

Arkansas Health Benefits Exchange - 101

Arkansas HBE Stakeholder Summit

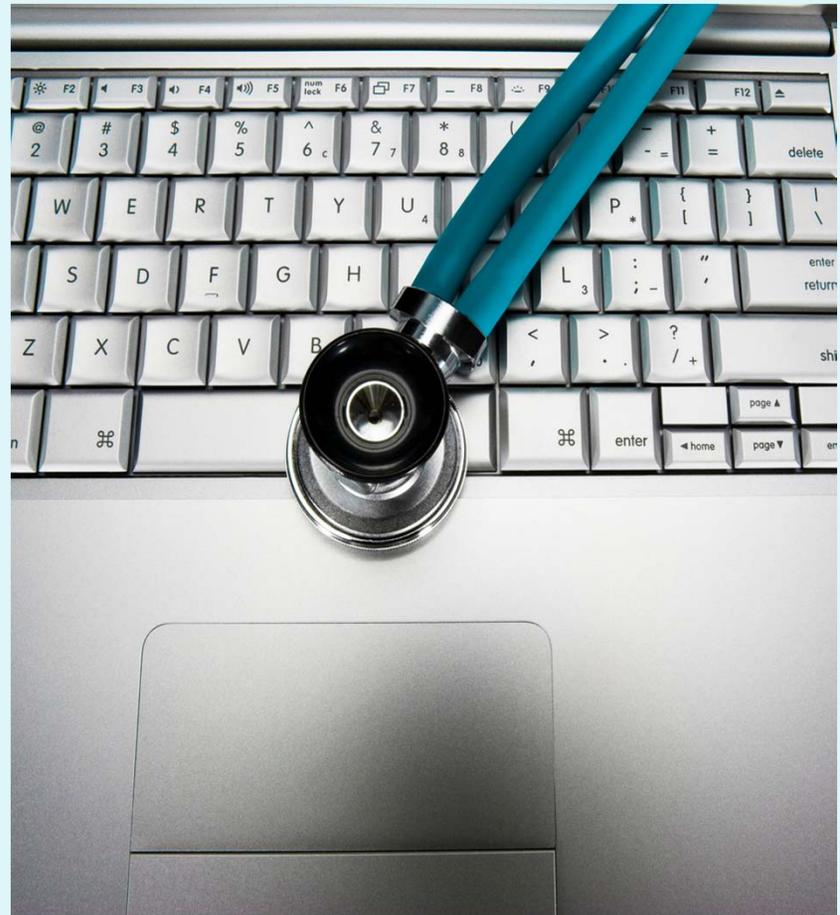
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What is a Health Benefits Exchange?

...a way to organize the health insurance marketplace to help informed consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on:



Price

Benefits and Services

Quality (new)

Health Benefits Exchange

Affordable coverage, consumer **choice**, and
“world class **customer service**” – *Joel Ario*

- Will assist eligible individuals and families receive:
 - Federal tax credits, or
 - Coverage through other Federal or State health care programs like Medicaid or CHIP
- Will give small businesses the same purchasing clout as large businesses
- Will make purchasing health insurance easier and more understandable

Said another way, EXCHANGES will...

Improve **consumer access** and **continuous enrollment** in **quality, affordable health coverage** that meets their needs.



Kaiser Family Foundation “Health Reform Meets Main Street”

http://www.youtube.com/watch?v=3-llc5xK2_E

American Health Benefits Exchange

OR

States Have Flexibility to Develop their own Health Benefits Exchanges so long as they meet minimal requirements of ACA.

Federal Leadership for ACA Exchanges

from the

Center for Consumer Information and Insurance Oversight (CCIIO)

- Administratively located in United States Department of Health and Human Services (DHHS)
Center for Medicaid and Medicare Services (CMS)
- To fund Exchange planning and implementation through 2014

Arkansas Insurance Department

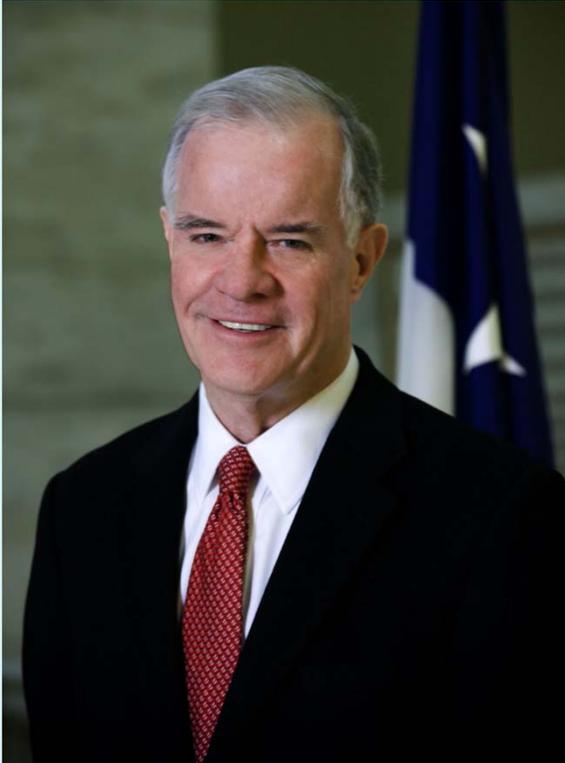


Mission Statement

The purpose of the Arkansas Insurance Department is to serve and protect the public interest by the equitable enforcement of the state's laws and regulations affecting the insurance industry.

The primary mission of the Arkansas Insurance Department shall be consumer protection through insurer solvency and market conduct regulation, and fraud prosecution and deterrence.

Commissioner Jay Bradford



Under the leadership of Commissioner Bradford, the AID Consumer Services Division recovered **\$14 million** for consumers in 2009.

