



Arkansas Health Benefits Exchange Stakeholder Summit

Tuesday
October 11, 2011

Embassy Suites
11301 Financial Centre Parkway
Little Rock, AR

Arkansas Health Benefits Exchange Stakeholder Summit

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Embassy Suites in Little Rock, AR

7:30 a.m. – 9:30 a.m.	Registration & Continental Breakfast	Foyer
8:30 a.m. – 9:15 a.m.	Pre-Summit Session: Health Benefits Exchange 101 Cynthia Crone, Health Benefits Exchange Planning Director	Ambassador
9:30 a.m. – 9:45 a.m.	Welcome and Introductions Jay Bradford, Arkansas Insurance Commissioner	Ambassador
9:45 a.m. – 10:30 a.m.	Health Benefits Exchange: An Arkansas Perspective Joseph Thompson, M.D., M.P.H., Arkansas Surgeon General	Ambassador
10:30 a.m. – 11:30 a.m.	Next Steps With Exchanges Joel Ario, J.D., M.Div., Immediate Past Director of the Federal Office of Health Insurance Exchanges	Ambassador
11:30 a.m. – 11:45 a.m.	Break	Foyer
11:45 a.m. – 1:00 p.m.	Lunch with Panel Discussion Panel: Arkansas Health Benefits Exchange Planning Research Findings Moderator: David Sodergren, First Data Government Solutions Panelists: David Deere, University of Arkansas for Medical Sciences (UAMS) Partners for Inclusive Communities; John Wayne, Ph.D., UAMS College of Public Health; Lars Powell, Ph.D., Powell and Associates; Debbie Hopkins, Arkansas Foundation for Medical Care	Ambassador
1:00 p.m. – 1:10 p.m.	Break	Foyer
1:10 p.m. – 2:00 p.m.	Panel: How Might The Health Benefits Exchange Operate in Arkansas? Moderator: Ed Choate, Delta Dental of Arkansas Panelists: Ron Boyeskie; Representative Barry Hyde; Cal Kellogg, Ph.D.; Drew Kumpuris, M.D.	Ambassador
2:00 p.m. – 2:50 p.m.	Panel: How Might The Health Benefits Exchange Meet Consumer Needs? Moderator: Herb Sanderson, AARP Arkansas Panelists: Fred Bean; Elisabeth Burak; Joni Jones; Randy Lee; Creshelle Nash, M.D., M.P.H.	Ambassador
2:50 p.m. – 3:00 p.m.	Break	Foyer
3:00 p.m. – 3:45 p.m.	Forum Discussion Sessions – One A. Exchange Business Model Facilitators: Arthur Wolover; Kenny Whitlock Topics Include: Active, Passive, or Hybrid Purchaser; Medicaid/CHIP Integration; Regional or Statewide; Separate or Combined Individual/SHOP; Quality Health Plan Rating; Mitigating Adverse Selection; Premium Collections; and more.	Ambassador III

B. Exchange Data and Consumer Needs Ambassador IV
Facilitators: Darlene Byrd, D.N.P, A.P.N; Marquita Little
Topics Include: Criteria for Plan Rating; Claims and Other Data Monitoring, Analysis and Communication for informed Consumer Decision-Making and Performance Improvement; Outreach/Education; Role of Navigators and Licensed Brokers/Producers; Complaints Processing/Resolution; and more.

C. Exchange Governance Envoy
Facilitators: David Deere; Derrick Smith, J.D.
Topics Include: Federal, State or Federally-Facilitated Partnership; Structure of State Governance; Management of Plans; Administration of Plans; and more.

D. Exchange Legal Issues Consulate I-II
Facilitators: Craig Wilson, J.D.; Annabelle Imber Tuck, J.D.
Topics Include: Ongoing Federal Litigation; State vs. Federal authority to implement Exchanges; State-Federal Agreements of Partnership Model; Penalties for Individuals and Businesses; Financial Viability for Exchange Operations and Sustainability; Regulating the Insurance Market Inside and Outside the Exchange; and more.

3:45 p.m. Break Foyer

4:00 p.m. – 4:45 p.m. Forum Discussion Sessions – Two
REPEAT OF FORUM DISCUSSION SESSIONS – ONE

A. Exchange Business Model Ambassador III

B. Exchange Data and Consumer Needs Ambassador IV

C. Exchange Governance Envoy

D. Exchange Legal Issues Consulate I-II

4:45 p.m. Wrap-Up and Evaluation Ambassador

5:00 p.m. Adjourn

Questions? Comments? Suggestions?

Contact: Health Benefits Exchange Planning Project at the Arkansas Insurance Department

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Health Benefits Exchange Planning

www.hbe.arkansas.gov

A Health Benefits Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available health plan options based on price, benefits, services and quality. Under the Affordable Care Act of 2010, legal residents in every state will have access to a health benefits exchange effective January 1, 2014, where they can shop for and enroll in qualified health plans. If Arkansas does not have a U.S. Department of Health and Human Services (DHHS)-certified Exchange operating by January 1, 2014 (with enrollment beginning October 1, 2013), the federal government will operate an Exchange in Arkansas. If Arkansas does establish an Exchange, it must be self-sufficient by 2015. Insurance carrier fees would be critical to Exchange sustainability.

It is estimated that nearly a half-million Arkansans could be determined newly eligible for Medicaid, federal subsidies for private plan premiums, or other cost reductions through the Exchange. Individuals and families with incomes under 139% of the federal poverty level will be eligible for Medicaid; those with incomes between 139% and 400% of the federal poverty level may be eligible for advanced tax credits. Small businesses (50 or fewer employees, with a State option for 100 or fewer employees) will also be eligible to shop through the Exchange. This portion of the Exchange is called SHOP (Small business Health Options Program). Actuarial projections are that 211,000 Arkansas residents will enroll in private plans through the Health Benefits Exchange and 175,000 residents newly eligible for Medicaid will enroll in coverage through the Exchange in 2014. This is expected to halve the percentage of uninsured individuals in Arkansas, from 20% in 2013 to 10% in 2014.

An increased risk pool size and administrative efficiencies of scale are expected to give small businesses the same purchasing power that large businesses now enjoy. In 2016, a small employer will be defined as having <100 employees. In 2017 Arkansas could opt to allow large businesses to shop through the Exchange.

Entry to the Exchange is through a single, secure and integrated web-based eligibility and enrollment portal. Eligibility determinations will require secure data exchange between the Arkansas Exchange and an integrated DHHS, Homeland Security, Treasury, and Social Security portal. Most residents are expected to access the Exchange directly through the web-based portal; however, phone, mail, and walk-in services are also required. Each state is required to develop a Navigator program to assist potential enrollees through outreach, education, facilitating enrollment, and assistance with registering and resolving complaints. Licensed insurance brokers and producers will also be able to assist consumers in accessing tax credits or other cost reductions and enrolling in an Exchange plan. Tax credits and other cost reductions are available only for plans purchased on the Exchange.

