

MAKING THE HEALTH CARE EXCHANGE WORK FOR ARKANSAS FAMILIES



BY ANNA STRONG AND APRIL MOORE

THE EXCHANGE IN ARKANSAS

The Patient Protection and Affordable Care Act (ACA) requires states to have a health insurance “Exchange” that will provide high-value and affordable coverage for consumers, including individuals and small businesses, in place by 2014. The Exchange will be a marketplace where Arkansans can go to enroll in private insurance plans and, for those with income up to 400 percent of the federal poverty level (about \$89,000 for a family of four), receive subsidies based on their income. The Exchange will also serve as a doorway for individuals and families to enroll in Medicaid or ARKids First if they qualify. This marketplace should empower consumers by giving them the information and tools they need to make the best choices for their health and budget.

States have had the opportunity to choose to operate an Exchange on their own or partner with the federal government to run the Exchange in the state. Arkansas abandoned efforts to establish a state-based Exchange after the legislature failed to pass a law enabling the creation of one. However, Governor Beebe is supporting and advocating for establishment of a Federally-Facilitated Exchange (FFE) Partnership Model for Arkansas. With this model, Arkansas will oversee the Plan Management and Consumer Assistance functions for the FFE, while the federal government will manage the remainder of the Exchange.¹ In April 2012, the legislature appropriated a \$7.7 million federal grant to the Arkansas Insurance Department (AID) for FFE Partnership planning for these two components.

Projections show that approximately 211,000 Arkansans will enroll in health plans through the Exchange in 2014, with another 170,000 more taking advantage of a newly expanded Medicaid program.² This will give scores of uninsured Arkansans access to affordable health coverage that they cannot access today. While the state has lost some control by not choosing to operate a state-based model, Arkansas families will need the same things from an Exchange regardless of who is ultimately responsible for managing it. The state should aim to retain as much influence as possible over the mechanics of the Exchange through the Partnership in order to ensure that it works for Arkansans.

The U.S. Department of Health and Human Services (HHS) issued final regulations governing the Exchange in March 2012. While the regulations do not specifically address how a Partnership Exchange will function, most of the rules will apply to the Arkansas Exchange. Following are recommended principles that to guide Exchange development through consumer participation, the Consumer Advisory and Plan Management workgroups, and decisions that will impact the success of the federal exchange. These elements are critical to developing an Exchange that meets the needs of Arkansas’s children and families.

RECOMMENDED PRINCIPLES FOR ARKANSAS’S EXCHANGE

Strong Consumer Voice and Participation

The Exchange will exist to serve consumers, so in every area of its development, consumers need to be represented. Arkansas consumers and small businesses know first-hand what will or will not meet their health insurance needs and should have a strong voice in planning, establishing, and evaluating the Exchange they will utilize. The consumer perspective is essential for developing an Exchange that is functional and appropriate for the communities it serves. This strong voice can be facilitated in several ways:

- *Give consumers a strong voice in Exchange decisions.* Even though Arkansas will have a Federally-Facilitated Exchange, the state should have a group or governance body charged with advising operational decisions for the FFE. Though HHS final rules only require one board member to represent consumers,³ a majority of Arkansas's advisory body should consist of individual exchange users, small business users, and representatives from organizations serving the interests of low-income, minority, or otherwise underserved consumers who will obtain coverage through the Exchange. This voice should be broader and more permanent than the Consumer Assistance and Plan Management advisory groups working on implementation.
- *Limit decision-making influence of those who could benefit financially from the Exchange.* Some stakeholders stand to benefit financially from the Exchange, posing a conflict of interest and jeopardizing the effectiveness of the Exchange advisory group in protecting consumer interests. To mitigate any conflict of interest, Arkansas should limit industry representatives such as hospitals, physicians, insurers, and brokers from serving on the body advising the Exchange in Arkansas. While their expertise will be critical to decisions, they can provide input through another avenue.
- *Value transparency and accountability.* All processes related to the Exchange should require open meetings; public reporting on information, process and key decisions; sharing of data and analyses; and open communication about intentions. Developing an infrastructure for two-way communication and information-sharing will ensure accountability for decision-makers and make the Exchange responsive to the needs of consumers.

Consumer Assistance

The Consumer Assistance Advisory Committee was convened by the state insurance department to help develop the state's Navigator program, outreach and education efforts, and consumer complaint resolution. These representatives will be responsible for ensuring that Arkansas develops the infrastructure to educate consumers about the Exchange, to help consumers understand their plan options, and to ensure that the Exchange is adequately marketed to maximize participation.

- *Develop a culturally competent, community-based navigator workforce.* Navigators will help consumers access and use the Exchange. Studies show that consumers want navigators to be knowledgeable, accessible, and be able to clearly explain consumer options.⁴ Arkansas should ensure that navigators have the appropriate capacity to reach uninsured and underserved populations, including communities with unique cultural, language, or literacy needs. The Exchange planning groups should produce a detailed profile of the uninsured and underinsured in Arkansas to help tailor navigators' approaches statewide.
- *Ensure the navigator program attracts diverse, effective organizations and individuals who can effectively reach uninsured Arkansans.* The Navigator grant program should be designed and marketed to encourage community-based organizations to apply. Adequate financial support should be available to qualified entities to ensure the success of the navigator program. Navigators must be impartial; therefore entities that stand to benefit financially from the Exchange or pose other conflicts of interest should be prohibited from becoming navigators. Programs should also accommodate communities who lack consistent internet access. The navigator program should be monitored to ensure it achieves quality outcomes and reduces the number of uninsured individuals.
- *Design the outreach campaign to reach under-insured and uninsured Arkansans.* Standard outreach materials that accommodate a variety of cultural and language needs should be developed for use by all navigator programs. A comprehensive certification and training program will ensure that all navigators –and others enrolling individual in plans inside the Exchange or in Medicaid or ARKids First –have the skills to reach uninsured consumers. A variety of outreach and media tools should be utilized to ensure that consumers are aware of the coverage newly available to them and how to connect with navigators and other avenues to enrollment such as user-friendly websites.
- *Collect data to improve the Exchange experience for underserved populations.* Navigators can help gather information that will lead to continual improvements in the Exchange. It is important that the Exchange be a vehicle for reducing health disparities by providing coverage to all Arkansans. Data and stories collected by navigators regarding consumers' interactions with the Exchange can inform state policymakers about what is and isn't working in order to improve programs.