WHY DO WE NEED CHANGE?

129 Million Non-Elderly Americans could be denied affordable coverage without it—often due to pre-existing conditions.

Up to 1 in 5 non-elderly Americans with a pre-existing condition (25 Million individuals) are UNINSURED.

And...

82 Million Americans with employer-based coverage have a pre-existing condition

- *Life Threatening Illnesses*
- *Chronic Conditions*

What if they have LIFE CHANGES?



Older Americans are at Particular Risk

Of Americans 55-64 years of age:

- *48% to 85% have a pre-existing condition*
- *15% to 30% in perfect health today are likely to develop a pre-existing condition in the next ten years.*

THIS WILL LIMIT THEIR CHOICES.



AND COSTS!!!



- From 2000 – 2010 Health Inflation was 48%
compared with Consumer Price Index Inflation of 26%
- Per Capita increase in health costs was 7.32%
compared to 1.1% overall inflation
- Physician and Hospital Claims in 2010
 - *Commercial Insurance increased 8.66%*
 - *Medicare increased 5.08% (sicker population)*
 - » *Health Leaders Media*

Annual U.S. Spending on Health Care

- 2000 - **\$1.3 Trillion** → 2009 - **\$2.5 Trillion**
- 1990 – **12 % GNP** → 2010 – **17 % GNP** *without comparable health improvements*
- Health **Costs Rising > 4X** Hourly **Earnings** of the People
- **49 Million** adults spent **> 10% of income** on **health insurance** and **health care costs** last year

What about in Arkansas?



A half-million individuals are without health insurance (ACHI)

- **17%** of our population (estimated 20% in 2013)
- **25% of 19-64** year olds are without health insurance
- **30% of 19-44** year olds are uninsured, with even higher rates for some geographic and demographic groups

How about those who *are* insured?



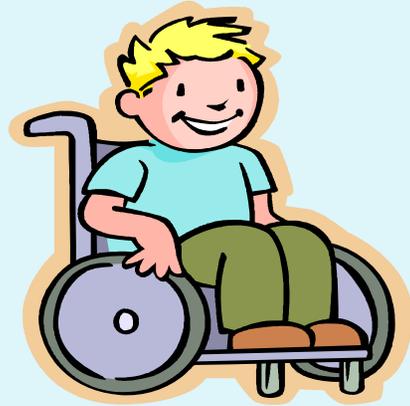
75% are insured through their employer

- **93% of large employers** offer health insurance
- **27% of small employers** offer health insurance (AHRQ)

*The majority of Arkansas employers (72.7%)
are small businesses*

What Consumer Protections has the ACA already accomplished in Arkansas?

- Prohibits pre-existing conditions denials for children under 19.



- Extends coverage for young adults to age 26



ACA Now!



- Eliminates lifetime limits and
and regulates annual limits until 2014
- Prohibits rescinding coverage by insurance
companies
- Establishes consumer assistance programs

ACA Now!

- Provides for small business health insurance tax credits (35% employers' contribution; 25% for non-profits)
 - 40,355 Arkansas Small Businesses (149,077 employees) eligible for tax credits for contributions toward health care for full time employees (IRS, 2010)
 - Create 2,000-3,200 jobs by reducing health care costs for employees (U.S. Public Interest Research Group, 2010)

ACA Now!

- Coverage for Early Retirees (55-64 years)
 - 31,100 through former employer until 2014
 - 76% of large employers who offer retiree coverage plan to participate

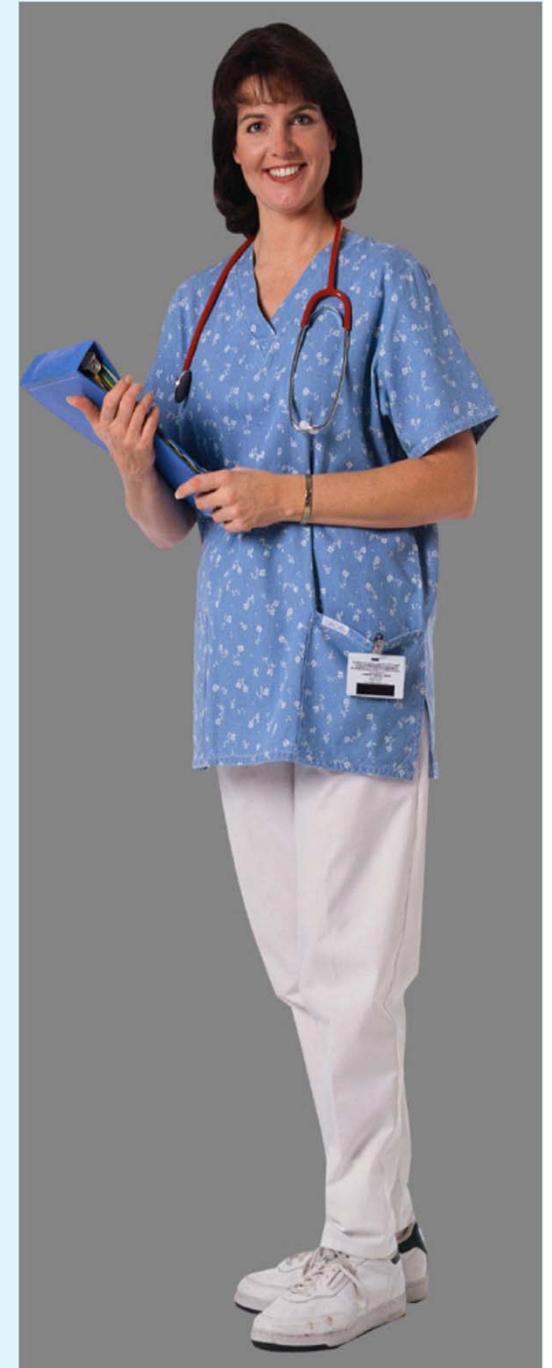


ACA and Elder Protections

- Relief for 506,000 Arkansas seniors who hit Medicare “donut hole” (*DHHS-Healthcare.gov*)
- Decrease premiums for 446,000 Arkansans not enrolled in Medicare Advantage
- 50% discount when buying Part D covered drugs until 2020

ACA Now!

