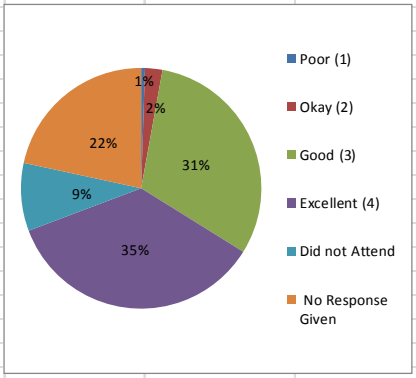
Arkansas Health Benefits Exchange Planning Summit Evaluation Results

ARKANSAS HEALTH BENEFITS EXCHANGE OCTOBER 11, 2011 SUMMIT EVALUATION RESULTS

Forums	Poor (1)	Okay (2)	Good (3)	Excellent (4)	Did not attend	No Response Given		TOTAL
Health Benefits Exc. 101			9	14	6	3		32
HBE: An Arkansas Prospective			9	22	1			32
Next Steps with Exchanges		1	14	16		1		32
Exchange Planning Research	1	5	15	10		1		32
How will the HBE operate in Arkansas		1	18	12	1			32
How will the HBE meet Consumer Needs	1		15	14	1	1		32
Exchange Business Model			5	2	7	18		32
Exchange Data and Consumer Needs			4	11	6	11		32
Exchange Governance		1	5	3	6	17		32
Exchange Legal Issues			4	4	7	17		32
Lunch and Refreshments			14	13		5		32
Overall Rating		1	7	15		9		32
Total	**2**	**9**	**119**	**136**	**35**	**83**		**384**



SYNOPSIS OF EVALUATION COMMENTS

There were Thirty-two Summit Evaluations returned to the Exchange Planning Committee. Twenty-six of the evaluations included comments that are summarized as follows: Twenty-five out of twenty-six comments indicated that the Summit was very informative. Five of the comments indicated an interest in holding more Summits across the state as additional information becomes available. One comment was made that a Pro and Con Fact Sheet is needed to show the consequences of a Federal Exchange versus a State Exchange. One comment suggested that it may be beneficial to make Arkansans aware that the mandate does not apply to those already insured. One comment indicated that some of the remarks made by Legislators to the Speakers were rude and unwarranted. One comment suggested that more consideration should be given for those who are hearing impaired and that the microphones were not adequate. One comment suggested the room temperature was too cold. One comment indicated that the time frames were not followed and felt the summit was poorly run.

Arkansas Health Benefits Exchange Planning

Stakeholder Summit Forum Discussion Summaries

October 11, 2011

I. Exchange Business Model-(Arthur Wolover and Kenny Whitlock)

SESSION I

- More than a clearinghouse
- Are decisions between provider and patient
- Manageable number of Insurers (Exchange not open to all to sell)
- Insurers sell to entire state
- Multiple providers offering multiple plans
- Quality Network/Drugs In Formulary
- Keep it Simple
- SHOP-Price Consideration, Flexibility, Choice

SESSION II

- Passive Exchange with as much competition as possible
- Navigator Role in choosing options available
- Medicaid Tie-In
- Statewide Coverage

II. Exchange Data and Consumer Needs –(Darlene Byrd and Marquita Little)

A. Navigators
   1. Well educated/trained with standardized curriculum/no college required/ Web-based learning/competency assessment /If insurance agent, should be independent
   2. There should be standards on number of Navigators and availability of Navigators
   3. Diverse/representative of consumers

4. Unbiased; Define choices, not influence
5. Well connected
6. Licensed or certified, with ongoing re-certification and (every two years) continuing education to keep up with changes and trends – look at certification requirements for "65 and over products"
7. Restriction on number of carriers an agent can be licensed with?
8. Good communication skills
9. Consistent messaging and information→standardized presentation
10. Professional
11. Multi-level system: Outreach/promotion only or licensed; availability of both
12. Knowledge of plans and QHPs, and requirements to be in Exchange
13. Community-based organizations
14. Trusted sources, local
15. Timely-readily available
16. Look to Medicare protocols (solicitation rules, educational tools, etc.)
17. Determine mechanism for information delivery for general information vs. customer specific
18. Call Centers with Information on local Navigators—can be referred from call center
19. All media (postage, TV, etc.)
20. "No secret shoppers"

B. <u>Data and Consumer Needs</u>
1. Reach consumers through internet, social media, churches, radio, TV, Community Health Centers, Local Health Units (push/pull), Call Centers (24 hour; mostly automated with few IVR prompts)
2. Easily Navigated Hotline (succinct, simple, short wait time, "Americans" answer, etc.)
3. Live Chat Option from website
4. Exchange Plan Options with standard names (i.e., A, B, C) "This plan approved for…"
5. Differences in plans
6. Explanation of rating system
7. Understanding plan coverage
8. Costs – comparative analysis inside/outside exchange
9. Education re: insurance terms
10. FAQs and acronym definitions
11. Correct info from all sources; repetitive
12. Penalty Implementation dates
13. Changes in Coverage implications, including if family status change
14. Impact on Medicare and Secondary Insurance
15. Consumer feedback on customer service
16. Clarification of product/carrier
17. Information on availability of providers enrolling patients now; other factors
18. Transparency of access fees
19. Transparency regarding owner of medical machines
20. Side by side comparison of plans
21. Cost, availability, out of pocket expense, networks, costs with and without subsidy
22. Incentives for pursuing health goals (for consumers to increase accountability; providers to promote health goals)
23. Information on "free" benefits

