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

This section sets general guidelines for the Navigator program. Once again the NAIC Model Exchange legislation serves as the framework for the section. Outlines general duties of the navigator and allows the State, not the exchange, to require individuals affiliated with a Navigator contract to be certified or approved to serve as a Navigator.

Issues for discussion:

- Any additional requirements for navigator program.

(14)(A) Select entities qualified to serve as "Navigators" in accordance with section 1311(i) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and award grants to enable Navigators to:

- (i) Conduct public education activities to raise awareness of the availability of qualified health plans;
- (ii) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986, as it existed on January 1, 2011, and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; 2
- (iii) Facilitate enrollment in qualified health plans;
- (iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January 1, 2011, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that health benefit plan or coverage;
- (v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;
- (vi) Counsel exchange participants about selecting or transitioning among Medicaid, the federal Children's Health Insurance Programs, and other coverage; and
- (vii) Insure significant numbers of Navigators to serve disadvantaged, hard-to-reach populations.

(B) The state may require individuals affiliated with any Navigator contract to be certified, licensed, or otherwise deemed able to carry out the duties as required by section 1131(i)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152;

15) Review the rate of premium growth within the exchange and of non-grandfathered health benefit plans outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

Please note that item 16 should be removed from the legislation. Amendments to ACA have removed the free choice voucher requirement for small employers to all employees to purchase coverage on the individual exchange.

- (16) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Patient Protection and Affordable Care Act, Pub. L. 30 No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and collect the amount credited from the offering employer;

Item 17 requires formalized consultation with stakeholders by the exchange and attempts to represent stakeholders from a variety of entities.

- (17) Consult with stakeholders relevant to carrying out the activities required under this chapter, including:
- (A) Educated health care consumers who are enrollees in qualified health plans;
 - (B) Individuals and entities with experience in facilitating enrollment in qualified health plans;
 - (C) The commissioner;
 - (D) Representatives of health carriers that offer qualified health plans through the exchange;
 - (E) Representatives of health carriers that are not offering qualified health plans through the exchange;
 - (F) Representatives of small businesses and self-employed individuals;
 - (G) The Department of Human Services, the Department of Health, the Office of Health Information Technology, the Department of Information Systems, and the Arkansas Center for Health Improvement; and
 - (H) Advocates for enrolling disadvantaged, hard-to-reach populations;
- (18) Meet the following financial integrity requirements:
- (A) Keep an accurate account of all activities, receipts, and expenditures and annually submit to Secretary of the United States Department of Health and Human Services, the Governor, the commissioner, and the General Assembly a report concerning such accountings;
 - (B) Fully cooperate with any investigation conducted by the Secretary of the United States Department of Health and Human Services pursuant to his or her authority under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and allow the Secretary of the United States Department of Health and Human Services, in coordination with the Inspector General of the United States Department of Health and Human Services, to:
 - (i) Investigate the affairs of the exchange;
 - (ii) Examine the properties and records of the exchange; and
 - (iii) Require periodic reports in relation to the activities undertaken by the exchange; and
 - (C) In carrying out its activities under this chapter, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications; and
- (19) Appoint at least one (1) or more advisory committee as deemed appropriate by the Board of Directors of the Arkansas Health Benefits Exchange.

This section establishes the standards that must be met for a health plan to be qualified to offer a qualified health plan on the exchange:

- (1) Must offer the required minimum essential health plan as required by ACA
- (2) Does not have to offer qualified dental plan as part of the health plan if an adequate choice of stand alone qualified plans exist in the exchange and appropriate disclosures are made.
- (3) Rates and contract language have been approved by the Commissioner.
- (4) Can provide at the least a bronze level of coverage, or catastrophic coverage for those eligible for that level of coverage if both silver and gold coverage are offered by the insurer in the exchange.
- (5) All cost sharing and deductible requirements are met as required by ACA
- (6) Must be licensed insurer or health maintenance organization in good standing to participate in the exchange.
- (7) Charges same rates on and off the exchange for the same products offered on and off the exchange

Issues for Discussion:

- This section used the NAIC Model legislation based on the option that a state would have an "any willing provider" model for insurers. If an active purchaser model or some other model is used to determine who can sell products on the exchange, the wording would need to be different.

23-104-107. Health benefit plan certification.

(a) The Arkansas Health Benefits Exchange shall certify a health benefit plan as a qualified health plan if:
(1) The plan provides the essential health benefits package described in section 1302(a) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (d) of this section, if:

(A) The exchange has determined that an adequate choice of qualified dental plans is available to supplement the plan's coverage; and

(B) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the Insurance Commissioner;

(3) The plan provides at least a "bronze" level of coverage, as determined pursuant to subsection 1311(c)(3) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-31 152 for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and if the plan is offered through the Small Business Health Options Program and the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 5 No. 111-152;

(5) The health carrier offering the plan:

- (A) Is licensed and in good standing to offer accident and health insurance or health maintenance organization coverage in this state;
- (B) Offers at least one (1) qualified health plan in the "silver" level, as defined in subsection 1302(d)(1)(B) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and at least one (1) plan in the "gold" level, as defined in subsection 1302(d)(1)(C) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, through each "component" of the exchange in which the carrier participates, where component refers to the Small Business Health Options Program and the exchange for individual coverage;
- (C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or through the non-exchange open market and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;
- (D) Does not charge any cancellation fees or penalties in violation of § 23-104-105(c); and
- (E) Complies with the regulations developed by the Secretary of the United States Department of Health and Human Services under section 1311(d) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and such other requirements as the exchange may establish;
- (6) The plan meets the requirements of certification as promulgated by regulation by the Secretary of the United States Department of Health and Human Services under section 1311(c)(1) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and by the exchange; and
- (7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.
- (b) The exchange shall not exclude a health benefit plan:
- (1) On the basis that the plan is a fee-for-service plan;
 - (2) Through the imposition of premium price controls by the exchange; or
 - (3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

This section sets the standards for certification of health plans and establishes a decertification process as well. Requires that health plan submit justification for any rate increase on the exchange before implementing the rate increase. Note: Rate increases are approved by the commissioner and that aspect is outside the exchange. This section does allow the exchange to consider the rate increases and recommendations from the commissioner in determining if offering the plan on the exchange is in the best interest of the public. This section also requires specific information to be posted by the insurance carriers for each plan they offer on the exchange, such as denial rates for claims, enrollment, disenrollment, etc as required by ACA.

(c) Presumption of Best Interest.