- ❑ Provides for preventive care without deductibles or co-pay charges by consumers
- ❑ Increases payment for rural providers
- ❑ Increases pay to CHCs
- ❑ Increases access to home and community care (October 2011)



How Can Insurance Exchanges Save Dollars?



- **Lower the administrative costs and adverse selection** generally borne by individual and small group policies.
- Provide for benefits of **pooling risks, market leverage, and economies of scale.**
- **Reduce transaction costs and increase transparency.**
- **Reduce fraud, waste, and abuse.**



Medical Loss Ratios

85% of collected insurance **premiums** for **large group** coverage must go directly toward **health care** and **quality improvements**

80% for *individual and small groups*

Carrier must reimburse consumer if greater than allowed percentage for administrative costs.

Carrier can only participate in Exchange if meeting these **requirements**.

Statutory Requirements of Health Benefits Exchange

- ▣ Certification/Decertification of Plans
- ▣ Toll-free Hotline
- ▣ Website with Information for Potential Enrollees
- ▣ Assign Price and Quality Ratings to Plans



Statutory Requirements - continued

- ▣ Present Benefit Plans in Standard Format
- ▣ Provide Information on Medicaid and CHIP
- ▣ Premium Calculator to Determine Actual Cost of Coverage (with cost sharing/tax credits)
- ▣ Establish a Navigator Program to Assist Consumers



Statutory Requirements - continued

- ▣ Establish a Small Business Health Option Plan (SHOP) through which Small Employers may Access Coverage for their Employees

- ▣ Enroll Eligible Individuals into a plan of their CHOICE

- ▣ Certify individuals “Exempt from Individual Responsibility”

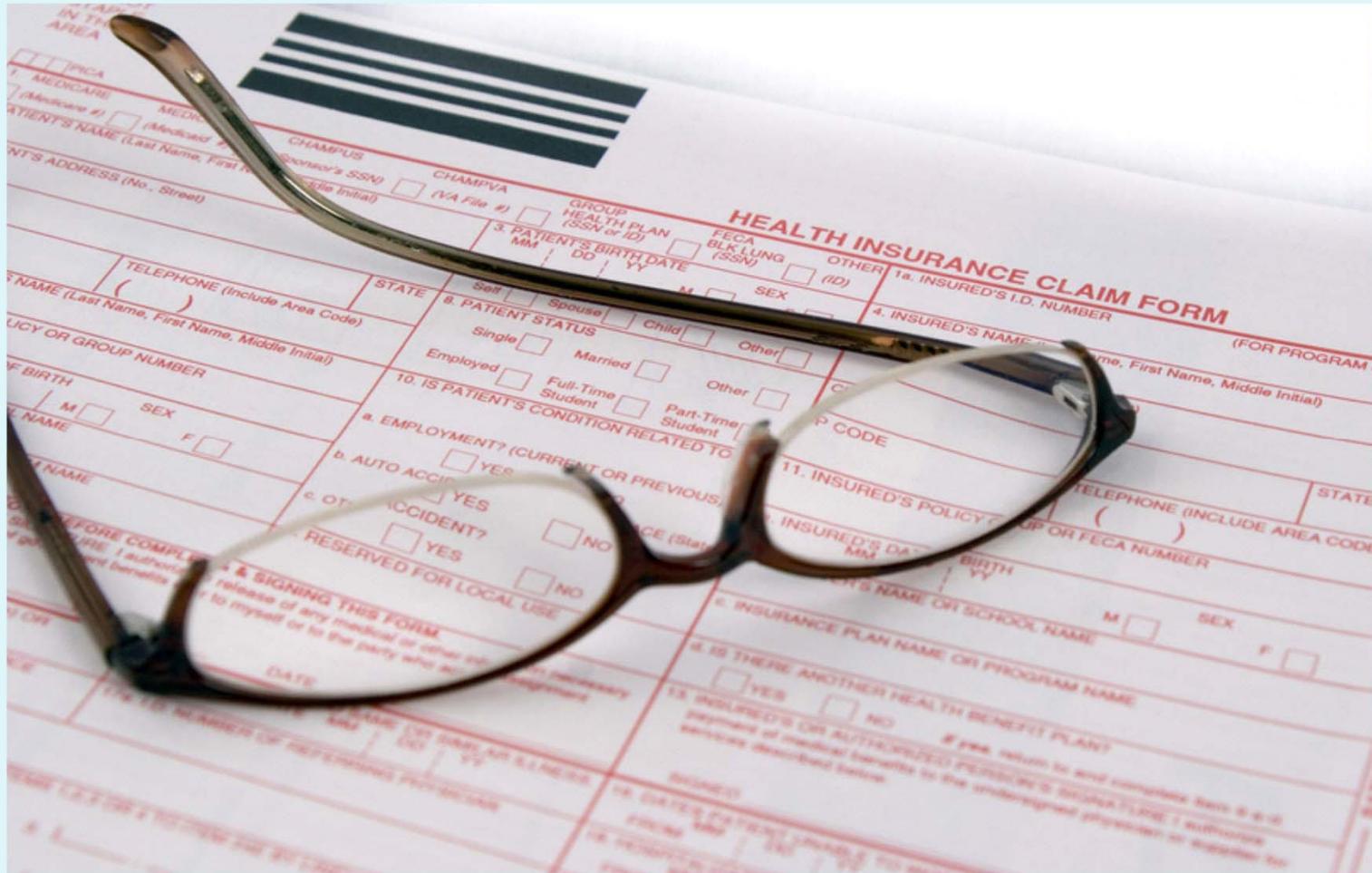
- ▣ Provide information on certain individuals to:
 - Treasury
 - Employers

Statutory Requirements - continued

- Provide Open Enrollment Periods
- Consult with Stakeholders
- Present Enrollee Satisfaction Survey Results
- Publish Data on Administrative Costs
- Publish Data on Fraud, Waste, and Abuse



Insure consumer protection through approval, certification, and regulation of qualified plans based on services, quality, price, and value.