Federal and state level leaders are committed to collaborative planning and partnerships to maximize resources and avoid duplication as we develop Arkansas's Exchange. We plan to design and implement shared, interoperable program and IT solutions. Public entities (Department of Information Services, Office of Health Information Technology, DHS/Medicaid, Arkansas Insurance Department, and the Exchange) will also work with private insurance carriers and other providers on Exchange Program-IT solutions. Current Exchange planning efforts are engaging key leaders in dialogue with consultants to identify existing technology, business requirements, planned improvements, gaps and recommend integrated solutions.

Arkansas Insurance Department is recipient of a one-year, one million dollar Health Benefits Exchange Planning Grant awarded by the U.S. Department of Health and Human Services (DHHS), Center for Medicaid and Medicare Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO). The planning goal is to design an integrated, efficient, and user-friendly Arkansas Exchange that is in compliance with federal and state law and provides consumer protections and choice of quality, affordable health plans. The ultimate goals are improved health outcomes, decreased uncompensated care, and decreased health-related financial risks for individuals and small businesses.

Five Core Functions of the Exchange

(CMS, September 19-20, 2011)

Consumer Assistance	Consumer support assistance; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Eligibility	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP eligibility applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
Enrollment	Enrollment of Consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost sharing reductions.
Financial Management	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

Health Benefits Exchange

A health benefits exchange is a way of organizing the health insurance marketplace that provides customers with easy comparisons of available plan options based on price, benefits, services, and quality. Exchanges in compliance with the Patient Protection and Affordable Care Act of 2010 are to include interactive, web-based services that allow individuals and small businesses to quickly compare, shop for, and enroll in a qualified health plan.

Required Duties for Exchanges

- Certification and Decertification of Qualified Health Plans that meet minimum standards and ensure “interests of consumers” are met
- Security and Privacy Protections of Personally Identifiable Data
- Toll Free Hotline
- Interactive Consumer-based Website
- Assign Price and Quality Ratings to Qualified Health Plans as established by the Secretary of DHHS
- Present Standard Benefit Plans in Standard Format, Understandable to Consumers
- Provide Information on Medicaid and CHIP Programs
- Determine & Manage Federal Tax Credits and Subsidies and provide a Calculator to Determine Actual Cost of Coverage and Benefits
- Establish a Navigator Program to Assist Consumers
- Conduct Outreach and Education Activities Separate from the Navigator Program
- Establish a Small Business Option (SHOP) through which Small Employers (< 50 employees; < 100 employees in 2016) may Access Coverage for their Employees
- Enroll Eligible Individuals into a Plan of their Choice
- Certify Individuals “Exempt from Individual Responsibility”
- Provide Information on Certain Individuals to the U.S. Treasury and Employers
- Provide Open Enrollment Periods
- Consult with Stakeholders
- Present Enrollee Satisfaction Survey Results
- Publish Data on Exchange Administrative costs
- Provide Data on Fraud, Waste, and Abuse
- Conduct Reinsurance and Risk Adjustment
- Administer the Federal “Essential Health Benefits” Package
- Track Premiums In and Out of the Exchange
- Establish a Consumer Assistance Function that includes a process for Appeals of Eligibility Determinations
- Evaluate Quality Improvement Strategies and Oversee Implementation of Enrollee Satisfaction Surveys, Assessments, and Ratings of Health Care and Quality Outcomes

Treasury Lays the Foundation to Deliver Tax Credits to Help Make Health Insurance Affordable for Middle-Class Americans

We are well on the way to implementing health reform and establishing Affordable Insurance Exchanges – one-stop marketplaces where consumers can choose a private health insurance plan that fits their health needs and have the same kind of insurance choices as members of Congress. The Treasury Department issued proposed regulations implementing the premium tax credit that gives middle-class Americans unprecedented tax benefits to make it easier for them to purchase affordable health insurance. Comments are due October 31, 2011.

The Premium Tax Credit:

- **Makes Coverage Affordable.** Millions of Americans will be given help to purchase private health coverage through an Affordable Insurance Exchange. To assist in making coverage affordable, the level of support is tailored to individuals' needs.
- **Provides a Substantial Benefit.** The Congressional Budget Office estimates that, when the Affordable Care Act is fully phased in, individuals receiving premium tax credits will get an average subsidy of over \$5,000 per year.
- **Builds on What is Best in the Existing Health Care System.** The Affordable Care Act includes crucial safeguards to ensure that the coverage purchased on an Affordable Insurance Exchange with the premium tax credits will supplement – not supersede – existing employer- and government-sponsored health programs (including TRICARE). This allows Americans to keep the coverage they have.

Key Facts about the Premium Tax Credit:

- **Broad Middle-Class Eligibility.** The premium tax credit is generally available to individuals and families with incomes between 100% and 400% of the federal poverty level (\$22,350 – \$89,400 for a family of four in 2011), providing a crucial safety net for the middle class. The Congressional Budget Office estimates that, when the Affordable Care Act is fully phased in, the premium tax credit will help 20 million Americans afford health insurance.
- **Larger Tax Credits for Older Americans who Face Higher Premiums.** The amount of the premium tax credit is tied to the amount of the premium, so that older Americans who face higher premiums will receive a greater credit.
- **Controls Health Care Costs by Incentivizing Families to Choose More Cost-Effective Coverage.** The amount of the premium tax credit is generally fixed based on a benchmark plan (which may be age-adjusted within Affordable Care Act limitations), so families that choose to purchase coverage that is less expensive than the benchmark plan will pay less towards the cost of that coverage.
- **Credit Is Refundable So Even Families with Modest Incomes Can Benefit.** The premium tax credit is fully refundable, so even moderate-income families who may have little federal income tax liability (but who may pay a higher share of their income towards payroll taxes and other taxes) can receive the full benefit of the credit.

- **Credit Is Advanceable to Help Families with Limited Cash-Flow.** Since many moderate-income families may not have sufficient cash on hand to pay the full premium upfront, an advance payment of the premium tax credit will be made by the Department of the Treasury directly to the insurance company. This advance payment will assist families to purchase the health insurance they need. Later, the advance payment will be reconciled against the amount of the family’s actual premium tax credit, as calculated on the family’s federal income tax return.

How the Premium Tax Credit Works

Eligibility

- Household income must be between 100% and 400% of the federal poverty level.
- Covered individuals must be enrolled in a “qualified health plan” through an Affordable Insurance Exchange.
- Covered individuals must be legally present in the United States and not incarcerated.
- Covered individuals must not be eligible for other qualifying coverage, such as Medicare, Medicaid, or affordable employer-sponsored coverage.

Credit Amount

- The credit amount is generally equal to the difference between the premium for the “benchmark plan” and the taxpayer’s “expected contribution.”
- The expected contribution is a specified percentage of the taxpayer’s household income. The percentage increases as income increases, from 2% of income for families at 100% of the federal poverty level (FPL) to 9.5% of income for families at 400% of FPL. (The actual amount a family pays for coverage will be less than the expected contribution if the family chooses a plan that is less expensive than the benchmark plan.)
- The benchmark plan is the second-lowest-cost plan that would cover the family at the “silver” level of coverage.
- The credit is capped at the premium for the plan the family chooses (so no one receives a credit that is larger than the amount they actually pay for their plan).

