

## Arkansas Health Benefits Exchange Planning

Healthcare Industry-Insurance Carriers/ Healthcare Providers/Professional Associations	August 15, 2011	Arkansas Studies Institute Rm. 204	9:00 AM – 1:00 PM
<b>Members Present:</b> Edward Anderson Donna Auld Julie Benafield Dr. Darlene Byrd Mike Castleberry Ed Choate Steve Gelios Raymond Ortega Billy Tarpley John Ryan	<b>Staff:</b> Cindy Crone Bruce Donaldson  <b>Guests</b> Delores Chitwood, Producer Cynthia Eden, MASH Joni Jones, DHI County Operations Jim Miles, Covenant Melissa Simpson, AID-SHIIP Crystal Williams, MASH Gwen Williams, DHS County Operations	<b>Members Absent:</b> Larry Alford Dr. Mark Attwood Jim Clark Austin Gaines Carla Groff John Harriman Leo Hauser David Holman (called) David Ivers Dr. Drew Kumpuris Treg Long Jacque Martin Sip Mouden Lesley Nalley Sharon Oglesby Marvin Parks Sam Partin Marie Sandusky Doug Stadter Mike Stock Sheila Waits Arthur Wolover	

### **Call to Order and Approval of Meeting Summary:**

Following welcome by Cindy Crone and Bruce Donaldson, those present introduced themselves. The July 21, 2011 meeting summary was approved.

Cindy asked for permission to rearrange the agenda in an effort to allow the visitors to present on their respective organizations. Everyone agreed.

**Four organizations that provide Outreach or Education services toward the goal of expanding health care coverage** were asked to present about their work.

### **DHS County Operations**

Joni Jones presented on how the Eligibility process works for various DHS programs. The Division of County Operations acts as the eligibility gateway for 1.3 of 1.5 million people that receive services from DHS. Eligibility is determined through a call center, face-to-face meetings, on-line, or by telephone. The top three programs are Medicaid/CHIP (>700,000 cases), SNAP and TANF. There are 83 County Offices and 6 Long Term Care processing units for TEFRA. A

DHS has established Access Arkansas, which is an online process. Access Arkansas is a portal that prescreens applicants for programs that they may qualify for. The applicant is asked a series of prescreening questions that will determine potential eligibility and then given the option to apply for those programs. If an application is submitted, it is then assigned out to caseworker. DHS is currently working on the ability to continue the process through an electronic eligibility approval feature.

Another project in the works for DHS is the Access CallCenter to help service those that are not computer literate or comfortable with using the online process. Using stimulus dollars, DHS has created an Access Arkansas Center which created 100 positions that were created (and filled) by displaced DHS workers. This center will open (handout) on September 23. It will transfer paper to electronic records, perform document management functions, issue automatic notices, initiate an integrated voice response system and use reverse call engineering.

DHS has 34 out stationed eligibility workers in hospitals that are charged with helping people apply for Medicaid services. DHS also works with AAA, Food Banks and Food Pantries (Arkansas Hunger Alliance), and Arkansas Advocates for Children and Families to help with outreach.

DHS piloted the Benefits Bank program which provided counselor assistance to help applicants complete applications for services. This program is similar to the Navigator Program.

DHS has taken some of the funds received for SNAP outreach to make and pilot these improvements. DHS created mobile units (handout) to go out into the field. Applicants can complete applications onsite at community events.

Access Arkansas is on track to be able to plug in easily to an Arkansas Health Benefits exchange.