The image shows a pair of dark-rimmed glasses resting on a "HEALTH INSURANCE CLAIM FORM". The form is filled with various fields and checkboxes, including sections for patient information, insurance details, and a signature area. The text on the form is partially obscured by the glasses. The form includes fields for "PATIENT'S NAME", "PATIENT'S BIRTH DATE", "INSURED'S I.D. NUMBER", "INSURED'S NAME", "INSURED'S POLICY GROUP OR FECA NUMBER", "INSURED'S DATE OF BIRTH", "INSURANCE PLAN NAME OR PROGRAM NAME", and "IS THERE ANOTHER HEALTH BENEFIT PLAN?". There are also checkboxes for "EMPLOYMENT?", "AUTO ACCIDENT?", and "OTHER ACCIDENT?". The form is titled "HEALTH INSURANCE CLAIM FORM" and has a subtitle "(FOR PROGRAM)".

Qualified Health Plans

Levels Based on Actuarial Value:

Platinum – 90%

Gold – 80%

Silver – 70%

Bronze – 60%

and

Catastrophic



Only Four Plan Rating Bands

Age

Tobacco Use

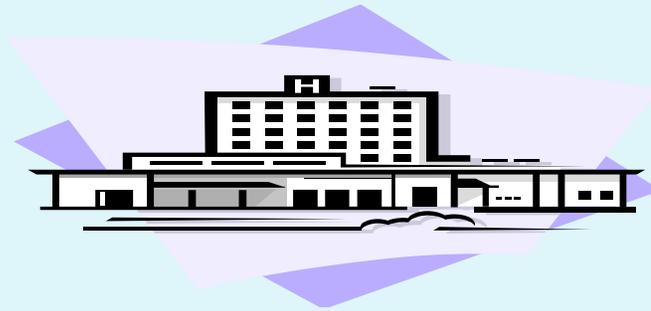
Geography

Individual/Family

Minimal Essential Benefits

Institute of Medicine Recommendations October 2011
Awaiting Final Rules

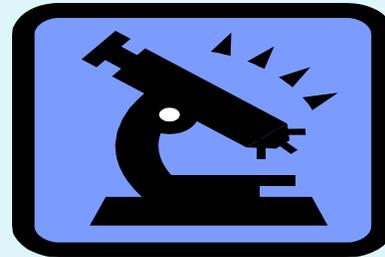
- Ambulatory Services
- Hospitalization
- Emergency Services
- Maternity and Newborn Care
- Mental Health and Substance Use Disorder Treatment
- Prescription Drugs



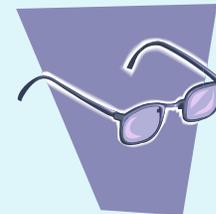
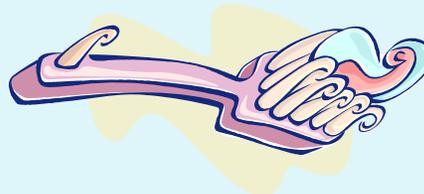
Minimal Essential Benefits – Con't.

- Rehabilitative and Habilitative Services /Devices

- Laboratory Services



- Preventive, Wellness, and Chronic Disease Management



- Pediatric Services, Including Oral and Vision Care

Essential Benefits Package

(Evidence-Based Practices, Population Health, Ethics, Economics)

- Affordable for consumers, businesses, and taxpayers
- Maximize the number of people covered
- Protect most vulnerable
- Encourage better care practices
- Advance stewardship of resources
- Address medical concerns of greatest importance to enrollees
- Protect against the greatest financial risk due to catastrophic events or illnesses

If State Exchange, Minimal Benefits Can be Adjusted at State Level

...so long as they're not too different than the federal requirements,

...and any additional coverage must be 100% funded by state.