- (1) In order to foster a competitive exchange marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the exchange to certify all health plans meeting the requirements of section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, for participation in the exchange.
- (2)(A) The exchange shall certify all health plans meeting the requirements of section 1311(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and § 23-104-107 for participation in the exchange.
- (B) The exchange shall establish and publish a transparent, objective process for decertifying qualified health plans to be offered through the exchange that are determined not to be in the public interest.
- (d) The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

- (1)(A) Submit a justification for any premium increase before implementation of that increase.
- (B) The health carrier shall prominently post the information on its Internet website.
- (C) The exchange shall take this information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January 1, 2011, into consideration when determining whether to allow the health carrier to make plans available through the exchange;
- (2)(A) Make available to the public, in the format described in 6 subdivision (A)(2)(B) of this section, and submit to the exchange, the Secretary of the United States Department of Health and Human Services, and the commissioner accurate and timely disclosure of the following:
- (i) Claims payment policies and practices;
 - (ii) Periodic financial disclosures;
 - (iii) Data on enrollment;
 - (iv) Data on disenrollment;
 - (v) Data on the number of claims that are denied;
 - (vi) Data on rating practices;
 - (vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
 - (viii) Information on enrollee and participant rights under title I of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and
 - (ix) Other information as determined appropriate by the Secretary of the United States Department of Health and Human Services.
- (B) The information required in subdivision (d)(2)(A) of this section shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and
- (3)(A) Permit individuals to learn in a timely manner upon the request of the individual the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider.
- (B) At a minimum, this information shall be made available to the individual through a website and through other means for individuals without access to the Internet.
- (e)(1) The provisions of this chapter that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with subdivisions (e)(2)-(4) of this 3 section or by rules adopted by the commissioner.
- (2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.
- (3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include at a minimum the essential pediatric dental benefits prescribed by the Secretary of the United States Department of Health and Human Services pursuant to section 1302(b)(1)(J) of the Patient Protection and Affordable Care Act, Pub. L. No. 12 111-148, as amended by the Health Care and Education Reconciliation Act of 13 2010, Pub. L. No. 111-152, and such other minimum dental benefits as the exchange or the Secretary of the United States Department of Health and Human Services may specify by regulation.
- (4) A health carrier and a dental carrier may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by the dental carrier and the other benefits are provided by the health carrier.
- (f) Appeal of Decertification or Denial of Certification.
- (1) The exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan.
- (2) The exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:
- (A) The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue; and
 - (B) A hearing and a decision on the record, to the extent that the exchange and the health carrier are unable to reach agreement following the submission of the information in subdivision (f)(2)(A) of this section.

(3) Any hearing held pursuant to subdivision (f)(2)(B) of this section shall be conducted by an impartial party or an administrative law judge with appropriate legal training and in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

This section allows a small employer to (1) either pick one or more specific health plans in which employees can enroll or (2) pick a level of coverage-i.e. "silver" and allow the employee to pick any plan in that level of coverage.

23-104-108. Choice.

(a) In accordance with section 1312(f)(2)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a qualified employer may either designate one (1) or more qualified health plans from which its employees may choose or designate any level of coverage to be made available to employees through the Arkansas Health Benefits exchange.

(b) In accordance with section 1312(b) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing the qualified health plan.

This section requires that an insurer pool all non-grandfathered plan risks for products off and on the exchange. All individual and small group new products sold off the exchange after March 23, 2010 and all products sold on the exchange after 1/1/2014 will be treated as one risk pool. Sections on consumer choice and voluntary nature of the exchange are drawn directly from the ACA. Wording allowing agents and brokers to operate in the exchange is drawn directly from the ACA as well.

(c) Risk Pooling.

In accordance with section 1312(c) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152:

(1) A health carrier shall consider all enrollees in all health plans, other than grandfathered health plans, offered by the health carrier in the individual market, including enrollees who do not enroll in such plans through the exchange, members of a single risk pool.

(2) A health carrier shall consider all enrollees in all health plans, other than grandfathered health plans, offered by the health carrier in the small group market, including those enrollees who do not enroll in such plans through the Small Business Health Options Program, to be members of a single risk pool.

(d) Empowering Consumer Choice.

(1) In accordance with section 1312(d) of the Federal Act:

(A) This chapter shall not prohibit:

(i) A health carrier from offering outside of the exchange a health plan to a qualified individual or qualified employer; or

(ii) A qualified individual from enrolling in or a qualified employer from selecting for its employees a health plan offered outside of the exchange; and

(B) This chapter shall not limit the operation of any requirement under state law or rule with respect to any policy or plan that is offered outside of the exchange with respect to any requirement to offer benefits.

(2) Voluntary Nature of the Exchange.

(A) Nothing in this chapter shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in the exchange.

(B) Nothing in this chapter shall compel an individual to enroll in a qualified health plan or to participate in the exchange.

(C) A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e) of the Patient Protection and Affordable Care Act, Pub. L. 12 No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a qualified individual may enroll in the plan 14 only if the individual is eligible to enroll in the plan under section 1302(e)(2) of the Patient Protection and Affordable Care Act, Pub. L. No. 11-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

(e) Enrollment through Agents or Brokers.

In accordance with section 1312(e) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, the exchange may allow agents or brokers:

- (1) To enroll qualified individuals and qualified employers in any qualified health plan offered through the exchange for which the individual or employer is eligible; and
- (2) To assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the exchange.

<p>This section establishes the funding mechanism for the exchange—up to 3% of premiums for plans sold on the exchange and establishes budgeting and disclosure rules.</p>

23-104-109. Funding -- Taxes, fees, and assessments -- Medical loss ratio -- Publication of costs.

(a)(1)(A) As required by section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, the Arkansas Health Benefits Exchange shall be self-sustaining by January 1, 2015.

(B) A budget for the exchange shall be prepared by the exchange and submitted to the Insurance Commissioner annually for approval.

(2) The exchange may charge assessments or user fees to health carriers up to three percent (3%) of each health carrier's direct written premium from health benefit plans sold through the exchange or otherwise may receive funding necessary to support its operations provided under this chapter.

(3) Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding.

(4) Services performed by the exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers.

(5) Any unspent funding by an exchange shall be used for future state operation of the exchange or returned to health carriers as a credit.

(b) Taxes, fees, or assessments used to finance the exchange shall be clearly disclosed by the exchange as such, including publishing the average cost of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange on a website to educate consumers on such costs.

(c) Taxes, fees, or assessments used to finance the exchange shall be considered a state tax or assessment as defined under section 2718(a) in the 24 Public Health Service Act, 42 U.S.C. § 201 et seq., as it existed on January 25 1, 2011, and its implementing regulations, and shall be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

(d)(1) The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange and the administrative costs of the exchange on an Internet website to educate consumers on such costs.

(2) This information shall include information on moneys lost to waste, fraud, and abuse.

(a) The Insurance Commissioner may promulgate rules to implement this chapter.

(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under title I, subtitle D of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

23-104-111. Relation to other laws.

(a) Nothing in this chapter, and no action taken by the Arkansas Health Benefits Exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.

(b) Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

This section establishes the requirements for an operational plan and the process to have that plan approved by the Commissioner, or developed if the exchange board does not deliver a plan of operation.

23-104-112. Plan of operation.

(a)(1)(A) The Arkansas Health Benefits Exchange shall submit to the Insurance Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and required administration of the exchange.

(B) The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or, unless he or she has not disapproved the plan of operation, within thirty (30) days.

(2) If the exchange fails to submit a suitable plan of operation within one hundred eighty (180) days following June 1, 2011, or if at any time thereafter the exchange fails to submit suitable amendments to the plan of operation, the commissioner, after notice and public hearing, shall adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter.

(3) The rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the exchange and approved by the commissioner.

(b) The plan of operation in addition to requirements enumerated elsewhere in this chapter, shall:

(1) Establish procedures for handling the assets of the exchange;

(2) Establish the amount and method of reimbursing members of the Board of Directors of the Arkansas Health Benefits Exchange;

(3) Establish regular places and times for meeting, including telephone conference calls of the board;

(4) Establish procedures for all record keeping required in this chapter;

(5) Establish a conflict of interest policy for the board; and

(6) Contain additional provisions necessary or proper for the execution of powers and duties of the exchange.

SECTION 8. LEGISLATIVE CONSTRUCTION AND INTENT.