Special Rules

- The credit is advanceable, with advance payments made directly to the insurance company on the family’s behalf. The advance payments are then reconciled against the amount of the family’s actual premium tax credit, as calculated on the family’s federal income tax return. Any repayment due from the taxpayer is subject to a cap for taxpayers with incomes under 400% of FPL. The caps range from \$600 for married taxpayers (\$300 for single taxpayers) with household income under 200% of FPL to \$2,500 for married taxpayers (\$1,250 for single taxpayers) with household income above 300% but less than 400% of FPL.
- The proposed regulation provides that a taxpayer is not required to repay any portion of the advance payment if a family ends the year with household income below 100% of FPL after having received advance payments based on an initial Exchange determination of ineligibility for Medicaid.
- Tax credits are available to qualified individuals offered (but not enrolled in) employer-sponsored insurance if (a) it is “unaffordable” (meaning that the self-only premium exceeds 9.5% of household income); or (b) it does not provide a minimum value (meaning it fails to cover 60% of total allowed costs). We anticipate that future regulations will define minimum value in a way that preserves the existing system of employer-sponsored coverage, but that does not permit employers to avoid the statutory responsibility standards. We also are contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage. Future guidance will define minimum value in a way that preserves the existing system of employer-sponsored arrangements, which does not require employers to provide a specific package of health benefits, but that does not permit the employers to avoid responsibility standards. We are also contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage.
- Solely for purposes of applying the employer responsibility provisions, we anticipate that future guidance will provide a safe harbor permitting employers to base the affordability calculation on the wages they pay their employees instead of employees’ household income.

Premium Tax Credit Calculation: Three Examples

Example 1: Family of Four with Income of \$50,000, Purchases Benchmark Plan

The premium tax credit is generally set based on the benchmark plan. The family's expected contribution is a percentage of the family's household income.

- Income as a Percentage of FPL 224%
- Expected Family Contribution: \$3,570
- Premium for Benchmark Plan: \$9,000
- Premium Tax Credit: \$5,430 (\$9,000 - \$3,570)
- Premium for Plan Family Chooses: \$9,000
- Actual Family Contribution: \$3,570

Example 2: Family of Four with Income of \$50,000, Purchases Less Expensive Plan

If a family chooses a plan that is less expensive than the benchmark plan, the family will generally pay less, thereby creating an incentive to choose a less costly plan and reducing overall health care costs.

- Income as a Percentage of FPL 224%
- Expected Family Contribution: \$3,570
- Premium for Benchmark Plan: \$9,000
- Premium Tax Credit: \$5,430 (\$9,000 - \$3,570)
- Premium for Plan Family Chooses: \$7,500
- Actual Family Contribution: \$2,070 (\$7,500 - \$5,430)

Example 3: Family of Four with Income of \$50,000, Parents are between the ages of 55 and 64

Because premiums are generally higher for older individuals, the premium tax credit also is higher for these individuals.

- Income as a Percentage of FPL 224%
- Expected Family Contribution: \$3,570
- Premium for Benchmark Plan: \$14,000
- Premium Tax Credit: \$10,430 (\$14,000 - \$3,570)
- Premium for Plan Family Chooses: \$14,000
- Actual Family Contribution: \$3,570

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst for improving the health of Arkansans.

Will Employers Drop, Keep or Add Health Insurance in 2014?

❖ August 2011

A question on the minds of many U.S. and Arkansas businesses—which are currently providing health insurance to employees—is whether to drop this benefit after 2014 or to keep it? For small businesses not currently providing health insurance to their employees, the question is whether to start providing health insurance by using the new health benefits exchanges. This is an extremely important issue for both employers and employees, who will have to find their own insurance if it is not provided through an employer.

Over the past year there have been several studies by prominent research groups either surveying employers' sentiments about this decision or predicting how employers will make this decision based on sophisticated economic modeling. These studies, along with other research, suggest that there is not a simple answer to this question. Each Arkansas business will have to make a decision depending on its own unique circumstances. This Issue Brief discusses the surveys and predictive studies that have been published on this subject.

These studies—along with the real-world experience of how employers reacted in Massachusetts when similar new health laws were enacted in 2006—suggest that the overall availability of employer-sponsored insurance is not likely to change much after 2014.

■ BACKGROUND

Key parts of the new health care law take effect in 2014, including the requirement that businesses with over 50 full-time employees provide basic health insurance coverage to their employees. If they elect not to do so, they will face a penalty. The law, however, does not require firms with less than 50 full-time employees to provide health insurance to their employees.

Over 70 percent of Arkansas businesses have less than 50 full-time employees, so none of these businesses will be legally required to provide health insurance. Businesses with less than 25 full-time employees, however, are now eligible for tax credits if they do elect to provide health insurance. After January 1, 2014, for these firms to take advantage of the tax credits they will have to provide health insurance to employees by purchasing the health insurance in the health benefits exchange.ⁱ

■ Factors that Suggest Employers Will Drop Coverage

What are some of the factors that may lead employers who currently provide health insurance to drop coverage?

❖ **Low-Cost Penalty.** National reports have suggested that some large firms may opt to pay the penalty for not providing health insurance. Because the penalty is relatively low compared to providing health insurance to employees (about \$2,000-3,000 per employee with the first 30 employees exempt vs. an average cost of \$9,773 (in 2010) to employers to provide family coverage to an employee)ⁱⁱ the cost to the employer to provide health insurance may be far higher than the penalty amount.

❖ **Generous Help.** For individuals who decide to buy their health insurance in a health benefits exchange, the financial help from the federal government may be generous. Employers may decide that it is better to drop health care coverage for their low to middle-income employees and let them buy insurance in the exchange, where federal help is potentially available even for a family-of-four earning up to about \$80,000.ⁱⁱⁱ

❖ **Lack of Tax Credits.** Although businesses with less than 25 full-time employees may be eligible for tax credits, larger employers are not eligible for the credits under the new law. If such tax credits did exist, this would provide an incentive for employers with more than 25 full-time employees to keep coverage.

■ **Factors that Suggest Employers Will Keep or Add Coverage**

What are some of the factors that may lead employers who currently provide health insurance to keep coverage or for small employers who do not currently provide coverage to add it?

❖ **Competitors' Behavior.** Many employers will continue to provide health insurance or add it as a benefit because their employees expect it—especially high-wage, highly educated workers—and they risk losing good employees to competitors that continue to provide this benefit.

❖ **Tax Benefits.** Employer premium contributions are tax deductible for employers and employee contributions may be paid with pre-tax dollars. That tax benefit will go away for both if the business drops coverage. Also, if a firm drops coverage, it will likely have to raise employees' salaries to compensate for the lost benefit, and an increase in salary leads to an increase in Social Security and Medicare payroll taxes.

❖ **Nondiscrimination Rules.** Nondiscrimination rules will require that firms offer health benefits to all employees and firms use a variety of workers at different pay levels. When firms make decisions, the interests of high-wage workers tend to outweigh those of low-wage workers. Should an employer attempt to drop coverage, employees would be likely to strongly oppose such attempts and may move to competitors.