#### COMMENTS OR QUESTIONS:

- If state run exchange, when/how would we switch from information that is submitted by the applicant to the information that is reported from federal portal?
  - What time frame will be given for the review process if there are mismatches?
  - Will operations for DHS look different if Federal exchange verses State exchange? *Probably not much.*
  - What publicity has DHS used to publicize Access Arkansas? *None yet, only web presence, yet we are getting users.*
  - Is DHS expecting a large increase in workload due to the anticipated increase in Medicaid eligible people? *Yes in some ways—particularly when there is a federal-applicant mismatch. However, we now have 65 Medicaid categories and require face-to-face meetings, so we expect a significant decrease in workload when eligibility can be determined on-line and by income/citizenship determinations only.*
- Do you see DHS employees acting as Navigators? *No.*

#### MASH

Cynthia Eden gave presentation on how this “eligibility company” works. MASH started out working with hospitals to help the uninsured and those that could not afford their medicals bills determine what insurance or other coverage services they may be eligible for. MASH has expanded to include nursing homes, cancer institutes, rehabilitation centers, and dialysis centers. MASH is eight years old and currently operates in 9 states. They are headquartered out of Fort Worth, Texas. MASH has a call center that operates 6 days a week including evenings and week-ends, and works one on one with all clients. They start with ten questions to help guide advocacy. Home visits are made if needed. They do a lot of disability work. Advocates walk clients through the application process. The organization is compensated through a percentage of any payment that the hospitals receive as a result of the applicants qualifying for a federal or state program. There is no compensation to MASH by individuals. MASH currently employs 12 people for the state of Arkansas, 6 of whom are in-house staff and 6 are stationed in the call center. MASH feels that they would be a good match to serve as Navigators. Some of the systems that they already have in place would easily transition to the Exchange. Their staff is already trained on various federal and state programs.

#### COMMENTS OR QUESTIONS

Commenter has observed in Oklahoma, hospitals already have kiosks in place for benefits applications. 75% of the people that utilize the kiosks have trouble and require assistance.

One major question that causes problems is “household composition”—especially with multi-family households. Most applicants also are uncertain of how to answer the income related questions and have a fear of entering incorrect information.

#### SHIIP (Seniors Health Insurance Information Program)

Melissa Simpson presented on the SHIIP program—federally funded and operated out of the Arkansas Insurance Department. Three handouts were provided (Volunteer Management Collaborative Technical Assistance Project; Services provided by Medicare or Medicaid Program; SHIIP Program Brochure). SHIIP uses information stations to house brochures on Medicaid and Medicare in grocery stores, drug stores, coffee shops, etc. Information stations are small stands that have pocket folders with brochures and are especially helpful in rural areas. SHIIP has started a volunteer program to help assist seniors with applying for Medicaid and Medicare. The volunteer role is a Medicaid/Medicare Counselor. Targeted volunteers are retired professionals with computer skills and the desire to learn about Medicaid and Medicare. They learn technical jargon and how to talk to people. The main attribute sought is CARING. The volunteers are required to pass a State and National background check, go through 16 hours of training and to complete a certification exam before they can begin to assist applicants. There are four certification exams; a score of 80% is required to pass. The volunteers are allowed three opportunities to pass the exam. The main two categories that SHIIP assists with are Medicare Part D and Medicaid. There are 29 volunteers currently available across the state. The SHIIP program can provide phone counseling, but fall short of telling a consumer what to do. Some of the organizations that SHIIP has partnered with are Area Agency on Aging, Community Action Agencies, Arkansas Foundation for Medical Care, Community Health Centers, Health Departments and some faith-based organizations that assist in serving Non-English speaking families. Because of the workload that SHIIP currently handles, they would not be interested in or able to be relied on for the Health Benefits Exchange Navigator role; however, the HBE Navigator program could learn from the Medicaid/Medicare Counselor positions.

#### COMMENTS OR QUESTIONS

How does SHIIP handle calls regarding recommendations for carriers? *They do not recommend a specific product or carrier.*

#### Covenant Medical Benefits

Jim Miles gave a presentation on Covenant. The company is based out of Jonesboro, Arkansas and will be celebrating their 10 year anniversary on October 1, 2011. Covenant works with hospitals to help self-pay patients find some way to pay medical bills. They look for existing third party coverage or coverage eligibility including screening for Medicaid, injury payments eligibility, or victims programs. Covenant helps to convert bad debt of hospitals into profit. 10 to 15% of some hospitals’ profit is derived from third party assistance. Covenant’s main focus is on Medicaid eligibility. Covenant works with DHS to help patients complete applications and to send DHS quality applicants that can be approved.