(a) The General Assembly declares that:

(1) This act is not to be construed as either resisting or supporting the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and

(2) The sole intent of this act is to maintain the current localized regulation of health insurance in the State of Arkansas.

(b) If any provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, is held to be unconstitutional in a final, nonappealable order or is repealed by the United States Congress, any part of this act affected by the unconstitutional or repealed provision shall be null and void.

SECTION 9. EFFECTIVE DATE.

(a) Section 23-61-103(a)(2) and Section 7 of this Act shall not take effect until the earlier of either:

(1) A ruling by the United States Supreme Court that the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended 34 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111 35 – 152 is constitutional; or (2) November 15, 2011.

(b) The Insurance Commissioner shall not spend any monies given through a federal grant dealing with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and

Education Reconciliation Act of 2010, Pub. L. No. 111 – 152, unless approved by all appropriate legislative bodies pursuant to existing appropriation requirements, and until the earlier of either:

(1) A ruling by the United States Supreme Court that the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No.

111 – 152 is constitutional; or

(2) November 15, 2011.

(c) Nothing in subsection (b) shall be construed to limit or prevent the commissioner from either spending any portion of the federal grant monies already procured by the State Insurance Department, or attempting to procure additional federal grants prior to the dates specified in subsection (b).

SUMMARY OF FIRST DATA RECOMMENDATIONS ON NAVIGATOR ROLE *

Review of Key Informant Interviewee comments on Navigators (by First Data staff/consultants):

- AID – emphatic that Navigators need to be licensed so that AID can monitor their performance and enforce the rules and qualifications for the person.
- DHS – assist in providing reliable information and navigating system, not limited to assisting with plan choice; collaboration of public and non-profit
- ADH – wants their staff to serve as Navigators.
- EBD – should be paid in a grant environment; anyone but insurance carriers would be best
- Office of the Governor – HBE must hold Navigator responsible for their actions; get correct information to them and insist they communicate in a fashion that individuals can understand. The Benefit Bank is an example of what NOT to do—used volunteers and got volunteer results. Good training, monitoring, and oversight is essential.
- AR BCBS – It will be difficult to find someone with influence but who is independent—suggested church organizations and “all kinds of different folks” be considered.
- Delta Dental – insurance industry would make best Navigators

Communication/Education/Outreach Plan – AFMC

Goal of the Navigator program should be to help guide and educate individuals who will seek health insurance through the Exchange. The Navigator role should be to raise awareness of the availability of QHPs and availability of tax credits and cost sharing reductions through the HBE, and to assist those wishing to enroll in the Exchange. The Navigator will not actually enroll those they assist.

A Navigator should not serve the same role as a producer. A Navigator should not engage in types of services or activities that would require licensure for producers, brokers, or agents. Enrollment should be completed by individuals for themselves through the Exchange portal or by a broker/producer, depending on the preference and/or needs of the individual consumer. Brokers/agents are in a better position to guide individuals or small groups through complex insurance decision-making requiring customized plans and explanations of tax or cost-sharing ramifications.

Further recommendations are that Navigators:

- interact with consumers in individual or group settings, serving as an advocate, educator, and guide, particularly for those who may not be computer-literate or well-versed in insurance terminology;
- protect personal health information;
- distribute fair and impartial information about the HBE, informing individuals and businesses of the availability of premium tax credits and cost-sharing reductions;
- be easily accessible in every county in Arkansas, demonstrating that they have or could easily establish service relationships with potential enrollees—such as with populations that have historically been difficult to reach or are underserved;
- serve as a source of consumer assistance for enrollees with a grievance, complaint or question regarding a health plan, coverage, or determination under such a plan or coverage. Assistance will be limited to referral to appropriate resources such as AID Consumer Services Division.

The Navigator program will be especially important in the months immediately following the Exchange's launch, when enrollment is at its peak and familiarity with the Exchange is low. It is predicted that Navigators will be less active after 2015 when the number of new enrollees is estimated to drop and new enrollees will likely seek help from licensed producers or from family members or friends who are already enrolled. Recruitment and retention of Navigators, except for chronically underserved populations and areas, will be less critical and the associated costs will likely drop.

Certification

It is recommended that Navigators achieve certification and be regulated by AID. Following online training and testing, competent Navigators would be certified/re-certified. In-person, observational testing is recommended as a supplemental certification method if resources allow.

It is further recommended that licensed producers selling products on the Exchange also obtain Exchange certification through brief on-line education and testing. This certification would prepare producers to competently assist their clients in enrolling in the Exchange and would highlight the differences in Navigator and producer roles.

A modest certification fee of \$25 is recommended for producers or Navigators. The certification program would include:

- Definition of actions/responsibilities requiring certification;
- Definition of services that can be provided under certification by Navigators and by producers;
- A criminal background check and review of state and federal "excluded provider" lists;
- Rules regarding full disclosure of potential conflicts of interest;
- Training in providing full disclosure to clients;
- Accountability and consumer protection standards;
- HIPAA law and protection of personal health information (PHI);
- Requirement that Navigator grantee provide proof of liability coverage;
- Requirement for electronic communication with Exchange and AID.

Navigator Payment

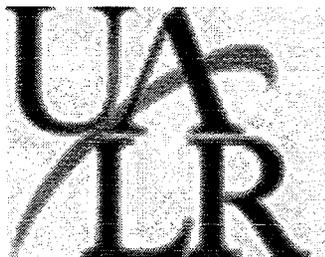
Payment would be by a traditional, competitive grant program with a predetermined funding amount calculated by geographic area or other method of distribution determined by the Exchange. Eligible grantees could be organizations/agencies (preferable) or individuals. Specific outreach/education/service deliverables would be required as would oversight for fraud, waste, and abuse prevention. There would be a requirement for grantees to demonstrate an ability to link potentially eligible residents with the Exchange regardless of English proficiency or other potential cultural or linguistic barriers.

It is recommended that Level One Establishment funds be used to hire a consultant to design and develop Arkansas's Navigator program including development of procurement and training documents/materials/processes and certification process. A plan to evaluate the Navigator program from the perspectives of the Exchange, Navigators, producers, and consumers would also be developed.

*by Cindy Crone

Arkansas Health Benefits Exchange Results of Modeling Efforts

Steering Committee Meeting September 6, 2011



Lawrence S. Powell, Ph.D.

Whitbeck-Beyer Chair of Insurance & Financial Services

UALR-College of Business, Little Rock, AR

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Why Individuals Enter Exchange

- Observed behavioral preferences
- Price or cost lower in exchange than outside
 - Subsidies
 - Assumes price increase from rating rules is less than decrease from subsidy

Why Groups Enter Exchange

- Adverse selection
 - Exchange population healthier than eligible group
- Fine is less than cost of coverage
- Strong employee economic preference

2014 outcomes	2013		2014	
	Membership	Cost PMPM	Membership	Cost PMPM
Medicaid/Arkids Total	682,000	\$522.07	857,000	
Total Exchange Population	N/A	N/A	210,755	397.09
Individual Exchange Total	N/A	N/A	115,925	399.59
From Groups <51			3,767	
From Nongroup Insured			22,047	
From Uninsured Individuals			86,811	
From CHIP/PCIP			3,300	
Groups Exchange Total	N/A	N/A	94,830	394.13
From Insured Groups <51			48,710	
From Insured Groups 51-100			12,641	
From Uninsured Groups			33,479	
	587,000	559.27	303,177	511.44
Uninsured Group Eligible	80,000	405.00	46,521	
Uninsured Medicaid Eligible			70,470	
Uninsured Individuals	\$507,000	583.62	186,186	
INSURED INDIVIDUALS	136,000	391.50	113,953	410.51
INSURED IN GROUPS <51	289,000	333.00	236,523	346.45
INSURED IN GROUPS 51-100	75,000	351.00	62,359	365.80