- *Establish a comprehensive appeals process for consumers that is administered by the Exchange.* The appeals process should include easy-to-read forms, reasonable timeframes to resolve consumers' grievances, and the opportunity for consumers to pursue an appeal through a neutral party, outside of the Exchange.

Plan Management

Plans sold in the Exchange must meet minimum requirements that provide a full range of services to Arkansans. AID tasked the Plan Management Advisory Committee with defining and delivering guidelines for Qualified Health Plans sold in the Exchange. It is essential that plans sold in the Exchange meet the health needs of children and families across the state.

- *Balance plan value and cost for families.* Plans offered in the Exchange should cover a set of Essential Health Benefits that meet the needs of children and families, including the full range of pediatric services recommended by the American Academy of Pediatrics and subsequent treatment recommended by providers.⁵ Private plans have been developed with working adults in mind, so they may not meet the unique needs of children. Comprehensive full-family plans should be affordable based on the family's income, and child-only plans should be offered for situations such as Medicare-eligible grandparents who have custody of a grandchild. The full cost of plans, including premiums, subsidies, and cost-sharing, should be explained clearly and simply so that families can make the best choices for their financial and health situations.
- *Emphasize high quality and prevention.* The Exchange should only offer plans that provide a comprehensive and high-quality package of health services. Every plan should prioritize prevention and work to reduce health disparities, and dental and mental health benefits should be included. Healthcare delivery networks should include essential community providers, and patients should have access to providers who speak their native language. By promoting community health through the fostering of collaborative efforts between insurers and local community organizations, the Exchange will ensure the efficient delivery of health information, health promotion, and disease prevention and screening services.
- *Authorize the Exchange to negotiate with insurers regarding quality and price of plans.* Arkansas should maintain its flexibility in negotiating with insurers by acting as an "active purchaser." Using its pool of consumers to drive competition for participation and price, Arkansas will be able to help provide the best plans with the highest value for consumers. The plans and their networks should also be able to handle an influx of new patients, ensuring access to health care. Implementing effective monitoring mechanisms, such as market research, will encourage continual improvement and further standardization of products offered through the Exchange, and increase value for consumers. There should be a low administrative burden for all so that administrative costs do not lead to increased healthcare coverage costs.
- *Give the Exchange tools to mitigate adverse selection.* Adverse selection occurs when sicker individuals purchase coverage through the Exchange and healthier, lower-cost consumers seek coverage elsewhere. The potential for adverse selection poses a significant threat to the strength and effectiveness of the Exchange, so our state must identify and adopt strategies to mitigate its impact. These strategies can include aligning market rules inside and outside the Exchange and requiring insurers outside the Exchange to offer the same products as those offered within the exchange.

Federally-Facilitated Exchange Considerations

Because Arkansas will have a FFE, the federal government will retain control over many aspects of the Exchange. Arkansas needs to ensure that, as the FFE is implemented, the necessary systems are in place to ensure that consumers have an easy-to-understand, seamless, high-quality experience and that the FFE is branded in a way that Arkansans will utilize it.

- *Integrate Medicaid and Exchange systems.* Not all Exchange consumers will be at income levels that indicate they should purchase private insurance through the Exchange. Some will qualify for Medicaid or ARKids First. Nationally, an estimated 75% of parents who will qualify for Exchange subsidies will have children eligible for Medicaid or CHIP (ARKids First in Arkansas).⁶ A split system could put children at the greatest risk of falling through the cracks if families are forced to duplicate application or enrollment processes or use multiple doorways. A modern "no wrong

door” system will fully and seamlessly integrate the Exchange with Medicaid eligibility, enrollment, and re-enrollment processes. The Exchange should be equipped with resources and expertise necessary to communicate with state agencies effectively and in a timely manner to facilitate real-time information access, easy enrollment into private or Medicaid coverage, and responsiveness to consumers.

- *Ensure continuous and consistent coverage for families facing complex coverage situations and frequent changes in income.* Many consumers, especially young families, will have parents who purchase private insurance through the Exchange but have children who are enrolled in ARKids First. Additionally, low-income families often face frequent changes in income or family structure that will cause their eligibility to churn between Medicaid and the Exchange. A recent study showed that 35% of low-income adults will move between the Exchange and Medicaid within six months of enrollment.⁷ Transitions between coverage types should be seamless and avoid gaps in coverage to reduce the negative effects of churning. Provider networks need to be consistent across plans to ensure that families can maintain a medical home regardless of coverage. The state could implement a Basic Health Plan that covers premiums for families between 133 and 200 percent of poverty, helping ensure that coverage is affordable and comparable to Medicaid.
- *Provide customers with a single, user-friendly, streamlined application and enrollment process.* The need for special enrollment processes for those participants who lack internet access or are otherwise disconnected from the health care system should be recognized and prepared for well in advance of the Exchange start date. The single application should also be able to facilitate enrollment in other services available to low-income families, such as supplemental nutrition assistance (SNAP). Online access for enrollment, information, and renewal would help families stay connected to their coverage.
- *Make applications accessible for all Arkansans.* Applications, plan descriptions, explanations of subsidies, and other information should be written in plain language at an appropriate reading level to empower and educate consumers.⁸ The Exchange interface should be accessible for consumers with disabilities, in compliance with state and federal laws. Arkansas should make materials, website, and navigators available in English, Spanish, Marshallese, and other languages as necessary to meet the needs of consumers.