■ **NATIONAL STUDIES**

There have been several national studies recently that have tried to answer the question of whether employers will drop, continue or add health benefits after 2014. These studies can be broken into two methodological groups: (1) employer surveys; and (2) economic models predicting future employer behavior.

■ **Employer Surveys**

Mercer

In a November 2010 survey of 2,800 employers released by Mercer,^{iv} employers were asked how likely they were to stop providing health-care insurance after 2014. For the great majority, the answer was “not likely.”

These survey responses varied quite a bit by employer size, however. Large employers remained the most likely to continue providing health insurance. Just three percent of employers with over 10,000 employees said they planned to drop coverage and only six percent of employers with over 500 employees said they planned to end coverage. Among employers with 10-499 employees, however, 20 percent responded that they were likely to drop coverage, especially employers with low-wage workers and high turnover rates.

In August 2011, Mercer released a survey of 849 employers as follow-up to the 2010 survey. It noted that the employers' opinions on whether to drop health insurance coverage were essentially unchanged.^v

McKinsey

A June 2011 study released by McKinsey^{vi} of 1,329 employers (ranging from less than 20 employees to over 10,000 employees) stated that “30 percent of employers will definitely or probably stop offering employer sponsored insurance after 2014.” That thirty percent was composed of nine percent of employers who responded that they would “definitely” stop offering health insurance and twenty-one percent who said that they would “probably” stop offering health insurance.

Because McKinsey found that such a large percentage of employers would likely drop health care insurance, the report received widespread media coverage. Debate ensued about the methodology McKinsey used to reach this result. When McKinsey released its methodology, it noted that its study was indeed an employer survey and not predictive modeling like studies by the Congressional Budget Office, Urban Institute and RAND.

	Likelihood that Employer Will Stop Providing Health Insurance
Mercer	Employers (over 10,000 employees): 3% Employers (over 500 employees): 6% Employers (10-499): 20%
McKinsey	30% Of the 30%, 21% responded “probably” and 9% percent “definitely”

■ Predictive Models

In 2010 and 2011, the **Congressional Budget Office (CBO)**, **Urban Institute** and **RAND** conducted studies^{vii} aimed at predicting whether employer-sponsored health insurance will increase or decrease after 2014. These studies use sophisticated economic modeling—referred to as micro-simulation models—to predict how employers will react to the variety of provisions that may encourage or discourage employers to provide health insurance under the new health care law.

CBO and the Urban Institute models predicted very little change in the availability of employer-sponsored insurance after 2014. CBO predicted approximately a 2-3 percent drop in employer-sponsored plans, whereas the Urban Institute predicted no significant net change—a decline of less than one-half of one percent in employer sponsored plans.

The RAND study, however, predicted an 8.7 percent increase in the number of employers that would provide health insurance to employees by 2016. Its model predicted increased demand for health insurance from employees, due to the individual mandate and lower cost options for small businesses that may buy health insurance for employees by using the health benefits exchanges.^{viii}

	Estimated Net Change in Employer Sponsored Insurance
Congressional Budget Office	About 2-3% net decrease
RAND	About 8-9% net increase
Urban Institute	No significant net change

■ MASSACHUSETTS EXPERIENCE

Massachusetts and Utah are the only two states currently operating exchanges, but Utah’s exchange is open only to small businesses, not individuals.

Massachusetts’s system, similar to the one envisioned under the new health care law, arguably makes it cheaper for employers to drop coverage for employees—yet this has not happened in Massachusetts. Instead, the percentage of employers providing health insurance has remained about the same. For example, of non-elderly adults in

Massachusetts, 76 percent had employer-sponsored insurance in 2010. In 2009, 77 percent had insurance from their employer and 78 percent in 2008.^{ix} Overall, more than three-fourths of non-elderly residents of Massachusetts continue to get health insurance through their employer.

■ CONCLUSION

In sum, these studies—along with real-world experience of how employers reacted in Massachusetts—suggests that the overall availability of employer-sponsored insurance is not likely to change much after 2014.

The above review illustrates three important points.

First, the business decision about whether to continue, drop or add health insurance is not simple. A number of factors—not just the penalty calculation—go into the mix. Factors such as tax credits, the income level of workers, tax deductions, competitors' behavior, and nondiscrimination rules are also important components in the decision. For each Arkansas business, the decision will depend on the specific factors that apply to that particular company.

Second, at the national level, the evidence from the employer surveys and microsimulation model studies is mixed as to how firms will react. The surveys by Mercer (especially for small employers) and McKinsey suggest a larger drop-off in the availability of employer-sponsored health insurance than the predictive models run by CBO, Urban Institute and RAND. Indeed, RAND's model predicts a significant increase in the number of employers who will provide health insurance.

Third, Massachusetts serves as a real-world example in which employer-sponsored insurance has not significantly changed after Massachusetts implemented changes similar to those called for in the new law.

In sum, these studies—along with the real-world experience of how employers reacted in Massachusetts—suggests that the overall availability of employer-sponsored insurance is not likely to change much after 2014.

Note: Information shared in this overview is based on the law, interim rules and regulations as they are known at this time, and is ACHI's best interpretation of the information. As the law continues to be written into final rules and regulations, it will be further interpreted. Details may change during this process.

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Endnotes

ⁱ For a discussion of the impact of the Affordable Care Act on Arkansas's businesses, see Arkansas Center for Health Improvement Issue Brief, *Effects of Health Reform on Arkansas Businesses* (July 2010).

ⁱⁱ Affordable Care Act, Sections 1513 and 10106. Kaiser Family Foundation, *Employer Health Benefits 2010 Summary of Findings* <http://ehbs.kff.org/pdf/2010/8086.pdf>.

ⁱⁱⁱ Affordable Care Act, Section 1402.

^{iv} Fewer employers planning to drop health plans after reform in place, survey finds. <http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place>. Accessed July 29, 2011.

^v US employer health enrollment up 2% under PPACA's dependant eligibility rule. <http://www.mercer.com/press-releases/1421820>. Accessed August 3, 2011.

^{vi} Employer Survey on US Healthcare Reform. http://www.mckinsey.com/us_employer_healthcare_survey.aspx. Accessed July 29, 2011.

^{vii} Congressional Budget Office, *Score of the Patient Protection Affordable Care Act*, March 20, 2010; Urban Institute, Bowen Garrett and Matthew Buettgens, *Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature* (January 2011); RAND Corporation, Christine Eibner and others, *Establishing State Health Insurance Exchanges* (2010).

^{viii} For a discussion of these studies and other studies, see Avalere, *The Affordable Care Act's Impact on Employer Sponsored Insurance: A Look at the Micro-simulation Models and Other Analyses* (June 17, 2011).

^{ix} *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys* (December 2010).

Featured Speakers

Joel Ario

Joel Ario has devoted his entire 30-year professional career to shaping and implementing public policy, primarily in the areas of health reform and consumer rights. After 13 years in the non-profit sector, Ario served for a decade as Insurance Commissioner in Oregon and Pennsylvania, and most recently led efforts to implement key provisions of President Obama's health reform initiative at the U.S. Department of Health and Human Services (HHS).