#### COMMENTS OR QUESTIONS

Mr. Miles would like to see the retroactive benefit of Medicaid stay in place and would also like to see the disability requirement for Adults to convert to a temporary disability requirement for those that are just above the 133% of poverty level.

The four presenters were thanked for coming and presenting information to help guide development of outreach/education/Navigator roles for the Arkansas HBE.

#### Announcements

- Skype is now available for those who can not be present at the workgroup meetings. Please contact Bruce so that he can provide you with access.
- The Stakeholders Summit has been confirmed for October 11, 2011 at Embassy Suites in Little Rock. It will be an all day meeting with a goal of sharing information and recommendations as well as receiving feedback from

diverse attendees. Lunch will be provided. Registration will begin at 8:00 a.m. An “Exchange 101” session will begin at 8:30 as an introduction to Exchanges. Otherwise, the meeting will begin at 10:00 am and we hope to have 250 attendees. Joel Ario will serve as a keynoter. *It was suggested that broad advertising be planned for the summit, to include small businesses and community based organizations.*

- District 11 Circuit court in Atlanta ruled that the mandatory insurance enrollment requirement of ACA is unconstitutional. That is in contrast to the Cincinnati court that ruled the mandatory provision constitutional. All other provisions of ACA were held Constitutional by the Atlanta court. This issue will likely ultimately be decided by the U.S. Supreme Court.
- Kansas joined Oklahoma in returning their Exchange Early Innovator funding to DHHS.
- A Democrat-Gazette article last week left the impression with some that Exchange Planning efforts in Arkansas are over. Exchange Planning and Early Innovator funding were both addressed in the article and many confused the two, resulting in the misunderstanding that Exchange planning has ended. Please let others know that planning is continuing. It is important to reach out to Community leaders, including business leaders and separate the Exchange from “Obamacare”.
- David Boling will be leaving the Steering Committee (and Arkansas) to take a position as Deputy Executive Director of the Mike Mansfield Foundation in Arlington, VA. Before he left, David drafted an ACHI Issue Brief (handout) titled, “Will Employers Drop, Keep or Add Health Insurance in 2014?” which predicts there will be little change in employer insurance coverage. David’s contributions to the Exchange Planning effort were acknowledged and he was thanked.

#### **CCIIO Update** a handout was presented

- Joel Ario, Exchange Lead at CCIIO, has resigned effective September 23, 2011. Steve Larsen is CCIIO Director.
- New set of proposed regulations released 8/12/11 on Premium Tax Credits, Medicaid/CHIP and ACA, and Exchange Eligibility and Employer Standards. Comments will be due 75 days after Federal Register posting. See [www.HealthCare.gov/news/factsheets/exchanges08122011a.html](http://www.HealthCare.gov/news/factsheets/exchanges08122011a.html)
- Send response comments for Exchange Planning responses to CCIIO on proposed regulations to [Bruce.Donaldson@Arkansas.gov](mailto:Bruce.Donaldson@Arkansas.gov) or [Cynthia.Crone@arkansas.gov](mailto:Cynthia.Crone@arkansas.gov). Remember to send comments on 7/11/11 released proposed regulations by September 9, 2011.
- CCIIO awarded \$185 million to 13 more states and District of Columbia on 8/12/11 in Exchange Development Level One awards. Arkansas plans to submit Level One application September 30, 2011.
- Last week, Kansas became second state to return Early Innovator funding.
- Arkansas will discuss budget revision and No Cost Extension requests with CCIIO project officers on 8/17/11. These are needed to meet project deliverables including Stakeholder Summit and public hearings in November/December.
- Upcoming Exchange Meetings (CCIIO Listening Session - Denver, August 24; CMS Eligibility/Enrollment - Baltimore, September 7-8; NGA – Arlington, VA, Sept. 8-9; UX 2014 – San Francisco, August 23 and September 12-13; CCIIO Exchange Grantee Meeting – Arlington, VA, September 19-20)
- CCIIO CO-OP Grant Opportunity announced with six application deadlines between 10/17/11 – 12/31/12. CCIIO is looking for every state to participate in this program to develop new non-profit health insurance programs; \$3.8 billion available to non-profits nationwide.