The Exchange provides a tremendous opportunity to connect thousands of uninsured Arkansans to insurance coverage. As it is planned and implemented, decision-makers should remain focused on serving those who most need health care coverage and services. Thankfully, Arkansas can use and build on the dramatic success of ARKids First, which has brought the rate of uninsured children in our state to its lowest levels on record. Using these principles, Arkansas can again lead the way by building an Exchange that will successfully extend health coverage to entire families and improve the health of all Arkansans.

For more information on the exchange or this report, contact **Anna Strong (astrong@aradvocates.org)** or **Rich Huddleston (rhuddleston@aradvocates.org)**. Call our office at (501) 371-9678.

¹Arkansas Insurance Department, stakeholder letter, February 2012.

²Arkansas Insurance Department, stakeholder letter, February 2012.

³U.S. Department of Health and Human Services. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Last retrieved April 2012 from <https://www.federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans>.

⁴Washington State Health Benefit Exchange: Potential Role and Responsibilities of Navigators. Retrieved from <http://www.hca.wa.gov/hbe/documents/NavigatorRecommendations.pdf>.

⁵EPSDT (Early Periodic Screening, Diagnosis, and Treatment) is a baseline for Medicaid that ensures children receive not only preventive care but follow-through on issues – all covered by insurance.

⁶Unpublished estimates by the Urban Institute as cited in the May 11, 2012 letter by the Georgetown University Center for Children and Families to the Department of Health and Human Services

⁷Center for Health Care Strategies, Inc. Strategies for building seamless health systems for low-income populations. February 2012.

⁸Enroll America. Communicating with Plain Language. February 2012.



Arkansas Department of Health

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Governor Mike Beebe

Paul K. Halverson, DrPH, FACHE, Director and State Health Officer

15 May 2012

Dear Insurance Commissioner Bradford:

Please see the enclosed information relative to the recommended tobacco cessation essential health benefits for the proposed Arkansas Blue Cross/Blue Shield PPO or QualChoice plan.

As you know, tobacco cessation is a GRADE A recommendation in the US Preventive Task Force guidelines. The Arkansas Department of Health recommends that the tobacco cessation benefits that is already currently in place for all federal employees, per the Office of Personnel Management, should be replicated in Arkansas (<http://www.opm.gov/insure/health/planinfo/index.asp>). This plan is almost consistent with the *US Smoking Cessation Clinical Practice Guidelines* (<http://www.ahrq.gov/path/tobacco.htm>).

Subsequent pages present excerpted pertinent parts of a current Blue Cross Blue Shield Services Benefit Plan Nationwide (<http://www.opm.gov/INSURE/HEALTH/PLANINFO/2012/states/ar.asp>) which is currently in place in Arkansas for federal employees and the rider of the QualChoice benefit plan.

Simply, the Arkansas Department of Health, in agreement with the Federal employee plan and the US Smoking Cessation Clinical Practice Guidelines, recommends that all insured enrollees receive tobacco cessation counseling and access to all FDA approved tobacco cessation products with no barriers to access and no co-pays. The attached BC/BS plan has a barrier to access for the Over-the-Counter Medications and this should be removed in the Arkansas plan (ie, no physician prescription should be required for OTC tobacco cessation medications, unless for a minor). The QualChoice plan has too many barriers for both prescription and OTC medications. We are unable to access the 'Breath for Smoking Cessation' module available through BC/BS, or the 'Kick the Nic' QualChoice program - which would then allow enrollees access to counseling. As we do not have access, we are unable to assess the potential counseling benefit and its evidence-base. Arkansas has an excellent evidence-based and cost-effective quitline (Arkansas Tobacco Quitline 1800QUIT NOW) that should be an allowed service for counseling – in addition to any plan's counseling program. The enrollee should be entitled to two quit attempts per year, with unlimited repeats (ie, no lifetime limits). The benefit should also be clear that it supports all tobacco product (nicotine addiction) cessation and not just smoking. Arkansas unfortunately has quite a high prevalence of smokeless tobacco addiction.

The Arkansas Department of Health would be pleased and able to provide further consultation on this key public health essential health benefit.

Sincerely,

Carolyn Dresler, MD, MPA

Tobacco Prevention and Cessation Program, Arkansas Department of Health

cc: Paul Halverson, DrPH

BlueCross
BlueShield
Federal Employee Program

Standard & Basic Option Service Benefit Plan Summary

What's NewFor 2012?

**BlueCross
BlueShield
Federal Employee Program
2012 Standard & Basic Option
Service Benefit Plan Summary
Wellness Support Section:**

Smoking Cessation

If you are ready to stop smoking, we have the support you need for success — our online coaching module provides a personalized interactive program to help you set goals, track results and ultimately improve your health by not smoking. You also get personalized emails in the Secure Message Center on Blue Health Connection for support and encouragement.

After you complete Breathe™, we have additional incentives to help you stop smoking. In 2012, when you use a Preferred retail pharmacy to obtain certain prescription smoking cessation medications, we will waive the cost share under both options. And, we will provide benefits in full for specific over-the-counter smoking cessation medications when you purchase the medications at a Preferred pharmacy.

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Preventive care, adult

We provide benefits for a comprehensive range of preventive care services for adults age 22 and over, including the preventive services recommended under the Patient Protection and Affordable Care Act (the “Affordable Care Act”).

Note: See page 51 for our coverage of smoking and tobacco cessation treatment.

Page 51:

Educational classes and programs

- Smoking and tobacco cessation treatment
- Individual counseling for smoking and tobacco use cessation

Note: Benefits are not available for group counseling.

- Smoking and tobacco cessation classes

Note: See Section 5(f) for our coverage of smoking and tobacco cessation drugs.

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Benefits Description

Note: The Standard Option calendar year deductible applies ONLY when we say below:

“(calendar year deductible applies) .”

There is no calendar year deductible under Basic Option.

Covered medications and supplies

Note: We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 96.

Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 96 for more information.

Benefits Description

Covered medications and supplies (cont.)

Note: See page 92 for our coverage of smoking and tobacco cessation medicines.

Page 92:

**Smoking and Tobacco
Cessation Medications**

**Benefit Description
Covered medications and supplies (cont.)**

If you are age 18 or over, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred Retail Pharmacy.