Individual & SHOP Exchanges (total) 210,755

Insured status: Previously uninsured 120,290

Gender: Male 106,346
Female 104,409

Age: 0-4 19,113
5-18 56,821
19-25 17,175
26-35 32,349
36-45 42,164
46-55 25,376
56-64 15,884

Family Income as %
of Poverty: 139-150% 18,402
151-200% 23,051
201-250% 58,113
251-300% 34,351
301-400% 58,823
>400% 18,015

CCIIO/Exchange Planning Grant Update to Steering Committee
Cindy Crone, Project Director: September 7, 2011

- I. Craig Wilson, an experienced health policy attorney employed by ACHI, will be assisting with Arkansas Exchange Planning efforts. Craig will fill the .20 FTE Exchange Planning Grant-funded effort previously provided by David Boling. Craig is already working on Exchange Issues and we look forward to having him part of our Team.
- II. ACHI will begin Outreach/Education Campaign targeting Small Business Owners this month. Background research findings and community stakeholder input will help guide messages. This education project is funded through CCIIO Exchange Planning Grant.
- III. Reminder: September 9 is deadline for sending any comments you want included in our Planning Grant's consolidated response on first three sets of proposed Exchange Regulations (those released July 11, 2011). Send comments to Bruce.Donaldson@Arkansas.Gov. We will continue to collect comments on second set of proposed regulations into October.
- IV. Discussions with CCIIO Project Officer and reviewing Grants Management Specialist indicate that Arkansas's request for HBE Planning Grant No-Cost Extension and Budget Revision will likely be approved. We were asked to submit a few minor revisions to our request which were submitted.
- V. A summary of the DHHS "listening session" held in Denver on August 24th and attended by Bruce Donaldson and others from Arkansas, was sent separately with today's meeting notice. As a reminder, other upcoming Exchange-related meetings include: Bruce and Linda Greer from DHS County Operations attending the CMS eligibility and enrollment meeting on September 7-8; Frank Scott of Governor's Office, Joni Jones of DHS, Dan Honey, AID Life and Health Division, and I will attend NGA meeting on Exchanges September 8-9; Randy Lawson of DHS County Operations and I will attend the User Experience 2014 Design meeting September 12-13, and Bruce, Dan, Linda, and I will attend the CCIIO Exchange Planning Grantee Meeting September 19-20. We'll keep you updated on what's learned.
- VI. Exchange Stakeholder Summit - October 11, 2011. Registration fee will be \$25 and include lunch, breaks, and materials. On-line registration will be available. We will be reaching out to community based organizations to attend, and to Steering Committee members to present or facilitate stakeholder feedback sessions. There will be an Exchange 101 for newcomers at 8:30 am, with the main sessions beginning at 10:00. More details to come soon. Save the date!

VII. We will be planning Arkansas's Level One funding application during September. This funding will advance efforts to meet DHHS requirements for Exchanges that will be certified to operate in each state with enrollment beginning October 1, 2013 and coverage effective January 1, 2014. Throughout the planning process, integrated Medicaid/CHIP/Exchange IT and program planning/procurement is required. Core areas to be addressed are :

- a. Continued Stakeholder Consultation;
- b. Legislative/Regulatory Action, including legal authority for Exchange;
- c. Governance Structure and Operating Structure in accordance with State and Federal law;
- d. Complete final requirements, interim development, and testing for Exchange Information Technology Systems, including software, hardware, interfaces, code review, and unit level testing, leading to complete testing of all components including data interfaces, performance, security, and infrastructure;
- e. Program Integration (Business and Systems) with collaborative procurement and development of Medicaid and Exchange IT systems needed to facilitate "no wrong door" for eligibility determinations;
- f. Financial Management to include a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees; assess adequacy of accounting and financial reporting systems, and conduct a third party objective review of all systems of internal control;
- g. Oversight and program integrity to include establishing procedures for independent, external Exchange audit by qualified entity;
- h. Providing assistance to individuals and small businesses to include coverage appeals and complaints, ensuring establishment of protocols and scope of work to handle coverage appeals functions and adjudication and broader ongoing performance improvement through analyzing data leading to training on eligibility requirements and strengthened QHP accountability and functioning of Exchange;
- i. Certification of QHPs – Integration of staff and IT systems to receive applications, evaluate data from carriers, and notify carriers of results of applications for QHPs. This will require developing strategy and timeline, developing RFP and applicable certification documents that will be used in connection with the certification process and terms or fees that will lead to certification/recertification/decertification, and beginning to train health plan issuers to become QHPs;
- j. Define requirements for Call Center and determine process for vendor selection;
- k. Navigator Program – Determine targeted organizations that would qualify to function as navigators and how to fund before 2014 when fees will pay for navigator grants;

- I. Outreach and Education to include development of a toolkit, performance metrics, and evaluation plan as well as a media strategy and other information dissemination tools; testing of materials with key stakeholders and consumers and making refinements based on input, and submitting final outreach and education plan (including performance metrics and evaluation plan) to DHHS;
- m. Determine system and operation requirements and timeline for development/testing for key components/processes including:
 - i. Exchange website and calculator to include online/website comparison of QHPs, online application and selection of QHPs, premium tax credit and cost sharing reduction calculator functionality to include out of pocket costs, requests for assistance, and linkages to other state health and human service subsidy programs as appropriate;
 - ii. Develop Quality Rating Standards and draft contract for QHPs in accordance with state and federal requirements, and include quality rating functionality;
 - iii. Leveraging existing Medicaid/CHIP expertise /funding relative to enrollment transactions and referrals, coordinating applications and notices, managing transitions, and communicating the enrollment status of individuals;
 - iv. Enrollment system requirements including providing information to individuals, submitting enrollment transactions to QHP insurers, receiving acknowledgements of enrollment transactions from QHP issuers and submitting relevant data to DHHS;
 - v. Beginning to customize Federal applications and notices as allowable/required for Exchange-created applications and notices;
 - vi. Exceptions from Individual Responsibility requirement and payment and exchanging information with DHHS;
 - vii. Premium tax credit and cost sharing reduction administration including providing relevant information to QHP issuers and DHHS to start, stop, or change the level of premium tax credits and cost sharing reductions;
 - viii. Notification and appeals of employer liability for the employer responsibility payment to include coordination of employer appeals with appeals of individual eligibility and submission or relevant information to DHHS;
 - ix. Information reporting to IRS and enrollee;
- n. Determine design and approach of the SHOP Exchange and whether it will be merged with the individual market, begin systems development and preparing for final user testing.