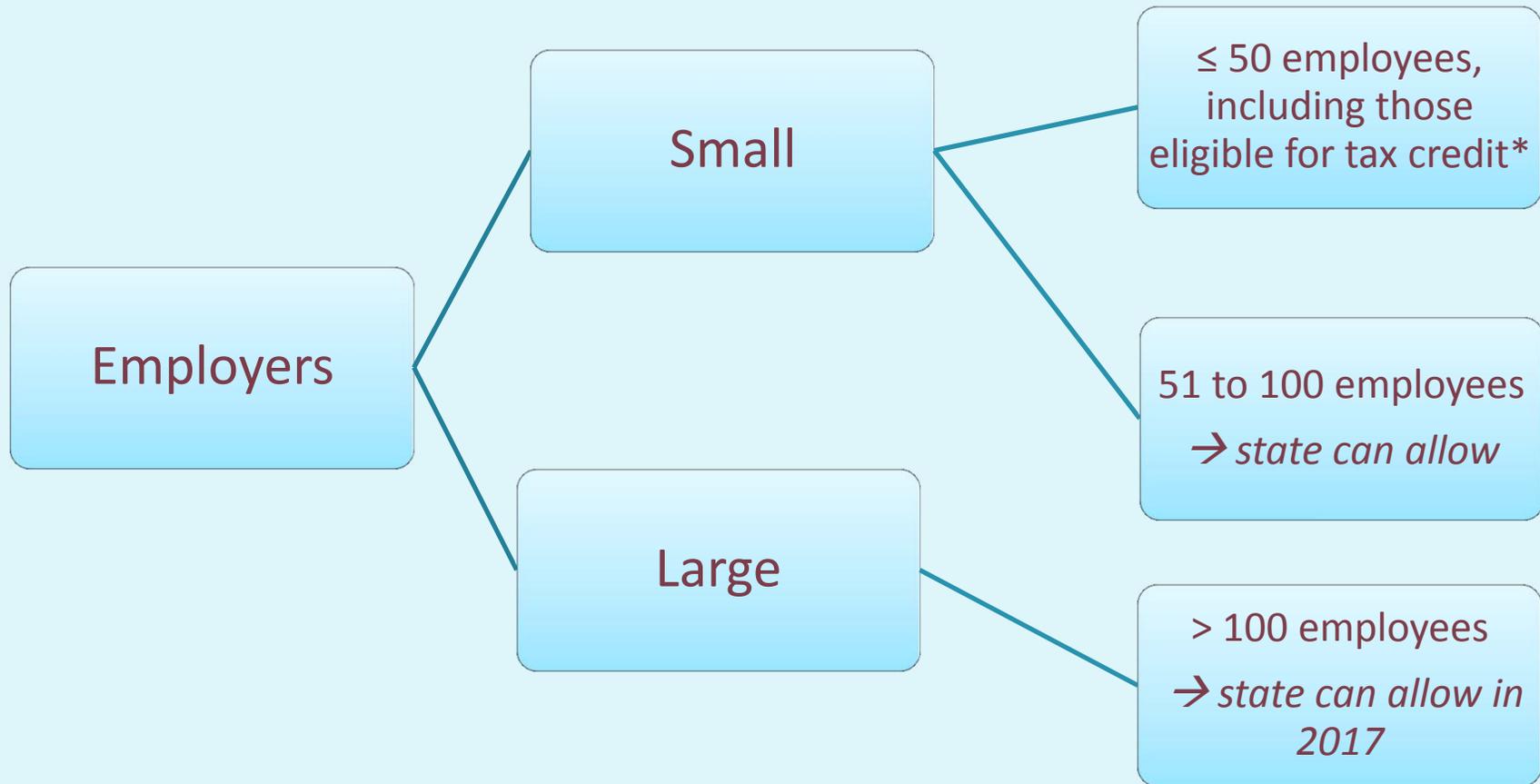
DHHS Regulatory Standards being Developed for QHPs

- Marketing
- Network Adequacy
- Accreditation for Performance Measures
- Quality Improvement and Reporting
- Uniform Enrollment Procedures



Employers Eligible for the Exchange

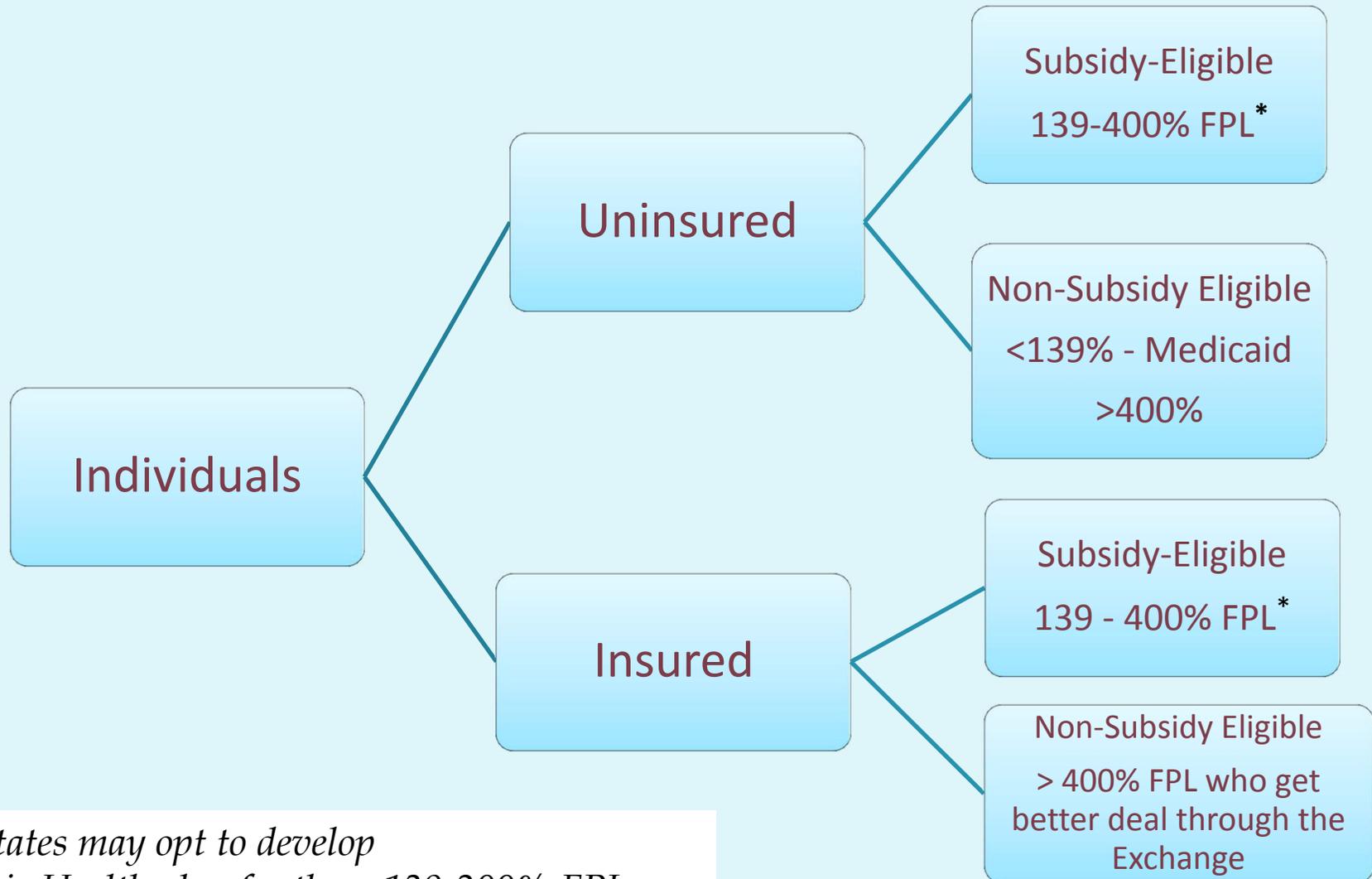
(Lynn Blewett, 2011)