To qualify, complete the Blue Health Assessment questionnaire and/or answer the initial consultation questions in the Breathe Module for smoking cessation on Blue Health Connection (BHC). For more information about the Blue Health Assessment questionnaire and the Breathe Module, see pages 106-107.

The following medications are covered through this program:

- Generic medications available by prescription:
 - Bupropion ER 150 mg tablet
 - Bupropion SR 150 mg tablet
- Brand-name medications available by prescription:
 - Chantix 0.5 mg tablet
 - Chantix 1 mg cont monthly pack
 - Chantix 1 mg tablet
 - Chantix starting monthly pack
 - Nicotrol cartridge inhaler
 - Nicotrol NS Spray 10 mg/ml
- Over-the-counter (OTC) medications

Note: To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred Retail pharmacy.

Note: These benefits apply only when all of the criteria listed above are met. Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above.

Note: See page 51 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.

Page 105:

Breathe™ for Smoking Cessation – Participate in this online smoking cessation program and receive your personalized action plan to quit smoking. Start by completing the Blue Health Assessment questionnaire and the initial consultation portion of the Breathe program. The program will then provide you with an individualized action plan that fits your life, your needs, and your goals. Once you complete the consultation portion of the Breathe program, you will qualify to receive certain smoking and tobacco cessation medications at no charge. See page 96 for more information.

Page 106

Blue Health Assessment

The Blue Health Assessment questionnaire is a quick and easy online health evaluation program. Your Blue Health Assessment answers are evaluated to create a unique health action plan. You can also participate in online health programs that can help you reach your health goals in areas such as physical activity, overcoming insomnia, nutrition, weight management, overcoming back pain, stress management, help with depression, and smoking cessation (see Breathe™ for Smoking Cessation on page 106).

When you complete your Blue Health Assessment questionnaire, you are entitled to receive a \$35 health account to be used for most qualified medical expenses. For those with Self and Family coverage, up to two (2) adult members, age 18 or over, will be eligible for the \$35 health account. We will send each eligible member a debit card to access his or her health account. Please retain your card for future use even if you have used your health account dollars as you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited.

In addition to the \$35 health account, you are entitled to receive up to an additional \$15 for completing up to three (3) online coaching modules through Blue Health Connection. For each module completed, you will receive an additional \$5 credit to your health account. This means that you are eligible to receive up to a maximum of \$50 in your health account for the calendar year. (Please note that the \$5 credit does not apply to completion of the Breathe™ for Smoking Cessation module.)

**RIDER TO QUALCHOICE EVIDENCE OF COVERAGE
(FORM # QC POS [HDHP] (10-1-10)) FOR
SMOKING CESSATION PROGRAM**

This rider (the "Smoking Cessation Rider") amends the QualChoice Evidence of Coverage (Form # QC POS [HDHP] (10-1-10)) (the "Certificate") and the Benefits Summary issued to the Enrollee. Unless otherwise stated herein, this Smoking Cessation Rider is subject to all terms, conditions, exclusions and limitations set forth in the Certificate and the Benefits Summary.

We have capitalized certain words in this Smoking Cessation Rider. Those words have special meanings and, unless defined otherwise in this Smoking Cessation Rider, are defined in Section 13, "Definitions", of the Certificate.

For purposes of this Smoking Cessation Rider and each section of this Smoking Cessation Rider, QCA Health Plan, Inc. ("QualChoice") is referred to as "us", "we" or "our", and "you" or "your" means the Certificate Holder, i.e., the Employee.

As an Enrollee who is the employee of the employer sponsoring the Plan or an employee's dependent spouse or child, you are eligible to participate in the QualChoice smoking cessation program, a program designed to give you tools and information to help you stop smoking. You can learn more about the details of the smoking cessation program by going to our web site www.qualchoice.com or calling us at (501) 228-7111. The QualChoice smoking cessation program allows you two (2) attempts during the Plan Year to stop smoking, with each attempt being a twelve (12) week program consisting of the following:

1. You enroll in the program by contacting a QCARE health coach by calling (501) 228-7111;
2. QualChoice will mail you a voucher to present to your treating physician that will cover two (2) office visits with that provider for smoking cessation counseling and smoking cessation covered medication management. That treating physician must submit the voucher with the claim when filing with QualChoice for reimbursement. You will be responsible for your Co-payment for each of these office visits as set out in your Benefits Summary;
3. You agree to participate in at least four (4) counseling telephone counseling sessions with a QCARE health coach; and
4. QualChoice will cover at no cost to you a prescription for varenicline. Any other drugs your treating physician wishes to prescribe will be covered as set out in your Benefits Summary.

Nicotine replacement therapy is *not* covered by QualChoice under the Certificate or this Smoking Cessation Rider.

The smoking cessation program is entirely voluntary and is offered to any Enrollee who is an employee of the employer sponsoring the Plan or an employee's dependent spouse or child.

QCA Health Plan (“QualChoice”) disagrees with the recommendation of the Plan Management Advisory Committee to adopt the Arkansas Blue Cross and Blue Shield (ABCBS) PPO plan as the “base plan” for the purposes of defining “essential health benefits” for the State of Arkansas. While the ABCBS PPO plan, HealthAdvantage HMO, and QualChoice HMO plans have some variations in coverage, overall the plans are very similar. The significant exception is that the ABCBS PPO plan covers in vitro fertilization, whereas *neither* of the HMO plans cover infertility treatment. *This difference is driven by state law.*

Arkansas Legislature Elected Not to Require HMOs to Cover In Vitro Fertilization

Arkansas Code Annotated § 23-86-118 mandates coverage for in vitro fertilization for *group* insurers, while A.C.A. § 23-85-137 mandates such coverage for *individual* health insurers. However, the Arkansas Legislature elected not to impose this same mandate on HMOs.