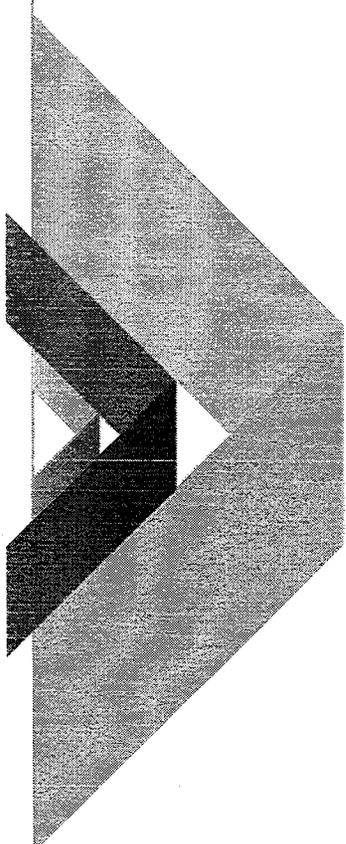
First Data[™]
beyond the transaction

September 6, 2011

Overview of the IT Integration Plan

Arkansas Health Benefits Exchange
Planning Project

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IT Integration

- Introduction
- Activities
- Findings
- Recommendations

Introduction

IT Integration Requirements:

- Analyze the IT systems for affected agencies;
- Identify components, hardware and software needed to perform the business requirements
- Recommend changes to policy, procedure, technology, staffing and other relevant factors



Participants

Interviews were conducted with the leaders of these agencies or organizations:

- Arkansas Insurance Department
- Arkansas Department of Human Services
- Arkansas Office of Health Information Technology
- Arkansas Department of Information Services
- Employee Benefits Division, Arkansas Department of Finance and Administration
- State of Arkansas, Office of the Governor
- Arkansas Blue Cross/Blue Shield
- Delta Dental of Arkansas
- University of Arkansas for Medical Sciences

Activities

- Activities were designed to gain an understanding of existing IT assets (applications, systems, and processes) that currently support the Health Services operations.
- Develop a comprehensive list of current systems and applications that could be used or reused to fulfill the function needs of the Health Benefit Exchange.



Activities

Questions addressed the following topics:

- Brief overview of the agency and its technical components
- Your envisioned role and responsibilities with the Exchange
- Available existing assets to leverage
- Asset descriptions including user volume, technologies, hardware/software characteristics, support models, and Operational/maintenance costs.
- ***Any new/alternative technologies planned***
- Other IT considerations – PM methods, SDLC, testing, and business continuity/disaster recovery.



Findings – Roles and Responsibilities

- **AID** – Lead responsibility for regulating Exchange, not a key resource for the IT development plan.
- **DHS** – Insourcing MMIS business including procuring new automation support. Inventory includes Arkansas Human Services eligibility portal. Acquiring Business Rule Management system.
- **OHIT** – Recently released SHARE RFP. Responsible for the coordination of the Arkansas Health Services initiatives (HIE, HBE, and MMIS)
- **DIS** – Publishes statewide policies and standards. Currently in the process of selecting a statewide Single Signon (SSO) solution.

Findings – Roles and Responsibilities

- **EBD** – Advisory role for insurance exchange implementation.
- **OOG** – Oversight of all the Health Services initiatives.
Monitoring interoperability between all of the new health care systems.
- **BCBS** – Manage the largest IT shop in the state of Arkansas.
Manages a complex public facing insurance portal.
- **Delta Dental** – Assist with development of the IT plan.
Operates a large call center.



IT Asset Inventory

- Access Arkansas
- ARBenefits
- Arkansas Health Information Network (AHIN)
- Medicaid Eligibility and Enrollment Business Rules Engine
- Core Medicaid Management Information System (MMIS)
- Enterprise Data Warehouse (EDW)
- Single Signon (SSO)
- SHARE
- eDoctus



Other Assets

- Federal Assets
- Enrollment UX 2014 project



Component Overview

- Portal
- Member Management (new)
- Finance Management
- Business Rule Management (new)
- Customer Relationship Management
- Health Plan Management
- Reporting
- Document Management
- Data Exchange
- Security



Alternative Technology Models

- Leverage existing assets – Arkansas assets, Federal assets, or Other States' assets (Early Innovator States)
- Commercial off the shelf (COTS) or Frameworks
- Custom Development
- Integrated or Hybrid Solutions



Overall Recommendations

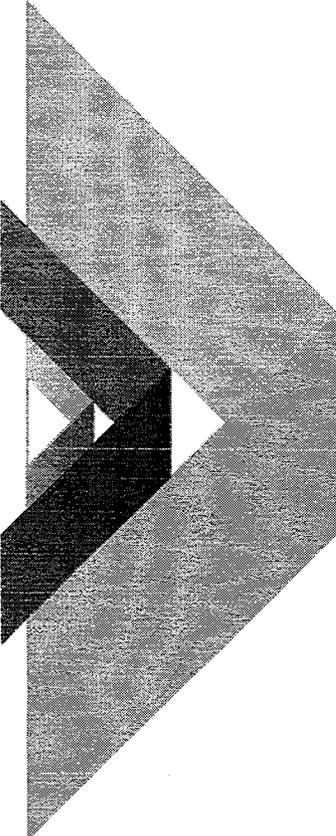
- Maximize AR Investments
- Continue Requirements Development
 - HBE Functional and Technical requirements
 - RFI/Third Party asset evaluation
- Establish Interagency Agreements
- Interagency Collaboration
 - Program Management
 - Enterprise Architect



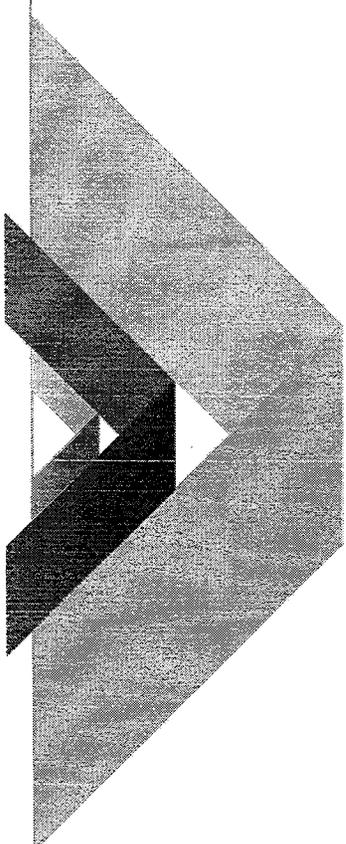
Overall Recommendations Con't

- Maximize Federal Support/Minimize State Maintenance
- Strengthen Exchange Relationships





Questions?



Exchange Operations

- Functional Areas
- Timelines
- Financials

Functional Areas

The following areas have been identified as core business areas:

- Exchange Leadership & Management
 - Administration
 - Communications/Outreach
 - Evaluation/Quality Assurance
 - Reporting
- Navigator Program
- Qualified Health Plan (QHP) Management
- Call Center
- Eligibility & Enrollment
- Financial Management
- IT Application Support
- IT Operational Support