#### **Steering Committee Update**

- New Committee Members – two new members have been appointed to the Steering Committee. They are Kevin Ryan, with ACHI, who will be replacing David Boling and Tim Lampe with DHS who will serve with Ray Scott as liaison to the IT Work Group.
- Governance – Commissioner Bradford is planning to work on interim appropriation authority for continued Exchange planning once the Level One funding request has been awarded. It is expected this will be in mid-November.
- Need for Public Education Campaign – The Self-Chartered Health Care Reform Advisory Group is seeking funds for a public opinion poll and advocacy campaign stressing the need for an Arkansas Exchange. The HBE Planning

Steering Committee discussed the need for a separate education campaign about the benefits of an Exchange for Arkansas small business owners. A more specific end-user consumer enrollment campaign would come later, following development of further details for the Exchange planned for Arkansas.

- First Data Contractors Dr. Lars Powell and actuary Mark Howland of SCIOInspire presented preliminary findings from micro simulation modeling and consumer migration from insured or non-insured status pre and post-Exchange implementation (2014).

#### **First Data Update**

- Planning contract is on track. Bi-weekly progress report is on web site at [www.hbe.arkansas.gov](http://www.hbe.arkansas.gov).
- Powell and Associates and actuary from SCIOInspire (formerly Solucia) presented preliminary work has begun micro-simulation modeling using Dr. Larson Powell's HIRSM model, and Solucia has begun actuarial studies for Arkansas.

#### **UAMS Community Stakeholder Update**

- David Deere prepared a preliminary report on the community meetings and a copy was distributed to the workgroup. The key areas of divergent opinions were Governance and Navigators. A full report is expected next week.
- The 15 item UAMS Exchange Survey remains active until August 25, 2011 and can be accessed through [www.hbe.arkansas.gov](http://www.hbe.arkansas.gov). An interim report (with responses through July 25, 2011) was prepared for the Steering Committee. This report showed about a third of responders strongly favor a state run exchange, about a third prefer a state-run exchange over a federal exchange in Arkansas, and slightly more than one-third are against any Exchange in Arkansas.

#### **Discussion Item**

Marketplace/Financial Model –We are collecting feedback, questions and other considerations to send back to the actuaries. The workgroup was provided a handout prepared by Dr. Lars Powell on the micro-simulation model he has prepared. It was developed based on the observed behavior of ~38,000 lives of persons demographically similar to Arkansans. Variables used were price and cost. The results indicate that 95% of Arkansans would choose to be insured based on subsidies (before penalties are introduced) and 100% would choose to be insured after penalties have been introduced. Small Group Employer and Individual behaviors were taken into consideration. It was predicted there would be an 11% decrease in premiums as well as a 21% decrease in price for Arkansans. The premium minus subsidy equals the price. The Actuary report showed assumptions of how people will migrate to the Exchange or other marketplace. The Arkansas numbers in the model are estimates and will be updated to reflect the actual numbers from Arkansas. Questions:

- How can the model be adjusted for “collective bargaining” employers versus employers that are not covered by collective bargaining?
- What is the timeline predicted? (2014)
- The group would like to see the specific numbers of individuals predicted to migrate from and to each group.
- What accounts for decreased medical costs per member per month?
- Does the model account for consumer education by Navigators?

#### **Public Comment:**

- Strongly recommend that the Steering Committee and Workgroups begin to move faster to make decisions in order to make a bigger impact at the General Assembly.

- What is the best way to move forward with decision making? Ideas included:
  - There is flexibility for a state exchange. The Massachusetts and Utah exchanges are models. Arkansas has flexibility to develop an exchange anywhere in between the two.
  - Commenter liked DHS taking on the role of Navigators.
  - Recommended certification over licensure for Navigators.
  - There are many decisions that need to be made before workgroups can move forward with planning efforts, e.g., “will small business be defined as 50 or 100 in 2014?”; “Will there be an inside and outside Exchange market?”; “ Will Navigators be licensed or certified?”; “ How will Navigators be paid?”