In A.C.A. § 23-76-103 (“Applicability [to HMOs] of the Arkansas Insurance Code . . .”) the Legislature declared that except as otherwise noted in Chapter 76, the provisions of Arkansas insurance law do *not* apply to HMOs. Then A.C.A. § 23-76-104 presents an extensive list of specific provisions contained in the Insurance Code that *are* applicable to HMOs. Notably A.C.A. § 23-76-104 does *not* include either § 23-85-137 (in vitro coverage for individual policies) or § 23-86-118 (in vitro coverage for group policies) in the list of Insurance Code provisions applicable to HMOs.

We suggest these omissions were not an oversight by our State Legislators, but were intentional and provides citizens of Arkansas the opportunity to elect between a PPO that contains in vitro fertilization coverage and an HMO that does not contain in vitro fertilization coverage. A.C.A. § 23-76-104(a)(14) states that the following group health insurance provisions of the Insurance Code do *not* apply to HMOs:

*(14) Sections 23-86-101 — 23-86-104, 23-86-106, 23-86-108 — 23-86-111, **23-86-113 — 23-86-117, 23-86-119**, 23-86-120, § 23-86-201 et seq., § 23-86-301 et seq., and § 23-86-401 et seq., referring to blanket and group accident and health insurance; (Emphasis added.)*

It simply cannot be ignored that the legislature skipped A.C.A. § 23-86-118 in this sequence ---- the mandate to include in vitro fertilization in *group* health insurance plans.

Similarly, the legislature elected not to include A.C.A. §23-85-137 which mandates in vitro coverage in *individual* health insurance plans in the list of provisions in Chapter 85 (individual health insurance coverage) that would apply to HMOs, even though other provisions of Chapter 85 are applicable to HMOs.

Making an exception for HMOs for coverage mandates is unusual. HMOs are required to cover most of the same procedures that health insurers are required to cover. Just a few examples of this include children’s preventative healthcare and gastric pacemakers. This further demonstrates the Legislature’s intent to carve out in vitro fertilization coverage for HMOs.

In short, it is clear that the Arkansas Legislature never intended to require HMOs to provide coverage for in vitro fertilization.

Recommendation by Advisory Committee Has Significant Implications

The recommendation made by the Plan Management Advisory Committee to adopt the ABCBS PPO which includes in vitro fertilization, if adopted by the Steering Committee, would force all HMOs licensed in the State to include in vitro fertilization coverage in small group and individual policies offered *inside* the exchange.

Moreover, assuming small group and individual policies offered *outside* the exchange must also set as their floor the base plan adopted by the state inside the exchange, HMOs in Arkansas would also have to include coverage for in vitro fertilization even *outside* of the health insurance exchange.

The implications of the Plan Management Advisory Committee's recommendation that the ABCBS PPO plan should define "essential health benefits" for Arkansas are significant, including:

1. Arkansas HMOs are forced to include coverage for a procedure that directly conflicts with state law and which was clearly never intended to be required by our Legislature;
2. While currently having a choice between selecting a PPO plan with in vitro coverage and an HMO plan without in vitro coverage, every Arkansan buying coverage in the small group or individual market both inside and outside the exchange will be forced to purchase a product that includes in vitro coverage, regardless of whether they want coverage for this very costly procedure;
3. The estimated \$5.4 Million in additional costs to add in vitro fertilization coverage to all small group and individual health plans sold in the exchange, increasing overall insurance cost by one percent (1%), would be imposed on every Arkansan buying coverage in the small group or individual market, regardless of whether they have the need for coverage for this type of procedure (See Public Consulting Group Issues Brief, May 9, 2012, Page 5); and
4. It disregards the fact that the Arkansas Legislature obviously did not think in vitro fertilization was a necessary benefit for all Arkansans given that it carefully and deliberately carved coverage for this procedure out of what HMOs are required to cover.

Advisory Committee Recommended ABCBS PPO Plan By Default

The Plan Management Advisory Committee does not appear to have recommended the ABCBS PPO plan because its members necessarily believe all Arkansans should be required to have coverage for in vitro fertilization. That is, there does not appear to be a general consensus among the Committee members that in vitro fertilization is really an "essential health benefit". Instead, we believe the Advisory Committee made this recommendation based on the Affordable Care Act's requirement that the cost of any state mandated benefit not included as an essential health benefit must be borne by the state. The

Committee assumed the Arkansas Legislature will not want to bear this cost. We disagree that this is the proper analysis.

The proper analysis is to determine which of the available plans typically offered in the small group market if chosen would provide essential health benefits for all Arkansans in the small group and individual markets without requiring a health plan to provide coverage which is not required by existing applicable law. This approach allows:

- A consistent application of existing law, while at the same time giving consumers choices between the types of coverage they want to purchase both inside and outside of the exchange just as they are doing today.
- Those who are not interested in paying for in vitro fertilization coverage to avoid the additional cost that will otherwise be included in the cost of their coverage.
- The Arkansas Legislature to evaluate the in vitro fertilization mandate during its 2013 session. It may very well be the Legislature finds coverage for in vitro fertilization is such that the State is willing to absorb the cost of the coverage. On the other hand, the Legislature would have the option to rescind or modify the mandate. Said another way, rather than the Advisory Committee making an assumption with regard to what the Legislature may or may not want to do about the in vitro mandate, adopting one of the HMO plans as the base benefit plan gives the Legislature the opportunity to act.

The available plans that accomplish these goals are the HealthAdvantage HMO plan and the QualChoice HMO plan, not the ABCBS PPO plan.

It should be noted that in the “Essential Health Benefits Bulletin” issued by the Center for Consumer Information and Insurance Oversight (CCIIO) on December 16, 2011, it is stated that CCIIO’s “intended approach to EHB incorporates plans *typically offered* by small employers and benefits that are covered across the current employer marketplace”. It notes this is the standard required by section 1302(b)(2)(A) of the Affordable Care Act. In its report, CCIIO points to research that across the country only about ten percent (10%) of people covered by small group policies live in a state covering in vitro fertilization. In Arkansas, we know that only 1 of the 3 largest small group plans covers in vitro fertilization. These facts do not support including in vitro fertilization as an essential health benefit since they do not meet the Affordable Care Act’s and CCIIO’s intent of defining essential health benefits based on plans “typically offered” in the small group market.