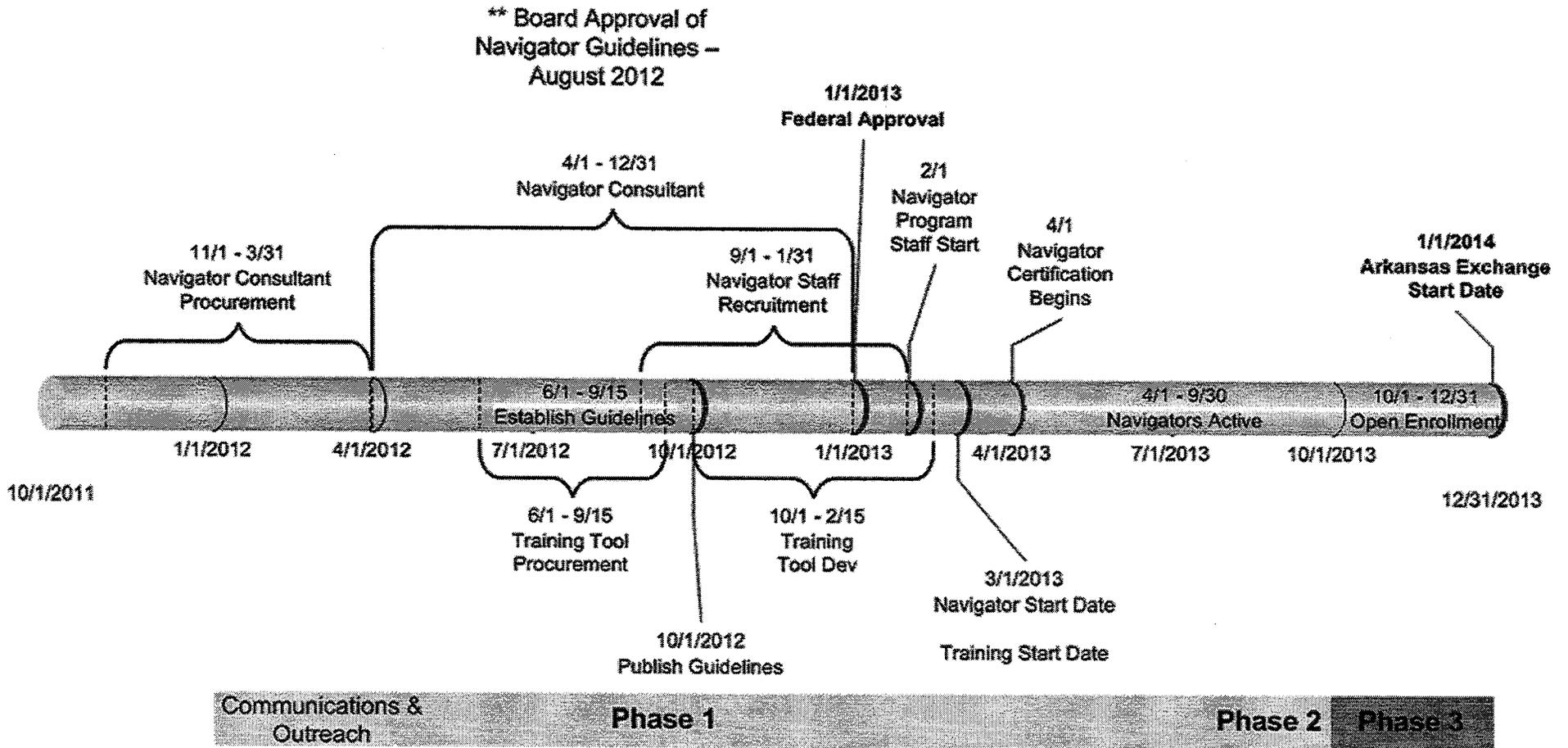
Navigator Program

Key Milestones -

- **Navigator Credentialing**
 - Establish Guidelines – 6/1/12 – 9/15/12
 - Board Approval – August, 2012
 - Publish Guidelines/Grant Procedures – 10/1/12
- **Navigator Contractor**
 - Procurement Stage – 11/1/11 – 3/31/12
 - Engagement – 4/1/12 – 12/31/12
- **Navigator Training Contractor**
 - Procurement Stage – 6/1/12 – 9/15/12
 - Engagement – 10/1/12 – 2/15/13
- **Program Staff**
 - Recruitment Stage – 9/1/12 – 1/31/13
 - Staff Start – 2/1/13



Navigator Program Timeline



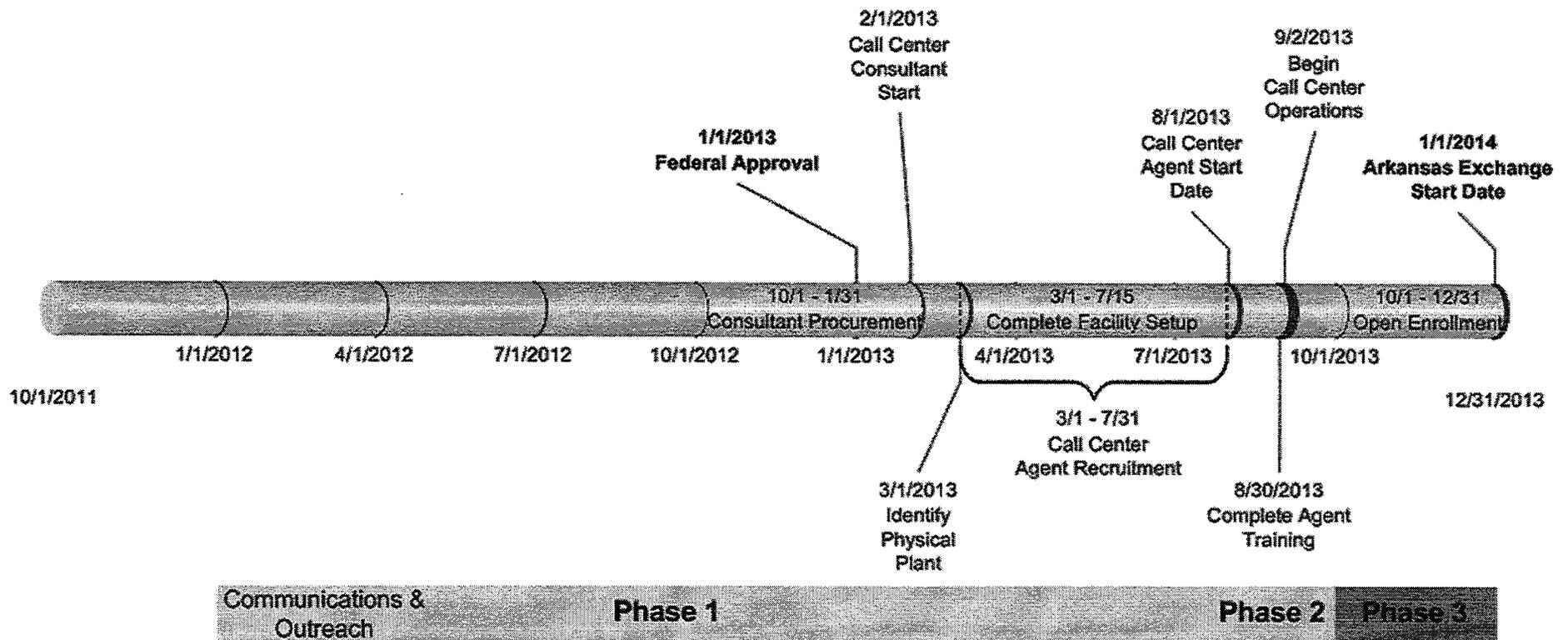
Call Center

Key Milestones -

- Call Center Start Date – 9/1/13
- Call Center Contractor
 - Procurement Stage – 10/1/12 – 1/31/13
 - Engagement – 2/1/13 – 12/31/13
- Facility Development
 - Facility Selection – 3/1/13
 - Facility Setup (Telephony, Hardware/Software, Facility prep) – 3/1/13 – 7/15/13
- Call Center Staff
 - Recruitment – 3/1/13 – 7/31/13
 - Staff Start – 8/1/13
 - Staff Training – 8/1/13 – 8/30/13