**Next Meeting**

- September 22, 2011 - 9:00am to 1:00pm at the Arkansas Studies Institute.
- Topic next meeting: Program- IT Integration Plan.

DRAFT

## TREASURY LAYS THE FOUNDATION TO DELIVER TAX CREDITS TO HELP MAKE HEALTH INSURANCE AFFORDABLE FOR MIDDLE-CLASS AMERICANS

August 12, 2011

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

### The Premium Tax Credit:

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

### Key Facts about the Premium Tax Credit:

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

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

### How the Premium Tax Credit Works

#### Eligibility

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

#### Credit Amount

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

#### Special Rules

- *The credit is advanceable, with advance payments made directly to the insurance company on the family's behalf. The advance payments are then reconciled against the amount of the family's actual premium tax credit, as calculated on the family's federal income tax return. Any repayment due from the taxpayer is subject to a cap for taxpayers with incomes under 400% of FPL. The caps range from \$600 for married taxpayers (\$300 for single taxpayers) with household income under 200% of FPL to \$2,500 for married taxpayers (\$1,250 for single taxpayers) with household income above 300% but less than 400% of FPL.*
- *The proposed regulation provides that a taxpayer is not required to repay any portion of the advance payment if a family ends the year with household income below 100% of FPL after having received advance payments based on an initial Exchange determination of ineligibility for Medicaid.*



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

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

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

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

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

❖ August 2011

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

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

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

### ■ BACKGROUND

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

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

### ■ Factors that Suggest Employers Will Drop Coverage

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

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

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

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

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

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

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

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

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

## ■ NATIONAL STUDIES

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

### ■ Employer Surveys

#### **Mercer**

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

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

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

#### **McKinsey**

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

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

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

■ Predictive Models

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

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

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

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

■ MASSACHUSETTS EXPERIENCE

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

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

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

## ■ CONCLUSION

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

The above review illustrates three important points.

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

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

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

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

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

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### Endnotes

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

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

<sup>iii</sup> Affordable Care Act, Section 1402.

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

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

<sup>vi</sup> Employer Survey on US Healthcare Reform. [http://www.mckinsey.com/us\\_employer\\_healthcare\\_survey.aspx](http://www.mckinsey.com/us_employer_healthcare_survey.aspx). Accessed July 29, 2011.

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

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

<sup>ix</sup> Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys (December 2010).

# Arkansas Health Benefits Exchange Stakeholder Input

## Report from Community Meetings

Prepared by David Deere and John Wayne

Community meetings were held in 16 cities in Arkansas to engage community stakeholders such as insurance professionals, healthcare providers, business owners and managers, community leaders and elected officials, and consumers in an open conversation about their ideas for the Arkansas Health Benefits Exchange. More than 500 persons attended the meetings, with good representation from all the various stakeholder groups.

The comments offered by the participants are organized around various decision points faced by planners of the exchange.

### Should Arkansas plan an exchange or accept the exchange that will be offered by the federal government?

A majority of the participants were in favor of proceeding with plans for an exchange designed by Arkansans, for Arkansans. Part of that group was excited about the prospects of an exchange, while others do not like the idea of an exchange but do not want to give up control of the design of the exchange. There was a strong and vocal minority of the participants who were unequivocally opposed to planning an exchange. Some of the opponents expressed that it was a waste of taxpayer money for the state to plan an exchange when the federal government will be prepared to initiate their version of an exchange. Others see an exchange as a part of health care reform and therefore undesirable.

### Who should govern the exchange?

With a few exceptions, most participants want to see the Insurance Department regulate plans and companies. On the issue of operational oversight, there was less agreement. Three models of governance were identified: placement within a state agency, awarding governance of the exchange to a not-for-profit through a bidding process, and governance by a board or commission. Of the three models, each had supporters and detractors. Participants noted concern that the exchange needs to be free from excessive regulations, while maintaining strong accountability. Several persons stated that in order to meet tight deadlines, the exchange will need to be nimble with regard to purchasing and hiring. That will also be important for making changes in response to ongoing continuous improvement activities. There were also advocates for various combinations of the three models.