From August 2010 to September 2011, Ario was the Administration's point person for standing up health insurance exchanges - the competitive Web-based marketplaces that will modernize the way Americans purchase health insurance and move the country toward universal coverage by making health care more accessible and affordable for millions of uninsured citizens. The Affordable Care Act gives each state the right to establish an exchange by 2014, and charges HHS with running exchanges in states that fail to establish their own exchange.

Prior to his federal service as Director of the Office of Insurance Exchanges, Ario was Pennsylvania Insurance Commissioner from 2007 to 2010, with responsibility for overseeing the state's \$85 billion insurance industry. In this capacity, Joel blocked a merger of the state's two largest health insurers as harmful to competition, collaborated with state and federal regulators to protect AIG policyholders when the company was financially distressed, and streamlined the department's consumer protection program. Ario also served as Oregon Insurance Administrator from 2000 to 2007, was elected three times by his fellow commissioners to serve as an officer in the National Association of Insurance Commissioners (NAIC), and was President of the National Insurance Producer Registry (NIPR) from 2002-2004.

Ario's regulatory career was marked by collaborative approaches that ensured consumer safeguards were in place and that enhanced the flexibility insurers needed to thrive in a fast-changing marketplace. Within the insurance and agent communities, Ario won high marks for carefully balancing regulatory concerns with the needs of consumers, and was widely respected as a fair and open-minded regulator.

Ario came to state insurance regulation in 1994 with a 13-year history of championing consumer rights with the Public Interest Research Groups (PIRGs), a network of state-based research and advocacy organizations. Ario was Executive Director of the Oregon PIRG from 1987 to 1994, and founded the Wisconsin PIRG in 1986.

Ario is a graduate of St. Olaf College (B.A. 1975), Harvard Divinity School (M.Div. 1978) and Harvard Law School (J.D. 1981). He is a Minnesota native, is married to Diana Myrvang with three sons, and lives in Hershey, PA. He serves as an elder at Derry Presbyterian Church, enjoys golf and hiking in the national parks, and is an amateur family historian and a professional C-Span junkie.

Jay Bradford

Jay Bradford was appointed Arkansas Insurance Commissioner on January 15, 2009, by Governor Mike Beebe. Bradford brings to the Department more than four decades of experience in the insurance industry, including thirty years as founder, chairman, and former shareholder of First Arkansas Insurance Group, a statewide network of independent property and casualty agencies. Customer service and consumer protection have been hallmarks of his career.

Prior to his appointment, Commissioner Bradford served for two years as the Director of the Division of Behavioral Health Services within the Arkansas Department of Human Services.

Commissioner Bradford served in the Arkansas Legislature for twenty-four years where he was chosen both Speaker Pro Tempore of the House and President Pro Tempore of the Senate. He also served as Chair of the Public Health, Welfare and Labor Committee in both bodies.

Some of the highlights of his service in the Arkansas Legislature include serving as chief sponsor of the Tobacco Settlement Funding Bill, legislation which resulted in Arkansas being the only state in the nation to mandate all the settlement monies be used for healthcare. He also served as lead Senate sponsor of breast care legislation which resulted in millions of dollars being made available for the prevention and treatment of breast cancer.

He has achieved numerous honors and awards during his service to the citizens of Arkansas, including the 2006 Arkansas Business Executive of the Year and the 2005 Libertarian of the Year from the American Civil Liberties Union. He is active in various community and political affairs. In 2011, Commissioner Bradford was named to the Arkansas Business Power List and was appointed to the Board of Directors of the National Alliance Research Academy.

A graduate of Subiaco Academy, Commissioner Bradford holds a Bachelor of Arts degree in Economics and

Psychology from Henderson State College and has also been recognized as a Distinguished Alumnus of that institution, now known as Henderson State University. He is a Certified Insurance Counselor (C.I.C.) and holds an Honorary Doctor of Science from the University of Arkansas for Medical Sciences.

Joseph Thompson

Dr. Joe Thompson's work is centered at the intersection of clinical care, public health and health policy. He is responsible for developing health policy, research activities and collaborative programs that promote better health and health care in Arkansas. Dr. Thompson works closely with the Governor's office, the Arkansas legislature and public and private organizations across the state on relevant health policy topics. Nationally, as Director of the Robert Wood Johnson Foundation (RWJF) Center to Prevent Childhood Obesity, he is leading a strategic partnership with PolicyLink that serves as the linchpin of RWJF's strategy to reverse the epidemic of childhood obesity by 2015.

Dr. Thompson has led vanguard efforts in planning and implementing health care financing reform, tobacco- and obesity-related health promotion and disease prevention programs. He was the lead architect of the Tobacco Settlement Act of 2000, at the forefront of Arkansas's nation-leading efforts against childhood obesity and instituted the Arkansas Health Insurance Roundtable. Under his leadership, ACHI helped pass the Clean Indoor Air Act of 2006, documented the state's success in halting progress of the childhood obesity epidemic, and helped implement ARHealthNetworks, Arkansas's health care benefits waiver for low-income workers.

He currently serves on the Arkansas Board of Health and is past President of the Arkansas Chapter of the American Academy of Pediatrics. Nationally, Dr. Thompson serves on the board of AcademyHealth and on the Health Care Financing and Organization National Advisory Panel. He is author of numerous articles and publications that reflect his research interests in the areas of health and health care including access, quality and finance.

Dr. Thompson earned his medical degree from the University of Arkansas for Medical Sciences and Master of Public Health from the University of North Carolina at Chapel Hill. He served as a RWJF Clinical Scholar at the University of North Carolina at Chapel Hill, the Luther Terry Fellow in Preventive Medicine advising the U.S. Assistant Secretary of Health in Washington, DC, and the Assistant Vice President and Director of Research at the National Committee for Quality Assurance in Washington, DC. In 1997, he served as the First Child and Adolescent Health Scholar of the U.S. Agency for Healthcare Research and Quality (then the U.S. Agency for Health Care Policy and Research) before returning to Arkansas.

Fred Bean

Fred entered the insurance industry in February of 1974. Among the positions he has held and honors received are: National Industry Service: He has previously served on the national board of LIFE and the Life and Health Insurance Foundation for Education in Washington D.C. He is the Past National President of the Association of Health Insurance Advisors in Washington D.C. and past member of the Board of Trustees of the National Association of Insurance and Financial Advisors. Arkansas Industry Service: Past president of Arkansas State Association of Life Underwriters, the National Association of Insurance and Financial Advisors. Named the Outstanding Insurance Agent in Arkansas by his peers. Served as NAIFA-Arkansas's liaison to the Arkansas Department of Insurance, on several advisory committees regarding both the revision of current insurance regulations and development of new industry regulation. Fred is not only known as a leader in the insurance industry in Arkansas but across the nation as well. He has spoken on various industry topics at state meetings from coast-to-coast as well as several national conferences. Active in his community, he is a past President of the Riverside Rotary Club, a Paul Harris Fellow of the Rotary International Foundation and the recipient of the Silver Beaver Award from the Boy Scouts of America.