Call Center Timeline



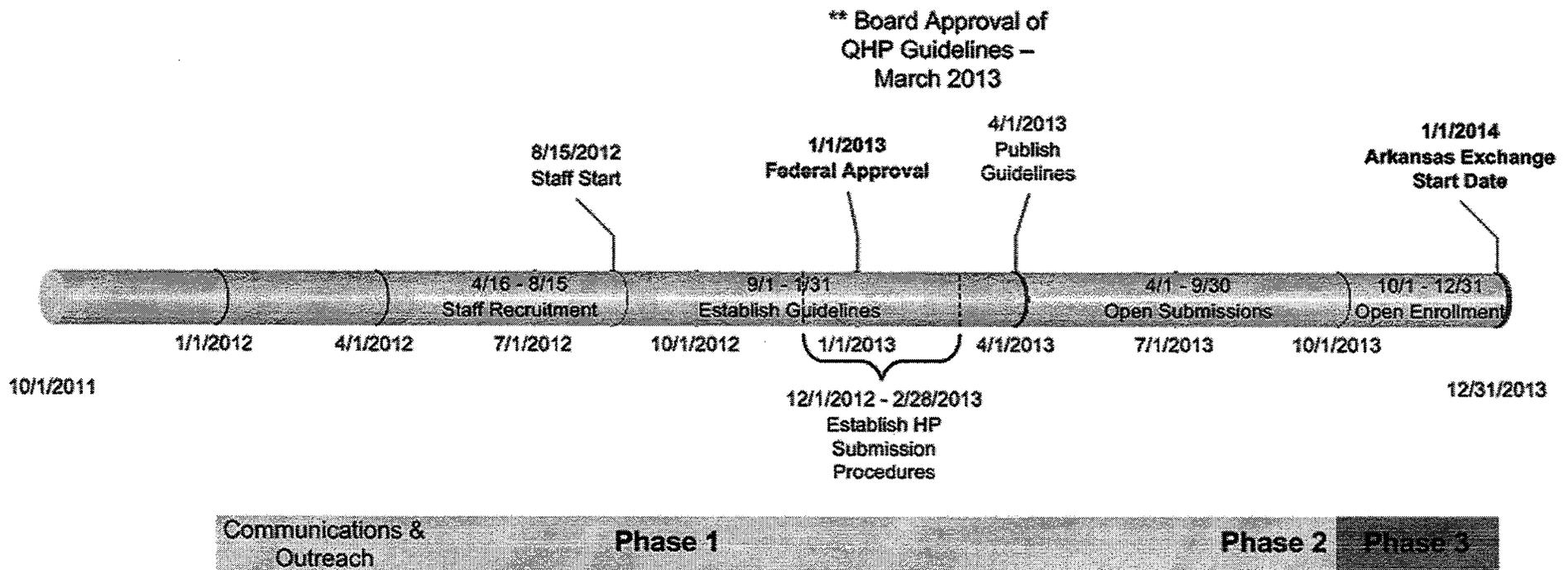
QHP Program

Key Milestones -

- **Qualified Health Plan Credentialing**
 - Establish Guidelines – 9/1/12 – 1/31/13
 - Establish Submission Procedures – 12/1/12 – 2/28/13
 - Board Approval – March, 2013
 - Publish Guidelines/Submission Procedures – 4/1/13
- **Operations Setup**
 - Health Plan Management Automation – 4/1/13
- **Program Staff**
 - Recruitment Stage – 4/16/12 – 8/15/12
 - Staff Start – 8/15/12
 - Staff Training / Credentialing Procedures – 8/15/12 – 2/28/13



QHP Timeline



Exchange Operations

Key Milestones -

- Exchange Leadership & Management – 4/1/12
- Qualified Health Plan (QHP) Program – 8/15/12
- Navigator Program – 1/31/13
- Call Center -7/1/13
- Eligibility/Enrollment – 10/1/13
- Financial Management – 1/1/14

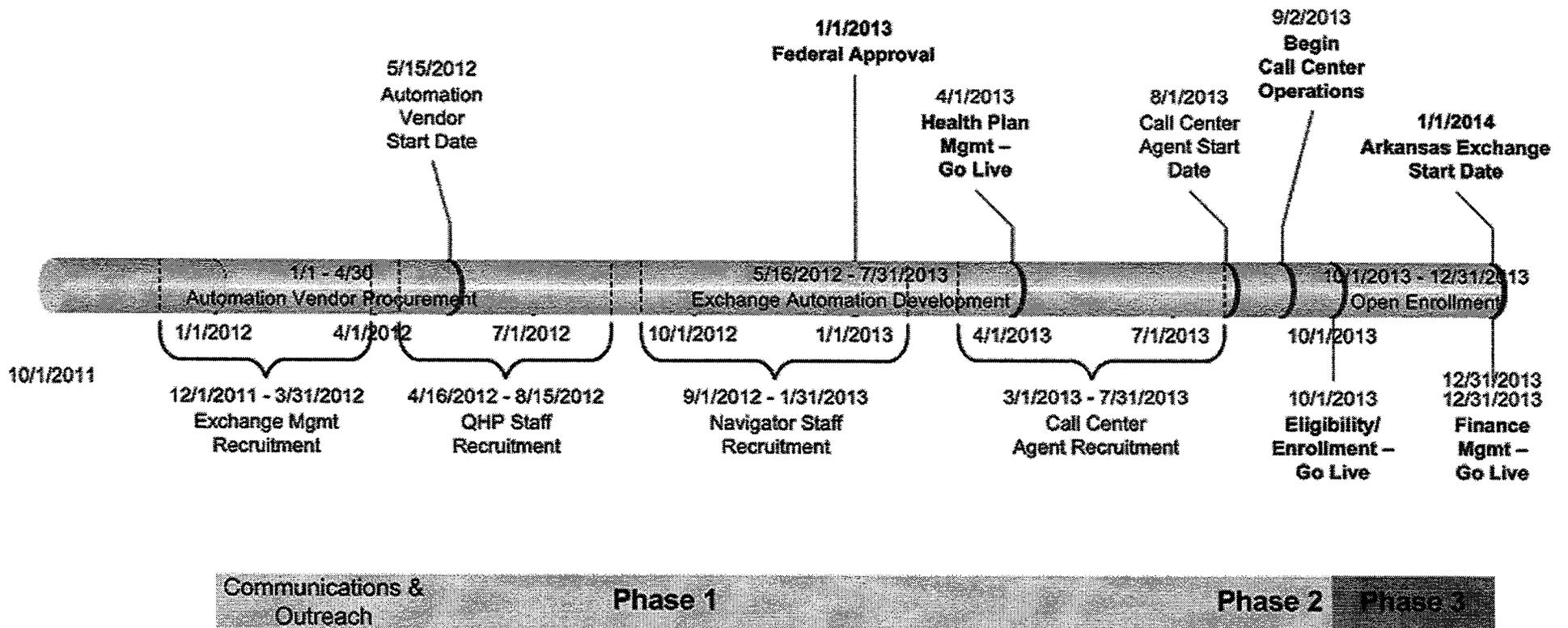
IT Automation

Key Milestones -

- RFP/Procurement – 12/31/11
- Design/Development/Implementation – 5/16/12 – 7/31/13
- Go Live Date
 - Navigator Program
 - Qualified Health Plan (QHP) Program
 - Call Center
 - Eligibility/Enrollment
 - Financial Management



Exchange Operations Timeline



Financials

- Exchange Development Costs
- Annual Revenue
- Annual Costs



Exchange Development Cost

- Through December, 2013
 - Exchange Automation – \$16,450,000
 - Call Center – \$1,183,000
 - Communication/Outreach – \$1,246,875
 - Navigator – \$1,636,250
 - Evaluation Plan - \$151,000

- Total - \$22,085,000

- Exchange Operations / AID Staffing - ??