** Employers must have fewer than 25 employees and average annual wages less than \$50,000 to be eligible for tax credit*

Individuals Eligible for the Exchange

(Lynn Blewett, 2011)



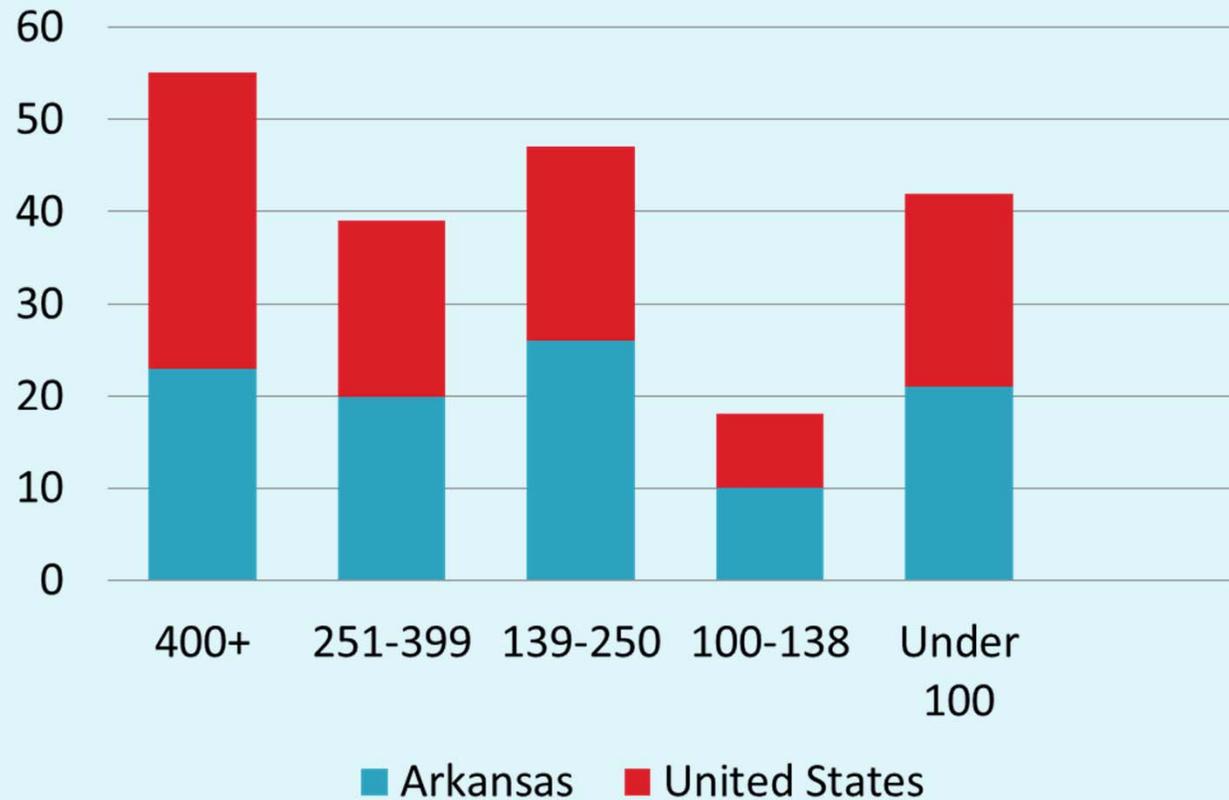
* States may opt to develop
Basic Health plan for those 139-200% FPL

2011 DHHS Poverty Guidelines

Size of Family Unit Contiguous 48 States and DC

1	\$10,890
2	\$14,710
3	\$18,530
4	\$22,350
5	\$26,170
6	\$29,990
7	\$33,810
8	\$37,620
Ea. additional person	\$ 3,820

Distribution of Population by % FPL (2008-2009: Kaiser State Health Facts)



Premium Tax Credits

- Makes coverage affordable – level of support tailored to individuals' needs
- Larger tax credits for older Americans who face higher premiums
- Incentives for families to choose cost-effective coverage
- Credit is refundable, so even families with modest incomes can benefit

Health Status

2008-2009 Kaiser State Health Facts

Indicator	Arkansas	United States
Infant Mortality Rate (per 1,000 live births)	8.2	6.8
Teen Death Rate (per 100,000 population)	93	62
AIDS Diagnosis Rate (per 100,000 population)	6.8	11.2
Overweight or Obese Children (% of children)	37.5	31.6
Adults who Visited the Dentist/Clinic (% of adults)	63.5	71.3
Adults with Disabilities (% of adults)	17.6	12.1

Health Costs and Budgets 2008-2009 (Kaiser)

Category	Arkansas	United States
Health Spending Per Capita	\$4,863	\$5,283
Average Family Contribution for Family Premium (% of total premium)	27	27
<i>2009 Personal Per Capita Income (U.S. Department of Commerce)</i>	\$31,956	\$39,138

What are the Projected Numbers for AR?