### Should Arkansas consider adding to the Minimum Essential Benefits?

Since little is known about the federally-mandated Minimum Essential Benefits, it was difficult for participants to identify benefits that should be included. There was concern that the benefits package be robust enough to provide adequate coverage while not pricing the plans out of the effective reach of the purchasers. A few participants expressed a need for

inclusion of specific services, such as therapies and equipment for individuals with disabilities.

Should individuals making more than 400% of the federal poverty level be allowed to participate in the exchange?

Many of the participants expressed a desire for the exchange to be as inclusive as possible. However, a sizable number of participants urged caution concerning opening the exchange to all. Reasons for limiting participation included the need to hold down costs of operation and concerns that if the exchange is larger it will magnify any unforeseen problems associated with start-up.

Should businesses with more than 50 employees be allowed to participate in the exchange?

The discussion for this issue was very similar to the discussion about expanding individual participation. Many favored the expansion, while others were concerned about increasing costs or about magnifying start-up problems.

Should Medicaid enrollment be integrated into the exchange portal?

While there were some concerns about adding this group and increasing the size and complexity of the exchange, most participants thought the benefits of Medicaid enrollment through the exchange will outweigh the costs and challenges.

How should the navigator program be run?

There was a general consensus that navigators should be well trained and either licensed or certified. Many noted their concern that there should be continuing education requirements for navigators. The greatest point of debate during the community meetings was over the role of licensed insurance agents. Should agents be able to serve as navigators? A number of participants, including many who were not agents, indicated that agents were the best trained to assist purchasers with the use of the exchange. On the other hand, some participants expressed concern over the perceived impartiality of agents, including independent agents. Questions were raised about whether navigators would be covered by errors and omissions.

Many participants expressed concern that navigators be local and available to work face-to-face. Other concerns voiced include:

- The help line should not be located overseas and should not require callers to navigate an automated system that “routes and re-routes you and keeps you on hold”.
- Participants should not be expected to drive a great distance to meet with a navigator.
- Navigators should be from the cultural groups they are serving.
- Use natural helpers from the communities as navigators. This might include people from local non-profits, area agencies on aging, churches, etc.

Should all qualified health plans be offered through the exchange, or should the exchange select the best plans?

While there seemed to be a preference for an exchange that is open to all plans, there were participants who preferred asking insurers to compete for the opportunity to sell through the exchange.

Preliminary Participation Results  
Arkansas Health Benefits Exchange

Steering Committee Meeting  
August 9, 2011



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Simulation Model

- Data
  - Current Population Survey (CPS)
    - 39,865 observations
  - Medical Expenditure Panel Survey (MEPS)
    - Healthcare spending
  - Survey of Income and Program Participation (SIPP)
    - Insurance Premium Paid

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Raw Data

■ Latest census stats	■ Raw data from CPS
- Male: 49.1%	- Male: 48.5%
- White: 77%	- White: 81%
- Poor: 37%	- Poor: 35%
- Child: 29%	- Child: 38%*

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**Calibration**

- Insured in raw data = 30,937 / 78%
- Insured: baseline model = 37,342 / 94%
- Insured: calibrated model = 30,861 / 78%
  
- Other distribution characteristics hold

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**Predictive model**

- Estimates plan take-up from changes in price and cost
  - Price elasticity = -0.138
  - Premium elasticity = -1.42\*
  - $\Delta = (\text{new} - \text{old})/\text{old}$ 
    - Subsidies, penalties, and rating restrictions
  - If  $\sum [\text{Elasticity} \times \Delta] + X'\beta > 0$  then purchase
    - $X'\beta$ : set of other predictors held constant
    - Income, gender, family size, etc.

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**Preliminary Predicted Results**

- 95% of Arkansans insured
- Subsidies in the exchange
  - Decrease premium for 11% of population
  - Decrease price for 21% of population
  - Including employer contributions
  
- Take up will approach 100% as penalties are worked into the model

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