Annual Revenue

- Assumptions –
 - Insurance Levy – 2.5%
 - Monthly Premiums – Projected PMPM plus load
 - Individual - \$399/month
 - Group - \$394/month
 - Projected annual membership – 207,191
 - Individual – 112,603
 - Group – 94,588
- 2014 Projected Revenue
 - \$27,196,890

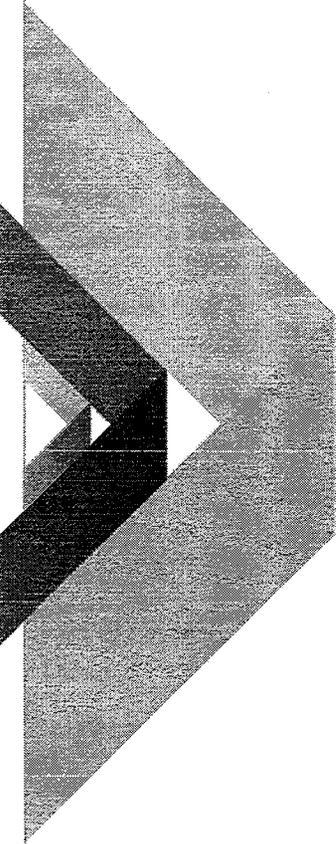


2014 Annual Cost

- Exchange Automation – \$16,450,000
- Call Center – \$1,663,000
- Communication/Outreach – \$802,500
- Navigator – \$2,715,000
- Evaluation/Quality Assurance - \$606,000

- Total non-Exchange Operations - \$10,656,000

- Exchange Operations (staffing) – ??



Questions?

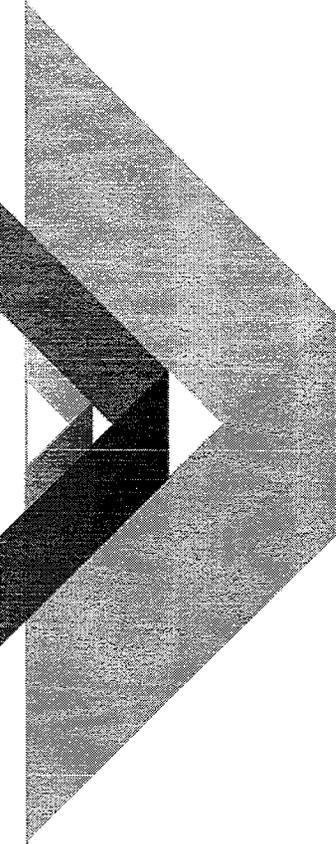


August 23, 2011

Arkansas Health Benefits Exchange Planning Project

State of Arkansas
Arkansas Insurance Department

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Evaluation

- Introduction
- Approach
- Methodology & Measures

Introduction

- Independent assessment of big questions...
 - Does the HBE effectively perform “essential functions?”
 - Does the HBE meet public policy goals?
 - What consequences are observed from implementation?
- Three components of evaluation
 - Implementation
 - Outcomes
 - Efficiency



Approach to Evaluation Design

- Reviewed measures tied to ACA objectives
- Studied existing state exchanges
- Assessed existing evaluation plans

- Resulted in recommendation to collect data to support use of established national measures published by the National Quality Measures Clearinghouse (NQMC)
 - Healthcare Effectiveness Data Information Set (HEDIS®)
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Implementation Effectiveness

- Use of the exchange
 - Consumer awareness
 - Ease of use
- Enrollment and Re-enrollment
- Disenrollment and Gaps in Coverage
- Navigator Education
 - Ability to answer consumer questions
- New Federally-Required Measures



Enrollee Satisfaction

- Health Plan
- Issuer
- Exchange Website
- Provider
- Agent
- Navigators



Provider Perceptions

- Access to Care
 - Meeting needs of existing patients
 - Delivering care to new patients
- Utilization of Services
 - Is appropriate utilization of services increasing?
 - Are benefits tailored appropriately to the needs of beneficiaries?



Insurance Coverage

- Reducing Number of Uninsured Arkansans
 - Trend annually by:
 - Household income
 - Race and ethnicity
 - Age
 - Geographic regions
- Assessment of Crowd-Out
 - Occurs when private industry ceases to provide a good or service once government assumes that function

Quality of Care

- **Technical and Process Measures**
 - Focus on areas of greatest need within Arkansas
- **Outcome Measures**
 - Determined by HBE
 - Use existing NQMC measures
- **Variation by Plan and Issuer**
 - Ability to make informed decisions
 - Directly compare plans



Beneficiary Perspectives on Access to Care

- Perceived Access to Services
 - Before and after comparison of access to:
 - Primary Care Provider
 - Prescription medication
 - Urgent care or emergency room
- Wait Time for Primary Care Visits
 - Getting care as soon as needed it
 - Seeing provider within 15 minutes of appointment time
- Travelling for Primary Care
 - Ask enrollee miles traveled
 - GIS software to approximate distance through zip codes

Access to Care contd.

- Referrals to Specialists

- Getting referrals as soon as needed
- Difficulty in getting appointment
- Receiving care in timely manner

- Affordability

- Measure level of financial burden of:
 - Monthly premiums
 - Relevant cost-sharing
- Measure the following due to out-of-pocket expenses:
 - Delaying care
 - Not accessing care
 - Going without prescription medication



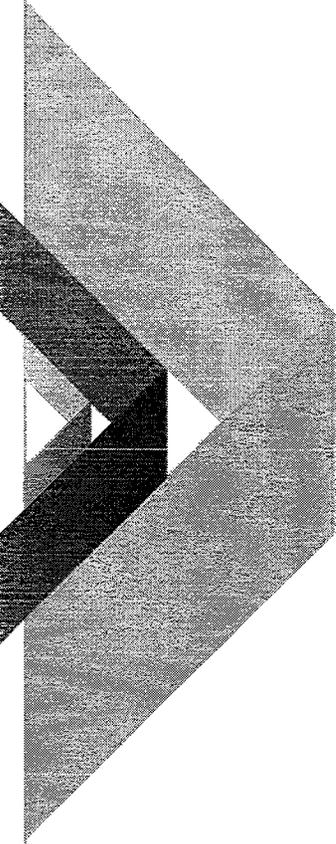
Utilization of Care

- Preventive Services
 - Use HEDIS measures to determine access and utilization
- Emergency Department for Non-Urgent Care
 - Monitor non-urgent use of ED
 - Trend over time and by benefit level
- Hospitalizations
 - Monitor 30-day readmission rates
 - Track long-term changes in care for chronic conditions



Costs of Care

- Expenditures by Plan
 - Across benefit levels and issuers
- Expenditures by Issuer
 - Compare to all-issuer average
- Trends in Health Expenditures
 - Including insured outside of HBE and remaining uninsured
- Contrast Private Issuers and Medicaid
- *Potential detection of fraud and abuse*



Effective evaluation will be critical to successful planning, implementation and management of the HBE in Arkansas.



September 6, 2011

Overview of the Exchange Operations Plan

Arkansas Health Benefits Exchange
Planning Project

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