Ron Boyeskie

Ron Boyeskie is Vice President of CBM Construction Co., Inc. in Little Rock, Arkansas. He graduated from England High School and the University of Central Arkansas. Ron has been in construction management for 36 years. He is a Past President of the Rotary Club of Little Rock. Ron has also served on the Boy Scouts of America Executive Board and a Past President of the Centers for Youth and Families.

Elisabeth Wright Burak

Elisabeth Wright Burak serves as Director of Health Policy and Legislative Affairs, Arkansas Advocates for Children & Families. She has more than a decade of experience in public policy at the national and state levels. Elisabeth joined Arkansas Advocates for Children and Families in 2008, where she oversees health policy and legislative affairs efforts. Elisabeth previously served as Director of Policy and Planning for the Arkansas Department of Human Services, where she created and led a central office dedicated to improving and connecting policy decisions across the department, from Medicaid and behavioral health to early childhood education and child welfare. She gained national- and state-level policy experience on a range of children's issues at the National Governors Association (NGA) Center for Best Practices and The Finance Project in Washington, D.C. A native Arkansan, Elisabeth received Master of Public Policy (MPP) and Master of Social Work (MSW) degrees from the University of Michigan and a BA in Social Psychology from Smith College. Elisabeth lives in Little Rock with her husband Joe, daughter Maddie, and two very large dogs. In coming months, Elisabeth will move to Washington D.C where she will serve as a senior program director at Georgetown Center for Children and Families.

Darlene Byrd

Darlene Byrd, D.N.P., has 22 years experience in the nursing profession, including 14 years as an Advanced Practice Nurse. She received a Bachelor of Arts from Ouachita Baptist University, and a Bachelor of Science in Nursing and Master of Nursing Sciences from the University of Arkansas for Medical Sciences. She recently completed her Doctorate in Nursing Practice from the University of Tennessee Health Science Center, and was inducted as a Fellow with the American Academy of Nurse Practitioners.

Her nursing experience includes surgical/trauma and cardiac critical care, home health and nursing research. As an Advanced Practice Nurse she holds national certification as a Family Nurse Practitioner from the American Nurses Credentialing Center and began her practice at Cabot Medical Clinic. Currently she is the owner and president of APN HealthCare.

Throughout her nursing career, she has worked extensively in health policy. Dr. Byrd served eight years as the APN representative on the Arkansas State Board of Nursing (ASBN), having served as vice-president and president. As a board of nursing member, she was appointed by the National Council of State Boards of Nursing Board of Directors to their APRN Committee. She had a leading role in developing APRN model statutory language and rules from the APRN Consensus model. Aside from nursing regulation, Dr. Byrd has served for 4 years on the National Advisory Committee for Rural Health and Human Services, having been appointed by Health and Human Services Secretary Michael Leavitt. She has provided testimony on various issues before the Public Health, Welfare and Labor Committee and the Joint Performance Review Legislative Committees.

She remains active in several professional organizations including, the American Nurses Association, Arkansas Nurses Association, The American College of Nurse Practitioners, the American Academy of Nurse Practitioners and Sigma Theta Tau International.

Ed Choate

Ed Choate joined Delta Dental of AR as President and Chief Executive Officer in July 2000. Prior to joining Delta Dental, he worked for 20 years in the managed healthcare industry in leadership roles at NovaSys Health, HealthScope Benefits, and Arkansas Blue Cross Blue Shield.

Ed was named the 2006 Arkansas Business Executive of the Year and was named a Distinguished Alumni at Southern Arkansas University in 2007.

Choate serves as chairman of the national Delta Dental Plans Association board of directors and its Executive Committee. He is also a board member of Baptist Health, Fifty for the Future, Arkansas Baptist College and the Arkansas State Chamber of Commerce.

Choate obtained a BBA from Southern Arkansas University (SAU) in 1975 and a BSE from SAU in 1977. He and his wife, Marilyn, have been married 34 years, have two children and live in Conway.

Cynthia C. Crone

Cynthia (Cindy) Crone is Health Benefits Exchange Planning Director at Arkansas Insurance Department. A licensed and certified nurse practitioner, Cindy has more than thirty years' experience advocating collaborative, effective solutions to public health issues affecting vulnerable populations. She has been recognized locally and nationally for leadership in innovative, effective program development and sustainability. She is a graduate of the University of Arkansas for Medical Sciences College of Nursing and Graduate School, and is an alumnus of the Robert Wood Johnson Foundation Executive Nurse Fellowship program, designed to prepare leaders to change the future health care system. She came to the AID in December 2010 from the University of Arkansas for Medical Sciences' Partners for Inclusive Communities where she was director of Family Treatment Consultation. Prior to that she was founding executive director of UAMS Arkansas CARES, a nationally recognized integrated treatment program for pregnant and parenting addicted women and their children and families. Crone and her husband of thirty-six years have one adult son.

David Deere

David Deere, M.S.W., M.Th., is the director of Partners for Inclusive Communities, a University Center for Excellence in Developmental Disabilities at University of Arkansas for Medical Sciences. He conducted a series of community meetings about the Health Benefits Exchange earlier this year and serves as a member of the steering committee for exchange planning. He is also a retired United Methodist minister.

Eugene I. Gessow

Eugene (Gene) Gessow has served as a Director of Medical Services in three states: Maine, Iowa, and, since 2010, Arkansas. Mr. Gessow worked in Iowa for six years, first as the Medicaid Director and then as the Director of the Department of Human Services. He held the position of Director of the Bureau of Medical Services in Maine from 2000 - 2003.

Mr. Gessow has a Master's degree in Public Administration from Harvard, a Master's degree in Law from New York University, a Juris Doctor degree from the University of Denver and a Bachelor's degree in Economics from the University of Wisconsin.

Debbie Hopkins

Debbie Hopkins recently joined Arkansas Foundation for Medical Care where she serves as a Governmental Affairs expert. She retired after 34 years of leadership experience with the Arkansas Department of Human Services (DHS), including extensive experience with federal grant programs. Her most recent role with DHS was as the Assistant Director for the Division of Medical Services, the Medicaid agency for Arkansas. Her primary responsibilities included administration of the Medicaid Management Information System (MMIS) including procurement, monitoring performance of the contracted fiscal agent, reporting, data security, communication with the Centers for Medicare and Medicaid Services (CMS), and development and administration of Advance Planning Documents with CMS. She also administered the Medicaid waiver quality assurance program and the Division's policy and program development section including maintenance of the Medicaid State Plan.

Barry Hyde

Representative Barry Hyde is currently in his third term in office as a member of the Arkansas House of Representatives serving North Little Rock and Sherwood (District 40). He is a voting member of thirteen committees in the House and chairman of five of these committees. Representative Hyde represents Arkansas on four different national committees working on matters of insurance and economic development. He has been a proud resident of the North Little Rock, Sherwood and Jacksonville area for the past 35 years and is the CEO of Hydco, Inc., a commercial construction company that he opened in this community 24 years ago. He has three grown children, son Jeremy and daughters Jaime and Carrie. He and his wife Jeanne have five grandchildren and are members of the Immaculate Conception Catholic Church in North Little Rock.