- 323,000 Arkansans will be eligible for tax credits (\$5.2 Billion in premium cost sharing and tax credits during first five years) - (*Senate Finance Committee*)
- Will decrease family premiums by \$1,330 - \$1,900 annually for same benefit – (*CBO*)
- 251,191 will be newly eligible for Medicaid (\$9.3 Billion in federal funding) - (*Senate Finance Committee*)

What Will Change With Exchanges in Arkansas in 2014?

In *first year*, actuaries estimate we will **cut the number of uninsured** in Arkansas **in half**.

- **211,000 will enroll in private insurance plans**
 - 95,000 through Small Group Market
 - 116,00 through Individual Market
- **175,000 newly eligible for Medicaid will enroll**

This represents 120,209 individuals who were formerly uninsured.

BIG QUESTION

State Exchange or Federally-Facilitated Exchange?

- State – total operations
- Federal – total operations
- Federal - Partnership Model
 - Option 1: States operate Plan Management
 - Option 2: States operate Selected Consumer Assistance Functions (Outreach/Education, Navigator)
 - Option 3: States with both of above

Arkansas Commitment

- **Coordinate, avoid duplication and lower costs**
- Build to **evaluate** and continuously **improve** health **coverage *and* outcomes**
- Multiple agencies working on **shared infrastructure, architecture and security**
 - AID
 - DHS
 - DIS
 - OHIT- SHARE
 - Carriers
 - Federal Agencies
 - More



Stakeholders Input Required

And there are Many!!!





Selected Headlines in Last Month

“Meeting set to discuss state insurance pool” – *Arkansas Democrat Gazette*, October 7, 2011

“Beebe: House partisanship scary” *Arkansas Democrat Gazette*, October 5, 2011

**“The truth about health care: Obamacare is working”,
Arkansas Times blog, September 27, 2011**

**“GOP lawmakers say no to health insurance exchange grants”
Arkansas News Bureau, September 27, 2011**

Where's the Consumer?





Guidelines for Health Benefits Exchange

- Offer **best value** for **informed customer**.
- Provide **public outreach** and insure **stakeholder involvement**.
- Create a **competitive environment** that will offer purchasers a range of products.
- Operate under **transparency**, protecting against **conflicts of interest**.
- Provide a framework for **SHOP Exchange**.



Arkansas Exchange Planning

- **Inclusive and open**
- **Well-researched** and Based on **Arkansas Needs**
- **Compliant** with Federal and State **Law**
- **Integrated** with other Arkansas Health System Improvement
- **Efficient** and **Financially Viable**
- **Protect Consumers**
- **Consumer Supported**



Health Benefits Exchange

Increase Access to
Continuous Enrollment in
Quality, Affordable
Health Coverage Plans

Planning Phase



Stakeholder Involvement

UAMS Partners for Inclusive Communities and
UAMS College of Public Health

- Key informant interviews
- Two way communication with diverse stakeholders
 - 64 Community Meetings in 17 cities/towns (June-July), including outreach to diverse stakeholder groups
 - Stakeholder Summit (Today)
 - Public Hearings (November –December)
- Web-based Survey

Planning Phase

Background Research Contract with First Data:

- ▣ Governance
- ▣ Marketplace
- ▣ Program Integration
- ▣ Information Technology
Integration
- ▣ Financial Modeling
- ▣ Operation Plans
- ▣ Education and Outreach
- ▣ Evaluation
- ▣ Communication with Stakeholders

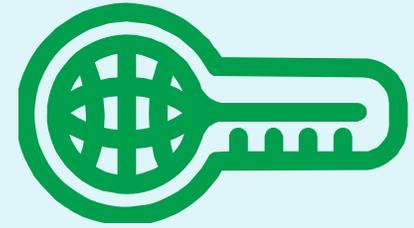


Planning Phase

- **Steering Committee**
- **Stakeholder Workgroups**
 - Consumers
 - Providers
 - Community Leaders
 - Outreach/Education/Enrollment
 - State Agencies
 - Information Technology
- **Staff Study**



Key Issues



- ▣ **Governance and Accountability** Structure?
- ▣ Will **individual and small business** Exchanges be **merged**?
- ▣ How will we **prevent adverse selection**?
- ▣ Will Arkansas **require benefits beyond federally mandated** minimal essential benefits?
- ▣ Will Arkansas establish a **competitive bidding process**?

Key Issues

- ▣ How will we ensure **continuity of coverage** and **provider networks** as individuals/families move between plans?
- ▣ How will we get **individuals** and **small businesses to participate**?
- ▣ What will Arkansas do about those that **remain without insurance coverage**?

Key Issues

- ▣ How will we implement mandatory **information technology** and **security procedures** to integrate state, federal, and private eligibility and enrollment into a **seamless system that allows for easy movement** between plans with consumer life changes?

Key Issues

- ▣ What will be the role of **Navigators**? Who will they be? How will they be paid? Regulated?
- ▣ What will be the role of **insurance producers**?
- ▣ AND MUCH MORE..

Establishment of AR Exchange

Controversial within 88th
Arkansas General Assembly

- HB 2138
- HB 1226
- Interim Study
- Level One Establishment Grant
not submitted September 30, 2011



What does this mean?

Many Arkansans believe an Exchange operated by and for Arkansans will better meet the needs of our people than an Exchange operated in Arkansas by the Federal Government.