It is for these reasons that QualChoice respectfully disagrees with the recommendation of the Plan Management Advisory Committee to the Steering Committee to adopt the ABCBS PPO plan as the base plan for defining essential health benefits in Arkansas. We would instead propose that one of the two available HMO plans that do not include in vitro fertilization coverage be adopted as the base benefit plan.

From: Rahn, Daniel [mailto:DRahn@uams.edu]

Sent: Saturday, May 12, 2012 10:02 AM

To: Cynthia Crone; John Selig; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Paul Halverson, DrPH; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Zane Chrisman

Subject: RE: Minimum Benefit Package

All,

I don't want to insert myself in this discussion other than to say that this is the reason that I asked about preventive services guidelines in our meeting this week. I would think it important to not only adopt initial EHB's but also a process for re-examination and updating according to new evidence or new positions by entities such as the USPSTF. I assume that the question of how payments are linked to the EHB profile is a separate question. This is another key issue for Arkansas since we are endeavoring to embark on system reform in which payment reform is a key foundational element. Have a great weekend.

Dan

From: DKumpuris@aol.com [mailto:DKumpuris@aol.com]
Sent: Saturday, May 12, 2012 10:19 AM
To: Cynthia Crone; annabelletuck@ymail.com; CEKELLOGG@arkbluecross.com
Cc: Jay Bradford; Zane Chrisman
Subject: Re: Minimum Benefit Package

Cindy et al,

I agree with John. The question he is asking is the same one I have asked on several occasions. My best understanding of the answer is that there "is no clear answer". If we mix and match benefits to meet our needs but do not adhere to one existing plan, we run the risk of being disqualified. From a practical standpoint, this makes no sense. I understand why our consultants are hesitant to endorse this approach. If it were to blow up, the finger pointing would likely begin with them.

My suggestion would be to delay on this decision, pending clarity, and move on to the market vs passive purchaser question. Hopefully the fed will clear this up or at least we can ask the question and better define the ambiguity. Just my thoughts.

Drew

In a message dated 5/12/2012 8:32:37 A.M. Central Daylight Time, Cynthia.Crone@arkansas.gov writes:

As co-chairs of the Plan Management Committee, I wanted you to have a copy of this feedback from John Selig and my response. You may want to start at the bottom and move up. Also, Paul Halverson wrote:

I concur with John's concerns and recommendation. We strongly believe that whatever plan is chosen cover all preventive services with strong incentives and low barriers to participants. If we are unable to wait, my recommendation would be to look to one of the nationally available federal plans as the base.

Paul

Paul K. Halverson, DrPH, MHSA, FACHE
Director and State Health Officer

From: DKumpuris@aol.com [mailto:DKumpuris@aol.com]
Sent: Saturday, May 12, 2012 10:19 AM
To: Cynthia Crone; annabelletuck@ymail.com; CEKELLOGG@arkbluecross.com
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Paul
Paul K. Halverson, DrPH, MHSA, FACHE
Director and State Health Officer

From: Jason Lee [mailto:Jason.Lee@dfa.arkansas.gov]

Sent: Monday, May 14, 2012 10:47 AM

To: Thompson, Joseph W; John Selig; Cynthia Crone; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Paul Halverson, DrPH; Dan Rahn; Ray Scott; Marilyn Strickland; Andy Allison; Wilson, Craig

Cc: Zane Chrisman; Pam Lambert

Subject: RE: Minimum Benefit Package

Cindy,

Please correct me if I am wrong, but since "Preventive and Wellness Services" is one of the primary ten categories of care that any essential health benefit must have and that the Affordable Care Act requires that US Preventative Care Task Force recommendations A & B be adopted by any non-grandfathered health plan, Dr. Thompson's goal number 3 will be met.

I did not think it was possible for us to craft a benchmark plan that met the requirements of having Essential Health Benefits and not offering a full array of 100% covered services to the membership.

From: Thompson, Joseph W [mailto:ThompsonJosephW@uams.edu]

Sent: Monday, May 14, 2012 10:30 AM

To: arkansas.gov, john.selig; Cynthia Crone; Jay Bradford; Zekis, Dawn; Jennifer Flinn; Janie Huddleston; Jason Lee; joseph.bates@arkansas.gov; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; nathaniel.smith@arkansas.gov; Paul Halverson, DrPH; Rahn, Daniel; Ray Scott; Marilyn Strickland; Andy Allison; Wilson, Craig

Cc: Zane Chrisman; Pam Lambert

Subject: RE: Minimum Benefit Package

To add a slightly different perspective and to advance the discussion, it seems like we have three interrelated goals for the essential health benefit decision:

- 1) We want the benefit package to be "affordable" so that most people/employers will be able to participate and thus not undermine the insurance system with excessive adverse risk selection

- 2) We want the benefit package to “fit” with whatever we decide the Medicaid package should be so that there is not a cliff at the interface (even though we might want to spend more during 100% federal funding to get people taken care of); and
- 3) We want the preventive benefits to be “robust” to address our chronic conditions and avoid future healthcare expenditures (current private sector benefits are pretty lean on preventive care even if covered);

Of importance, preventive care services (at least A&B USPSTF) don’t cost very much and are not very subject to overutilization (no one volunteers for an extra colonoscopy)—so let’s be sure to pursue all three of the above—I believe we may need to seek approval for adding benefits of the Congressionally mandated A&B to the BCBS PPO as we pursue the more “affordable” option. The expensive state mandates of autism and IVF would be outside the basic scope.

jwt

From: John Selig [<mailto:John.Selig@arkansas.gov>]

Sent: Monday, May 14, 2012 9:10 AM

To: Cynthia Crone; Jay Bradford; Zekis, Dawn; Jennifer Flinn; Janie Huddleston; Jason Lee; joseph.bates@arkansas.gov; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; nathaniel.smith@arkansas.gov; Paul Halverson, DrPH; Rahn, Daniel; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Zane Chrisman; Pam Lambert

Subject: RE: Minimum Benefit Package

Thanks Cindy. I appreciate the explanation and the effort you’re putting into this.