Joni Jones

Joni Jones was appointed to the position of Director of the DHS Division of County Operations in December 2001. A Little Rock native, Joni has worked for the Department of Human Services since 1978. In her thirty-four years with DHS, she has served as the Administrator of the Research and Statistics Unit, the Administrator of the Corrective Action Unit, the Senior Assistant Director for the Division of Economic and Medical Services, and both Deputy Director and Director of the Division of County Operations. Her Division has been re-engineering the consumer access portals and eligibility processes for the core public assistance programs (Medicaid, SNAP and TANF) by converting to electronic case records and implementing the Access Arkansas Website. The agency recently opened the Access Arkansas Processing Center in Batesville, a state-of-the-art center for high-volume case processing.

Cal Kellogg

Cal Kellogg, Ph.D. is Senior Vice President and Chief Strategy Officer for Arkansas Blue Cross Blue Shield. His responsibilities include strategic planning, human resources, leadership and executive development, and process improvement activities. His recent focus has been on health care reform and its strategic implications for the industry.

Cal has a Ph.D. in Business Administration from the University of Arkansas-Fayetteville. Prior to joining ABCBS in 1995, he was the Chairman of the Department of Management and Associate Dean of the College of Business Administration at the University of Arkansas at Little Rock. He also served as the Assistant Dean for Undergraduate Students at the School of Business at the University of Mississippi and was a faculty member at Illinois State University and Arkansas Tech University. He is the former chairman of the board for the Governor's Quality Award. He also serves on the Advisory Board for the UALR College of Business Executive Summit, and is a member of the Sam M. Walton College of Business Center for Executive Education Advisory Board.

Drew Kumpuris

Andrew G. Kumpuris, M.D. is in the practice of clinical cardiology in Little Rock, Arkansas. Over the last several years he has served as Medical Director of the CCU and Step-Down Units at St. Vincent Infirmiry Medical Center, Director of Cardiology at Doctor's Hospital, and Director of Quality Assurance at St. Vincent Medical Center. Dr. Kumpuris is an honor graduate of Baylor College of Medicine where he completed his internship and residency and served as Chief Medical Resident. He also completed a cardiology fellowship in 1978, served as Assistant Professor of Medicine at Baylor, and was affiliated with the Methodist Hospital in Houston, Texas. Dr. Kumpuris is a fellow in the American College of Cardiology, American College of Physicians, The Society of Cardiac Angiography, and the American Society of Cardiovascular Interventionists. He served on the Health Care Advisory Board for President Clinton's Health Care Reform Task Force and as the Chairman of the Governor's Task Force for Health Care Reform in Arkansas. For Governors Tucker and Huckabee, Dr. Kumpuris chaired the Arkansas State Employee/Public School Personnel Insurance Board. In 2001 and 2002 he moved to Washington DC where he completed a Health Care Policy Fellowship sponsored by the Robert Wood Johnson Foundation and the Institute of Medicine (National Academy of Science). While in Washington, he served as Legislative Assistant for Health Policy with Senator James M. Jeffords (I-VT) and as Liaison with the U.S. Senate Finance Committee and Health, Education, Labor, and Pensions Committee. In September of 2002 he returned to Little Rock where he resumed his practice in clinical cardiology. Dr. Kumpuris currently serves on the Health Policy Board for the Arkansas Center for Health Improvement, is an Adjunct Professor of Health Policy at the Clinton School of Public Service and sits on the State and Public School Life and Health Insurance Board at the invitation of the Governor of Arkansas.

Randy Lee

Randy Lee is the Director of the Center for Local Public Health with the AR Department of Health. He began his public health career as a Public Health Nurse in 1978. During his career with ADH, he has served as Nursing Supervisor and Area Manager for Area V in Southwest Arkansas. Randy was the Regional Director for Southwest Region until 2004, when he became the Director of Public Health Regions, with responsibility for the oversight of the state's 94 local health unit operations in 75 counties. In 2006, Randy became the Director of the Center for Local Public Health. His Center is responsible for the clinical, environmental, in-home, and community services throughout the state.

Marquita Little

Marquita Little serves as the Senior Policy Analyst for the Arkansas Department of Human Services (DHS) and helps to coordinate the policy agenda for DHS. Little is responsible for facilitating cross divisional projects, improving data utilization, anticipating program/policy changes, and providing leadership on several child health policy projects. Little also serves on the DHS Health Care Reform Team and facilitates the activities of the Medicaid Expansion work group, in addition to serving on the Health Benefits Exchange State Agency Workgroup. Little has several years of experience in behavioral health services policy analysis and research, and program evaluation in the nonprofit and public sectors. This includes working as a program evaluation consultant to the Arkansas Minority Health Commission and coordinating with the Governor's Task Force on Best Practices for Afterschool and Summer Programs to research afterschool programs throughout Arkansas.

Little earned a Master of Public Service degree from the University of Arkansas Clinton School of Public Service and a B.A. in Psychology from Hendrix College.

Creshelle R. Nash

Dr. Nash is a native of Texarkana, Arkansas. She graduated from Hall High School and received a J.R. Hyde full scholarship to Rhodes College in Memphis, TN. She then attended the University of Maryland at Baltimore School of Medicine. At that time she began her interest in community medicine and minority health. During her training she also achieved a W.K. Kellogg Fellowship in Community Medicine. She received her medical degree in 1994, and completed a residency in primary care internal medicine at George Washington University Hospital, Washington, D.C., in 1997. She also received a Master's in Public Health from Harvard School of Public Health and was a Harvard University Commonwealth Fund Fellow in Minority Health Policy in 1997-1998. Upon completion of her fellowship she returned to Arkansas to address minority health policy.

Dr. Nash continues her work in minority health policy, research and clinical practice. She has been increasing awareness about public health policy and racial and ethnic health disparities within the state of Arkansas. She co-authored the Arkansas Racial and Ethnic Health Disparity Study that served to define the state of minority health and make policy recommendations to eliminate health disparities. In addition to conducting research on health disparities in Arkansas, Dr. Nash helped to develop and was inaugural faculty of both the UAMS College of Public Health and the UA Clinton School of Public Service. She serves as Assistant Professor, Health Policy and Management. Dr. Nash is currently working with multiple minority health disparity initiatives at the institutional, local and state levels. These include consulting with the Arkansas Minority Health Commission, community based organizations in the Arkansas Delta and within UAMS. She continues her clinical practice, teaching and mentoring activities as Assistant Professor of General Internal Medicine at UAMS.

Lars Powell

Dr. Lars Powell holds the Whitbeck-Beyer Chair of Insurance and Financial Services at the University of Arkansas at Little Rock. He earned a Ph.D. in Risk Management and Insurance from the University of Georgia. His primary research interests include insurer capitalization and the effects of regulation on insurance markets. He provides economic legislation and litigation services to private and public entities. Before pursuing an academic career, Lars worked as an insurance agent and a medical malpractice claims adjuster.