THEREFORE,
Arkansas Insurance
Department will continue to lead non-partisan planning efforts by diverse stakeholders to develop the best possible Arkansas Benefits Exchange.





Timeline – Critical Dates

EXCHANGE DEVELOPMENT

- #### FEDERAL FUNDING
- Planning Grant
 - Level One Establishment
 - Last Date to Apply is December 30, 2011
 - Level Two Establishment
 - Last Date to Apply is June 29, 2012

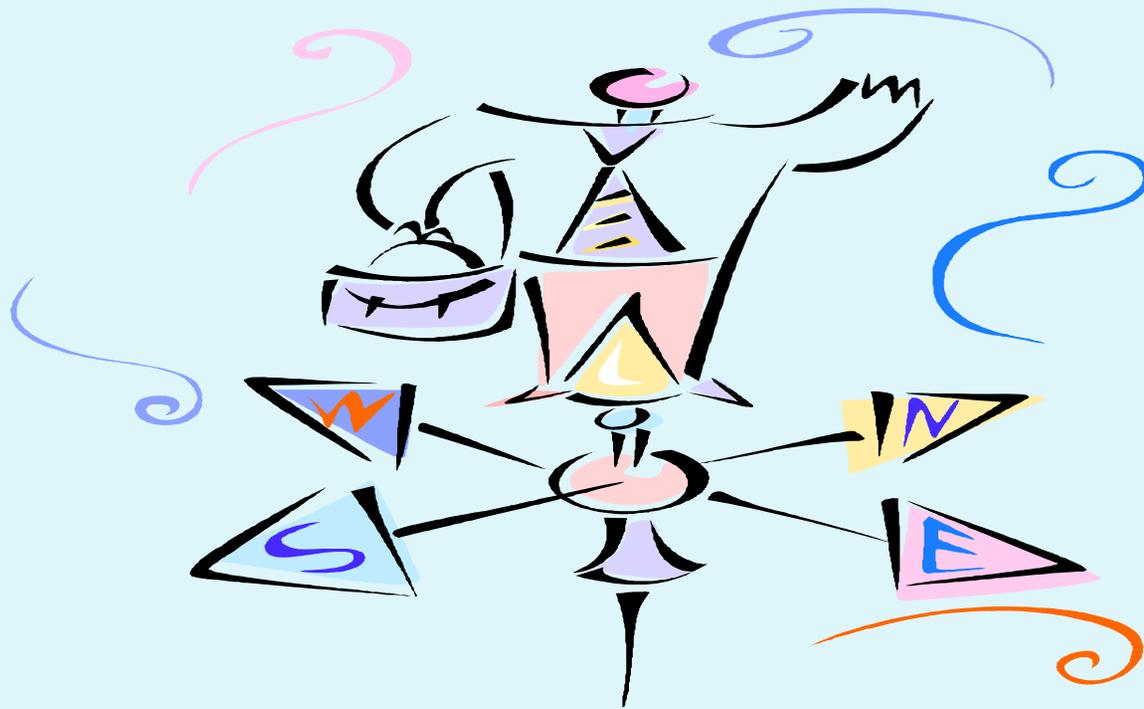
- States apply to DHHS for Certification – October 2012
- DHHS Certification or Conditional Certification – January 1, 2013
- Enroll Consumers – October 1, 2013
- Fully Functional “covering lives” – January 1, 2014
- Self-Sufficient – Jan. 1, 2015

What Will It Cost to Provide
Increased Access to Affordable
Care for Arkansans?

What Are We Paying Now?

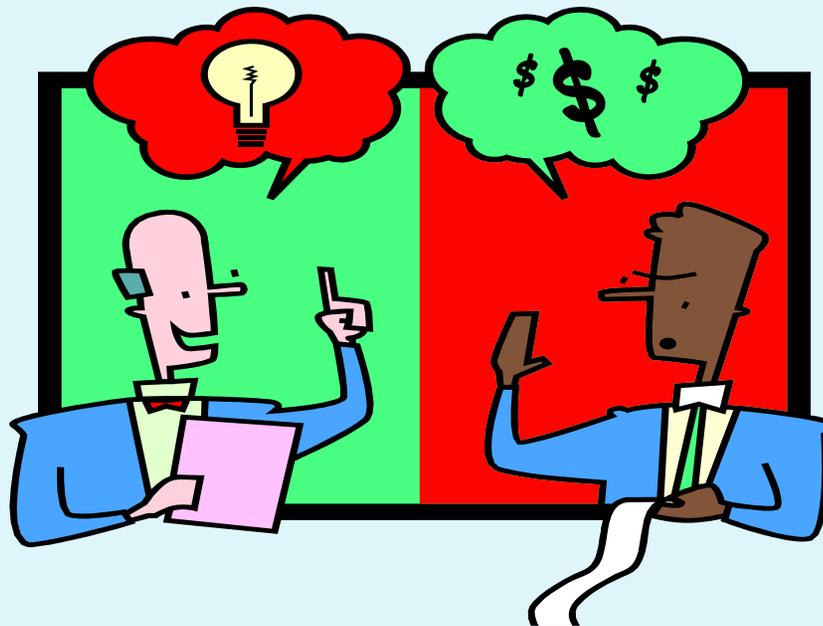


We Must Change



Increased Access to Appropriate Care Improves Health Outcomes and Lowers Costs

- We know what we need to do.
- The question is “How do we do it?”



How can we move forward...

...to alter the predicted course of increasing health costs?

...to improve health outcomes while not increasing costs?

...for a new future, pre-empting the status quo?

What are our Shared Interests?

- What do different groups need?
- How can we begin our journey together?
- What is next step?

We have great minds and talent
in Arkansas



Arkansas Benefits Exchange



TOGETHER, WE CAN!

Questions?

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