Arkansas Health Benefits Exchange Planning

Outreach/Education/Enrollment/ Navigators/Producers/Agents	August 16, 2011	Arkansas Studies Institute Rm. 204	10:00AM-12:00PM

Members Present:	Members Absent:
Fred Bean	Rose Adams
Rose Crane	Patty Barker (called)
Robbi Davis	Greg Hatcher
Dr. Cal Kellogg	Glenn Jones
Kurt Knickrehm	Greg Jones
Randy Lee	Chris Newell
Sr. Joan Pytlik	Terri Patrick
Derrick Smith	Ann Sperry
Lisa Weaver	Henry Tuck
	Guests:
	John David True, Producer
Staff: Cindy Crone	Delores Chitwood, Producer
Bruce Donaldson	Dale Ramsey, Producer
	Heady Nezhadpour, Ark LTC

Meeting Summary
Meeting summary from July 19, 2011 meeting was approved.

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 for newcomers. 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 through a press release, mail lists, website, word of mouth, and individual invitations from Commissioner Bradford to state legislators advertise the summit. It was also suggested that community-based organizations be approached. A small registration fee might assist with registration and attendance.*
- District 11 Circuit court in Atlanta ruled that the mandatory insurance enrollment provision of the ACA is unconstitutional. That is in contrast to the Cincinnati court that ruled the mandatory provision is constitutional. All other provisions of ACA were held Constitutional by the Atlanta court. This issue will likely be ultimately 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 readers 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.
- 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.

Updates

CCIIO –Cindy Crone

- Joel Ario, Director of Exchange Planning has resigned effective September. No announcement has been made as to whether or not there will be a replacement.
- Newly released proposed federal regulations for Exchanges came out on Friday, August 12, 2011 in addition to the Proposed Federal Exchange regulations that were released on July 11, 2011. Each workgroup member should have received an electronic link to the two documents. Comments are due to DHHS by September 9, 2011 for the July regulations and the Exchange Planning office will collect and submit comments. Send your comments to Bruce.Donaldson@arkansas.gov or Cynthia.Crone@arkansas.gov. Anyone interested may submit comments on their own as an individual or organization. The comments for the regulations released on August 12, 2011 will be due within 75 days from the publishing date.
- CCIIO granted $185 million in Level One Funding on Friday, August 12, 2011 to 13 states and the District of Columbia. Arkansas will be applying for Level One Funding in September. $20 million was awarded to our neighbor Mississippi and $21 million to Missouri.
- We will be meeting with Project Officers Anna McCourt and Jabaar Gray on August 17th, 2011 regarding the budget revision and no cost extension request to CCIIO in order that we meet deliverables for Summit and Public Hearings to be held in November and December 2011.
- Upcoming Exchange Meetings are: 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.
- There is a Co-Op Grant opportunity available. CCIIO is looking for each state to participate. The grant is available to a non-profit to develop a new insurance program for the state of Arkansas. There is 3.8 billion dollars available for this program nationwide. You can find out more information on the Grants.Gov website.

Steering Committee- Fred Bean

- UAMS web-based survey will close on August 25, 2011; please take time to complete the survey and make others aware of it as well.
- Lars Powell presented his marketplace findings and predicts that 95% of Arkansans will choose to be insured as a result of ACA and the availability of more affordable coverage.
- The Self-Chartered Health Care Reform group has commissioned Paschall Strategic Communications to perform a public opinion poll to get feedback on the public's view regarding the Exchange. There will be a scientific random sampling of registered voters.
- Cindy reported the Exchange Planning grant will begin a separate outreach education campaign focusing on small business owners.
- Cindy reported that Tim Lampe with DHS has joined the Steering Committee as liaison (with Ray Scott) to the IT Workgroup. Kevin Ryan with ACHI will be replacing David on the Exchange Planning Steering Committee.

First Data

- Activities are progressing; bi-weekly progress report is on web-site at www.hbe.arkansas.gov

UAMS Community Stakeholder Involvement

- David Deere (UAMS) compiled a two page preliminary report (handout) on findings from the Exchange Planning community meetings held across the state. A final report is expected next week. Two areas of divergent views were Exchange Governance and Navigator Role.
- UAMS has created a web-based Exchange survey which will remain "live" through August 25, 2011. Everyone was encouraged to participate and spread the word about the survey which can be found on the Health Benefits Exchange website, www.hbe.arkansas.gov.

Discussion

- Dr. Lars Powell's Arkansas Exchange predictive model was developed based on observed behaviors in ~38,000 lives using variables of price and cost. Preliminary results indicate that 95% of Arkansans would choose to be insured when subsidies are introduced and before penalties are introduced, and close to 100% would choose to be insured after penalties have been introduced. Small Group Employer and Individual consumer behaviors were taken into consideration and results indicated an 11% decrease in premiums as well as a 21% decrease in price for Arkansans. The premium minus subsidy equals price. A model of migration from current insurance coverage or non-coverage to coverage in 2014 was demonstrated. The numbers in the model were "good" for the nation, but only estimates for Arkansas at this time. A discussion resulted in the following questions:

1. What percentage of residents will be willing to pay at the different actuarial levels with subsidies?
2. Will the price be compatible to willingness to pay for the different levels?
3. How many Arkansas Small Employers took advantage of the premium tax credit in 2010?
4. Is the 100% transfer in the model a valid assumption?
5. Will the subsidy change based on tobacco use?
6. Has access to providers been considered (especially for Medicaid recipients)?