24. Health care provider quality
25. Patient outcome data—utilize existing quality measures
26. Wait-time for appointment, hours of clinic, after hours?
27. Who are you dealing with?
28. Have product name and logo
29. Internet "relationship" with language and educational match for consumer
30. Network up to date

C. Quality Rating of Plans/Providers
1. Website→provider/plan index
2. Provider ranked by quality indicators including patient outcomes using standardized measures (ACHQ)
3. Include plan savings
4. Proximity
5. Culturally and linguistically competent with universal language / multi-lingual (including generational, literacy, ethnicity, etc.)
6. Standardized forms/applications
7. Percent of premiums for claims paid out vs. administrative costs
8. Percent of denials
9. Timeliness/accuracy of claims payment
10. Wait time for appointment
11. Time spent per patient/number of patients seen per day
12. Providers' utilization of electronic medical/health records
13. Medical Home
14. IT Systems
15. On-site lab?
16. How is copay applied to lab?
17. Credentials of staff
18. Quality rating on care coordination
19. Method for public sharing of consumer experience—with standard criteria for rating provider and office staff
20. Provider of Specific Disease Treatment in clinic
21. Physician/Provider specialty or availability of specialists in group
22. "Stop treating death like an option"
23. Plan design issues

III. Exchange Governance-(David Deere and Derrick Smith, J.D.)

5 Things the Exchange is Suppose to Do
1. -Consumer assistance: help them with educational outreach
2. -Plan management role
3. -Business Model:
    a. -Massachusetts model: Active purchaser role
    b. -UTAH model: any will provider...
4. -Determine eligibility based on income
5. **Have to be self-sustaining by 2015**
6. -Question on Governance: How do you get there?

    a. -Option to have federal or state designed exchange
    b. -3 models for State Governance, quasi governmental group, non-profit
    c. -Another alternative is to have a fed/state partnership
7. -Question on Governance: What do you do if the state's program didn't work?
    a. -The fed would step back in and help run it because all states are required to have one.
8. -Question on Governance: Do you end up with a more effective market when the insurance department does both functions, or is it better to have creative tension between the insurance department and the exchange or the state?
9. -Question on Governance: Since the state collects tax revenues through the insurance department, if the fed ran the exchange, would all of those dollars go to them?
    a. -The answer to that is not clear just yet.

<u>We Discussed:</u>

1. -How the governance proposal initially came about
    a. -The proposed law started out as a quasi governmental model
    b. -Insurance Department was responsible for hiring employees
    c. -Insurance Department was responsible for determining how the exchange would be funded
2. -Exchange board did not have rule making authority and all rules were determined by the insurance department, but with the advice of the exchange board-Federal Exchange
    a. -If there is a federal design, there will still be input from the stakeholders from the state which suggests that a one size fits all model will not work
    b. -The eligibility, finance, and enrolling will probably be the same process across the states, although the exchange plans could be really different
    c. -Variance in plan management and that variance will probably be marginal
3. -Ideas that are wanting to be put into the planning process:
    a. -Even though the exchange has plan management options, the insurance department still has regulatory superiority over the exchange panel
4. -If there is a requirement to have expertise for plan management, then it's hard to find it because it would have to be within the insurance department or the insurance company itself
5. -If we have a state run exchange, we can pretty much determine what that program will look like
6. -ACA says federal money cannot be used to pay navigators; it will pay for almost everything else about the exchange, but Navigators grants are excluded
    a. -Planning for the navigator will be covered, but actually reimbursing them will have to be solely money from the state
7. -Navigator being paid to just be there not based on outcome or productivity
8. -AARP favors state run exchanges and the rationale is because they "feel that it's closer to their members and insurance has always been a state based industry and the consumers will be better served if the state has the ability to run the program based on their unique factors...they know how to cater to their own, basically.
9. -If there is a fed exchange, the call center will be in DC, whereas if it was a state, it would be here
10. -AARP thinks if it is a state run exchange, you can go to the state to maybe change regulation, but if it's fed, you'd have to get a consensus of the entire Congress or get the Department of Human Services to change it. Ultimately it is easier to change policy and

to get your point across to local people than someone who is trying to run a program nationally

Concerns: -There was concern on double billing to medical supply people

IV. Exchange Legal Issues-(Craig Wilson and Justice Annabelle Imber Tuck)

Craig Wilson gave a rundown of the various cases making their way through the federal court system, explained the levels of the federal court system, and noted the tendency of the justices to want to avoid being used as a political tool in order to maintain institutional integrity.

We discussed the issues in each of the cases appealed to the court of appeals level, including jurisdictional issues such as standing and ripeness, commerce clause (activity having a substantial effect on commerce), insurance as commerce, individual liberties, and mandate as tax/penalty.

Justice Imber Tuck discussed the importance of the jurisdictional issues and her views on whether the justices would reach the merits of the cases. She also discussed the lengthy history of Supreme Court precedent on the commerce clause, pointing out that some of the more recent cases in which Congressional action has been found unconstitutional have been limited to criminal cases. She noted that some of the more conservative justices would have to severely deviate from past opinions in order to find the mandate unconstitutional.

Some notable comments:

One gentleman said if the mandate is not unconstitutional, then laws such as EMTALA requiring emergency rooms to treat patients without regard to insurance should be repealed. He said, “They need to just turn them back out into the streets like stray dogs.”

One student stated that it is beneficial to the insured population to have the uninsured covered, much as it is with car insurance.