Herb Sanderson

Herb Sanderson is Associate State Director of Advocacy for AARP Arkansas. From 1974 to 1977, Mr. Sanderson worked for the Maternal and Child Health Division of the Arkansas Department of Health. From 1977 to 1984, he was employed as Executive Director of the East Arkansas Area Agency on Aging. In 1984 Governor Bill Clinton appointed Mr. Sanderson head of the Arkansas Division of Aging and Adult Services. He held this position under Governors Jim Guy Tucker, Mike Huckabee and Mike Beebe until 2008 when he assumed his current position.

The Division of Aging and Adult Services received the Council of State Governments Innovations Award and the American Public Human Services Association Innovations in State Human Services Award under Mr. Sanderson's leadership. He was a Presidential appointee to the Policy Committee of the 1995 White House Conference on Aging. Mr. Sanderson also served on the Robert Wood Johnson Foundation Community Partnership National Advisory

Committee and was a Fellow in the University of Minnesota's School of Public Health Balancing Long Term Care program.

Mr. Sanderson holds a B.A. in Political Science from Arkansas State University (1972) and a Master of Public Administration from the University of Arkansas at Fayetteville (1974). He holds a certificate in Long Term Care for the Elderly from the University of Southern California.

He is married to Denise Gilliam, Ph.D. They have two children.

Derrick Smith

Derrick Smith, J.D., is an attorney at Mitchell Williams Law Firm in Little Rock, Arkansas. He received his B.A. with Distinction from Hendrix College in 1997 and his J.D. with Honors from the University of Arkansas at Little Rock William H. Bowen School of Law in 2000. Mr. Smith was admitted to practice in Arkansas in 2000 and in District of Columbia in 2006. In 2007 he was admitted to practice before United States Supreme Court.

Mr. Smith provides legal and counseling services on insurance issues and regulatory matters in Arkansas and nationwide, including insurance company formations, admissions, product filings, mergers and acquisitions and producer and other insurance-related entity licensing. He has represented insurance companies, trade associations, and other business entities before administrative agencies, the state legislature, and in preparing and coordinating legislation. He has represented clients before state and federal appellate courts. Prior experience including service as a law clerk to the Honorable Olly Neal, Arkansas Court of Appeals, 2000-2001.

David Sodergren

David Sodergren is a certified Project Management Professional (PMP) for First Data Government Solutions, LP. He has over 16 years of extensive experience with public sector business solutions. This experience includes leading multiple business-driven, transformational initiatives within state government agencies including Enterprise IT Services, Revenue/Tax, Unemployment Insurance/Workforce Development, Human Services (TANF, SNAP, Services), Medicaid, and Insurance Exchange Planning. His leadership expertise includes managing complex, multi-team, multi-phased efforts with a focus on change management including strategic planning, business process analysis and redesign, and incorporation of automation to increase operational efficiencies in modernization efforts.

Annabelle Imber Tuck

Justice Imber Tuck serves as a Supreme Court representative to the Arkansas Access to Justice Commission. She replaced Professor Chuck Goldner in 2010 as Chair of the Commission.

Justice Imber Tuck's contributions to the bench and bar began in 1977 when she graduated from the University of Arkansas at Little Rock School of Law. She practiced law in Little Rock, eventually becoming a partner in the Wright, Lindsey & Jennings law firm. In 1984, then-Governor Bill Clinton appointed her to serve as circuit judge for the Fifth Division of the Sixth Judicial District. Later, Justice Imber Tuck was elected chancery judge for the Sixth Division of the Sixth Judicial District, where she served from 1989 to 1996. It was during this time that Justice Imber Tuck presided over the Lake View case and declared that the public-school financing system then in effect violated the equal protection and education provisions of the Arkansas Constitution. In 1997, Justice Imber Tuck became the first woman elected to the Supreme Court of Arkansas where she served until her retirement at the end of 2009.

John Wayne

John B. Wayne, Ph.D., Professor of Health Policy and Management, has been a member of the Masters of Health Services Administration faculty since 1988 and a member of UAMS College of Public Health faculty since 2001. He teaches in the areas of health care finance, health information systems, health economics, and management/leadership skills.

Dr. Wayne's current research focuses on the effectiveness of public health systems, improving the public health infrastructure, disaster preparedness, evaluation of health services delivery, rural health, and the prevention of unhealthy behaviors. Previous research was centered on the economic impact of specific illnesses.

During his career Dr. Wayne has provided extensive university, professional, and public service. He helped plan the UAMS College of Public Health and served as the interim-chair of the Health Policy and Management Department

during its formation. His professional activities include leadership positions in the American Public Health Association and the Association of University Programs in Health Services Administration.

Prior to moving to Arkansas, Dr. Wayne was a faculty member for eleven years in the Department of Health Care Organization and Policy, in the College of Public Health, at the University of Alabama at Birmingham. His academic preparation includes an undergraduate degree in Electrical Engineering, an MBA degree from the University of Florida, and a doctoral degree in administration of health services from UAB.

Kenny Whitlock

Kenny's human services career has spanned four decades beginning in 1969 as a caseworker in the Clark County Social Services Office and concluding in the Spring of 2008 as Executive Vice President of the Mental Health Council of Arkansas. Kenny's achievements during his career at the Arkansas Social Services and the Human Services Departments are considered outstanding and were recognized by the Mental Health Council with a President's award. In 1995 he took his leadership and solid experience to the Mental Health Council as Executive Vice President. Now retired, Whitlock is a co-chair of the Revenue Coalition Committee for the Arkansas Advocates for Children and Families organization. He also serves on the Arkansas Health Benefits Exchange Steering Committee.

Craig Wilson

Mr. Wilson is a policy analyst for the Arkansas Center for Health Improvement (ACHI), a health policy organization that serves as a catalyst for collaboration and innovation, with the ultimate goal of improving the overall health of Arkansans. In his role, he focuses on governmental relations as well as the legal and policy implications of health care reform. Previously, Mr. Wilson practiced health care law at the Mitchell Blackstone law firm in Little Rock, where he focused on Medicaid fraud and provider payment issues, whistleblower law and governmental relations.

Arthur B. Wolover

Arthur B. Wolover, CRNA, has been in clinical practice and nurse anesthetist education for 29 years. He began his career in La Crosse, Wisconsin, at Gundersen Lutheran Medical Center, where he practiced for 10 years, serving as the clinical coordinator for the St. Francis School of Anesthesia student nurse anesthesia cardiovascular and neurosurgery rotation. The next eleven years were spent at Mercy Medical Center North Iowa in Mason City. For the past eight years he has been employed by Jonesboro Anesthesia Inc., practicing at St. Bernards Medical Center, where he is the Chief CRNA and is a clinical instructor for the Arkansas State University Nurse Anesthesia Program. Wolover has held elected positions on boards of directors and as an officer in the Wisconsin, Iowa, and Arkansas Association of Nurse Anesthetists, for which he is currently serving as president.