Other Comments

- Where are we on the organizational structure of the exchange? *Most prefer quasi-governmental structure with non-profit board connected to Arkansas Insurance Department. It was suggested we review the proposed legislation from last session and look at board composition.*
- Commenter reported encouragement that the contractors are actually providing numbers, percentages and dollars for the workgroups to consider.
- It is critical to start gaining grassroots supporters for an Arkansas-run Exchange. Several hurdles have been recognized that may prevent grassroots support of the exchange. They include tax dollars being spent for health care reform, "fear of Obamacare", and misinformation.

Next Meeting

- The next meeting will be held September 20, 2011 in room 124 of the Arkansas Studies Institute.
- The major topic of discussion will be Program IT Integration.

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.

- **<u>Credit Is Advanceable to Help Families with Limited Cash-Flow</u>**. 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.

<u>How the Premium Tax Credit Works</u>

<u>Eligibility</u>

- *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.*

<u>Credit Amount</u>

- *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).*

<u>Special Rules</u>

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

- *Tax credits are available to qualified individuals offered (but not enrolled in) employer-sponsored insurance if (a) it is "unaffordable" (meaning that the self-only premium exceeds 9.5% of household income); or (b) it does not provide a minimum value (meaning it fails to cover 60% of total allowed costs). We anticipate that future regulations will define minimum value in a way that preserves the existing system of employer-sponsored coverage, but that does not permit employers to avoid the statutory responsibility standards. We also are contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage. Future guidance will define minimum value in a way that preserves the existing system of employer-sponsored arrangements, which does not require employers to provide a specific package of health benefits, but that does not permit the employers to avoid responsibility standards. We are also contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage.*
- *Solely for purposes of applying the employer responsibility provisions, we anticipate that future guidance will provide a safe harbor permitting employers to base the affordability calculation on the wages they pay their employees instead of employees' household income.*

Premium Tax Credit Calculation: *Three Examples*

Example 1: Family of Four with Income of $50,000, Purchases Benchmark Plan
The premium tax credit is generally set based on the benchmark plan. The family's expected contribution is a percentage of the family's household income.

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

Example 2: Family of Four with Income of $50,000, Purchases Less Expensive Plan
If a family chooses a plan that is less expensive than the benchmark plan, the family will generally pay less, thereby creating an incentive to choose a less costly plan and reducing overall health care costs.

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

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

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

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

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

❖ **August 2011**

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

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

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

BACKGROUND

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

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

Factors that Suggest Employers Will Drop Coverage

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

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

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

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

Factors that Suggest Employers Will Keep or Add Coverage

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

- **Competitors' Behavior.** Many employers will continue to provide health insurance or add it as a benefit because their employees expect it—especially high-wage, highly educated workers—and they risk losing good employees to competitors that continue to provide this benefit.
- **Tax Benefits.** Employer premium contributions are tax deductible for employers and employee contributions may be paid with pre-tax dollars. That tax benefit will go away for both if the business drops coverage. Also, if a firm drops coverage, it will likely have to raise employees' salaries to compensate for the lost benefit, and an increase in salary leads to an increase in Social Security and Medicare payroll taxes.
- **Nondiscrimination Rules.** Nondiscrimination rules will require that firms offer health benefits to all employees and firms use a variety of workers at different pay levels. When firms make decisions, the interests of high-wage workers tend to outweigh those of low-wage workers. Should an employer attempt to drop coverage, employees would be likely to strongly oppose such attempts and may move to competitors.

NATIONAL STUDIES

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

Employer Surveys

Mercer

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

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

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

McKinsey

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

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

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

Predictive Models

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

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

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

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

MASSACHUSETTS EXPERIENCE

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

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

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

CONCLUSION

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

The above review illustrates three important points.

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

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

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

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

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

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Endnotes

[i] For a discussion of the impact of the Affordable Care Act on Arkansas's businesses, see Arkansas Center for Health Improvement Issue Brief, Effects of Health Reform on Arkansas Businesses (July 2010).
[ii] Affordable Care Act, Sections 1513 and 10106. Kaiser Family Foundation, Employer Health Benefits 2010 Summary of Findings http://ehbs.kff.org/pdf/2010/8086.pdf.
[iii] Affordable Care Act, Section 1402.
[iv] Fewer employers planning to drop health plans after reform in place, survey finds. http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place. Accessed July 29, 2011.
[v] US employer health enrollment up 2% under PPACA's dependant eligibility rule. http://www.mercer.com/press-releases/1421820. Accessed August 3, 2011.
[vi] Employer Survey on US Healthcare Reform. http://www.mckinsey.com/us_employer_healthcare_survey.aspx. Accessed July 29, 2011.
[vii] Congressional Budget Office, Score of the Patient Protection Affordable Care Act, March 20, 2010; Urban Institute, Bowen Garrett and Matthew Buettgens, Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature (January 2011); RAND Corporation, Christine Eibner and others, Establishing State Health Insurance Exchanges (2010).
[viii] For a discussion of these studies and other studies, see Avalere, The Affordable Care Act's Impact on Employer Sponsored Insurance: A Look at the Micro-simulation Models and Other Analyses (June 17, 2011).
[ix] Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys (December 2010).

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.

<u>Should Arkansas plan an exchange or accept the exchange that will be offered by the federal government?</u>

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.

<u>Who should govern the exchange?</u>

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.

<u>Should Arkansas consider adding to the Minimum Essential Benefits?</u>

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

UALR

1

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

2

Raw Data

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

3

Calibration

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

- Other distribution characteristics hold

4

Predictive model

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

5

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

6