From: Cynthia Crone

Sent: Saturday, May 12, 2012 8:25 AM

To: John Selig; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Paul Halverson, DrPH; Dan Rahn; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Zane Chrisman

Subject: RE: Minimum Benefit Package

John,

We can check on what critical dependencies are affected by slowing this decision. Please remember we are under a very tight timeline. The next decisions become even harder. And we have acknowledged that the benchmark recommendation could be re-considered should compelling (e.g., cost) information come forward.

One thing to clarify-- We are not determining specific benefits (thus costs) at this point, only comparing plans for inclusion of minimal essential benefit "buckets" with consideration of state mandates, since AR (vs. DHHS) will pay for mandates not in the benchmark plan chosen. There is a plan for actuarial review, even though federal guidance asks that benefits, not costs, be considered in this step. The major decision points yesterday were:

- 1) Are we looking to enhance services (as Dr. Halverson suggests by selecting a federal plan) or curb costs to make insurance more affordable? – the group consensus was we needed to look at curbing costs at this juncture—and with a plan that is acceptable in the current Arkansas marketplace;
- 2) Are we selecting a benchmark plan with or without state mandates (AR will pay for any mandates not in the benchmark plan)? The two benefits in question –others were offered consistently--are Autism and IVF. Only one plan covered IVF (the one chosen). All but the federal plans covered autism. There are other issues relative to the AR law re: autism coverage r/t plans inside and outside the Exchange which are still being investigated.

We also acknowledged that pediatric vision and dental services do not meet EHB standards, and this will be addressed. Stand alone dental and vision products are allowed—only pediatric portions are eligible for federal subsidies or cost reductions. The group would like to consider substituting EPSDT dental and vision benchmarks (at present our option allowed by DHHS is a federal plan option). We plan to investigate DHHS acceptance of allowing the EPSDT option when we meet with the federal team next week. The group also asked for more information on Preventive Services.

The benchmark plan options considered by the Advisory Committee yesterday were: 1) the three largest (by enrollment) small group plans in the current market—benefits among these three plans are very close and they represent the lowest overall costs; 2) the state plan (better coverage, higher costs, lacks IVF); 3) Federal Plans (richest in benefits and highest in cost and lacking two state mandates – autism and IVF). The BCBS PPO was preliminarily chosen by a vote of 15-2. It was the only plan that included the state mandated IVF. A recommendation report, which also will include minority views, is scheduled to go forward to the Steering Committee on May 17.

The Plan Management Advisory Committee received issue briefs prior to five hours of fruitful discussion over two days on this topic. There was a great deal of discussion about the need for more information on Medicaid-Private Plans EHB interface—and on costs. Continuing work by FFE-Partnership Exchange consultants and Medicaid staff will help us better evaluate Medicaid and Exchange Plans and their potential interfaces.

We will now also be evaluating the “preliminary choice” plan against federal requirements to date.

Again, please be reassured that there is a plan for cost evaluation, the selected benefit plan can be changed if we learn more that would inform a decision change is needed between now and September, and the plan selected is the benchmark for two years at which time CMS may have different rules. Also, please remember that in order to meet Exchange timelines, we need to have the Qualified Health Plan certification process (and all policies that define that) complete and approved by the *end of this calendar year* so that business and automation needs can be finalized and insurance carriers can submit plans to AID for QHP approval in early 2013, be certified, and Arkansans provided with adequate information in advance of October 1, 2013 enrollment. Decisions yet to come will address costs and AR specific needs.

Sorry for the long email, but I wanted to more fully explain our process, decisions, and timeline. I am also attaching the briefs the Committee has reviewed, and will be happy to add this distribution list to receive additional information as it is developed. (Note the May 9 document is a revision/update of the April 30 document—so you may want to only review the May 9th one!). Our original plan was for the “*pro-con*” *brief with recommendations* (the one that will be ready May 15) to go to Health Agency Leaders before the Steering Committee; however, it may be that we need to modify that plan to include this group with every preparatory document...Let me know if you want us to do that.. Of course all are welcome to participate in the stakeholder meetings.

Thanks again for your leadership and concern with expanding affordable coverage for Arkansans. We definitely value and look forward to consensus on how we proceed.

Cindy

From: John Selig

Sent: Friday, May 11, 2012 9:54 PM

To: Cynthia Crone; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Paul Halverson, DrPH; Dan Rahn; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Subject: RE: Minimum Benefit Package

Just a couple of additional thoughts..

You note that you're defining benefits now, not costs. However, I don't see how the two aren't tightly linked. I don't think you can say what benefits you'll include without having a sense of what they will cost? If the cost wasn't important, we'd all just say cover everything.

I realize the Committee is just advisory, but once you ask for their recommendation, it will be difficult to decide to go a different direction. Better, I think, for them to make a more informed recommendation even if it takes a little longer.

From: Cynthia Crone

Sent: Friday, May 11, 2012 5:43 PM

To: John Selig; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Paul Halverson, DrPH; Dan Rahn; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Pam Lambert

Subject: RE: Minimum Benefit Package

John,

Thanks for relaying this concern. It is an understandable concern. Please remember, this is step one. We are basically defining the benefits not the costs—the cost step comes later as more plan specificity is determined. The Advisory Committee will make a recommendation to the Steering Committee that then recommends to the Commissioner. The Steering Committee meeting is after Bethesda. Nothing from this preliminary work will be so much in stone that it cannot be modified as more is learned. We need to get preliminary decisions in order to move forward on other decisions and meet our timelines. Unless there is a federal change, we must submit our selected EHB Benchmark Plan no later than September 30, but the deadline could be sooner. If we don't choose, there is a default

strategy. I do understand your suggestion that we request a modification of the current benchmark selection method. And we know there's more guidance expected relative to how to "borrow" from other plans in creating a benchmark.

Thanks again for writing. Let's keep the dialogue active.

Cindy

From: John Selig

Sent: Friday, May 11, 2012 2:12 PM

To: Cynthia Crone; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Paul Halverson, DrPH; Dan Rahn; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Pam Lambert

Subject: Minimum Benefit Package

I understand that the Exchange Plan Management Advisory Committee is scheduled to vote Tuesday to choose which plan will serve as our package for the exchange. We at DHS have discussed the options today, and we don't feel we have adequate information with which to advise our representative how to vote. For example, while we have the broad comparison of the plans, we have little detail on what's really covered in each category and, to my knowledge, no estimates of cost associated with each plan. Without material like that, it's difficult to make an informed decision.

In addition, while the federal gov't has said that we need to pick a plan, I think it may be worth pushing on that point at the Bethesda meeting to see if there's some flexibility to mix and match to meet the state's needs.

Is there truly a need for the Committee to make a recommendation on this prior to the Bethesda meeting and prior to getting a more detailed analysis of the choices and policy implications? If not, I'd suggest we hold off for a while.

Thanks.

Zane,

Below are our comments concerning the choosing of a benchmark plan and the standard for pediatric care. Please let us know if you have any questions. Thanks.

In choosing benchmark plan for Arkansas that meets requirements for essential health benefits outlined in the ACA, Arkansas Advocates for Children and Families advises selecting a standard for pediatric care that ensures children receive all services necessary to help them develop into healthy adults. If health problems are discovered early, health care costs can be reduced in the long run. Receiving adequate preventive care is a key component of early diagnosis and treatment. It is important for the Exchange Plan Management advisory group to recognize that children's unique needs are not always met by "adult" plans and that investing in children's health pays off in the long run. Providing children with EPSDT benefits or, at minimum, the benefits outlined in the Bright Futures guidelines, will ensure they receive optimal care throughout the course of their childhood.

The **EPSDT** (Early Periodic Screening, Diagnosis, and Treatment) program has been around since 1967. EPSDT is a mandatory set of services and benefits for all children under age 21 who are enrolled in Medicaid (ARKids First A in Arkansas). EPSDT aims to discover health issues in children and treat them to prevent small problems from escalating. The "Screening" component includes physical, mental, developmental, dental, hearing, vision, and other services such as immunizations. As problems are confirmed through "Diagnosis," children should receive "Treatment" for the issues. Essentially, EPSDT requires that children on Medicaid receive all the screenings and most treatments deemed necessary by their doctor.

For more information on what is covered by ARKids First A, see <http://www.arkidsfirst.com/bene.htm>. For the HRSA overview, see <http://mchb.hrsa.gov/epsdt/overview.html>. AACF also produced a brief on EPSDT screening, found at <http://ccf.georgetown.edu/index/aca-protects-and-improves-access-to-preventive-care-for-children>.

Alternatively, the **American Academy of Pediatrics developed Bright Futures**, a national health care promotion and disease prevention initiative that uses a developmentally based approach to address children's health care needs in the context of family and community. Its purpose is to promote and improve infant, child, and adolescent health within the context of family and community (<http://brightfutures.aap.org>). A brief released in March 2012 by the Georgetown Center for Children and Families stated that "New plans, as of September 23, 2010, must: 1) **cover all preventive services as**

defined by the Bright Futures guidelines of the American Academy of Pediatrics, widely recognized as the definitive standard of care; and 2) provide preventive services at no cost to enrollees—no co-pays, deductibles, or co-insurance for defined, preventive services.” (see “ACA Protects and Improves Access to Preventive Care for Children,” <http://ccf.georgetown.edu/index/aca-protects-and-improves-access-to-preventive-care-for-children>.)

Rich Huddleston
Executive Director
Arkansas Advocates for Children & Families
Union Station, Suite 306, 1400 W. Markham
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Zhane,

With some additional reflection, I have some concerns related to choosing the BCBS small group plan rather than one of the two HMO small group options as the benchmark plan. These concerns primarily relate to implications for in vitro fertilization benefits. Under current Arkansas law health insurers, but not HMOs or the state employee plan, are required to provide in vitro fertilization coverage up to \$15,000. The primary effect of selecting the BCBS plan is that HMOs not previously required to provide coverage for in vitro fertilization would be required to do so beginning in 2014 in and outside the exchange. This result presents obvious separation of powers. If the Insurance Department recommends the BCBS plan as the benchmark, a regulatory agency will either directly require or recommend the federal government require HMOs to provide a benefit the federal government has thus far not required and the state legislature explicitly chose not to require. This is different than making recommendations on pediatric vision and dental because those benefits are expressly included within the definition of essential health benefits.

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From: Cynthia Crone

Sent: Saturday, May 12, 2012 8:38 AM

To: Paul Halverson, DrPH; John Selig; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Dan Rahn; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Pam Lambert; Zane Chrisman

Subject: RE: Minimum Benefit Package

Dr. Halverson,

Thanks for your comments. Our group was very concerned with the costs of the federal plans at a time when we are working to make coverage affordable for all Arkansans. I definitely value preventive services; there may be ways to consider certain, targeted services that are specific to AR health needs as we design AR Plan Certification Requirements. The Committee requested more information on preventive services and we are looking at the materials you suggested Wednesday as well.

I have provided a more lengthy response to the Plan Advisory Committee's work in a separate email you should have also received.

Thanks for writing and your continued leadership to improve Arkansans' health.

Cindy

From: Paul Halverson, DrPH

Sent: Friday, May 11, 2012 2:49 PM

To: John Selig; Cynthia Crone; Jay Bradford; Dawn Zekis; Jennifer Flinn; Janie Huddleston; Jason Lee; Joe Bates, MD; Joyce Dees; Mccarthy, Suzanne G; Money, Kenley; Nate Smith, M.D.; Dan Rahn; Ray Scott; Marilyn Strickland; Thompson, Joseph W; Andy Allison

Cc: Pam Lambert

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Paul K. Halverson, DrPH, MHSA, FACHE

Director and State Health Officer

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