

## Arkansas Health Benefits Planning Exchange

<b>Steering Committee Meeting</b>	<b>August 23, 2011</b>	<b>AR Health Benefits Exchange Planning Hearing Room</b>	<b>3:00 PM – 5:00 PM</b>
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<p><b><u>Members Present:</u></b>  Fred Bean  Elizabeth Burak  Ed Choate  David Deere  Joni Jones  Rep. Barry Hyde  Dr. Cal Kellogg  Dr. Drew Kumpuris  Tim Lampe  Ray Scott  Dr. John Wayne  Kenny Whitlock  Dawn Zekis</p> <p><b><u>Staff:</u></b>  Cindy Crone  Britton Kerr</p>	<p><b><u>Consultants:</u></b>  David Sodergren-First Data  Kathy Grissom-First Data  Lisa Bilello-AFMC  Carol Cassil-AFMC  Debbie Hopkins-AFMC  Jason Scheel-AFMC  Amy Schrader-AFMC</p> <p><b><u>Guests:</u></b>  Jim Johnson-Delta Dental  Melissa Masingill-Delta Dental  Representative David Meeks  Carol Roddy-GetInsured.com  Dwane Tankersley</p>	<p><b><u>Members Absent:</u></b>  Patty Barker  Deborah Bell-called  Jim Glick  Annabelle Imber Tuck-called  Kevin Ryan  Frank Scott  John Selig  Marilyn Strickland  Rep. Jon Woods</p>
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### **Meeting Summary:**

**Welcome and Introductions:** Facilitator David Sodergren opened the meeting; participants and visitors introduced themselves.

**Meeting Summary from August 9, 2011** was approved as printed with one exception: Pam Lambert is not a member of this group. The corrected summary will be posted on the Exchange Planning website, [www.hbe.arkansas.gov](http://www.hbe.arkansas.gov).

### **Updates**

- **UAMS Web-based Survey and Community Meetings** – Dr. John Wayne of UAMS College of Public Health provided an update on the active web-based survey (a handout was provided). The survey will be open until August 25; a final report will be submitted at the end of the month. Preliminary results from 431 valid responses indicate that 36.3% support State Exchange Planning efforts, 31.6% support State Exchange versus Federal Exchange but have concerns regarding the planning efforts, and 32.1% feel the planning efforts are a waste of time and money. More than two-thirds support moving ahead with planning. The final report on the statewide community meetings will be available later this week.
- **First Data Activities** –David Sodergren reported that multiple planning efforts are underway and that more reports will be available by the next meeting. The Program Integration, Communication and Outreach, and Evaluation Plans will be discussed later in today’s agenda. September workgroup discussions will also focus on the complete Marketplace and Financial Plan. All plans will be complete and presented by the end of September.
- **Self-Chartered Healthcare Reform Group**- Dr. Cal Kellogg reported that a random telephone survey of 600 Arkansas residents is underway. The goal of the survey is the gain insight into the public’s sentiment regarding a State Exchange versus a Federal Exchange. The survey is expected to continue for the next two weeks and the findings will be provided within the next four weeks.

- CCIIO/Planning Grant - Cindy Crone provided a handout with update. In summary:
  - New Federal Regulations were released on August 12, 2011. DHHS is hosting a listening session on the regulations in Denver on August 24, 2011. Bruce Donaldson, Marquita Little, Linda Greer, and Representative Jon Woods will be attending the meeting. Comments on the July-released as well as the August-released proposed regulations are being accepted by Exchange Planning staff for compilation..

CCIIO has awarded Level One Funding to 13 more states and the District of Columbia as of August 12, 2011. The total award amount on August 12 was \$185 million.

Kansas announced their decision to return Early Innovator Funding. They are the second state to make that decision.

CCIIO has announced that they do not have funds appropriated to implement a Federal Exchange.

There will be an Exchange Planning Grantee meeting September 19-20 in Arlington, VA.

Using Exchange Planning funds, the Small Business Outreach Education effort will start in September, with ACHI taking the lead.

The Stakeholder Summit has been confirmed for October 11, 2011 at the Embassy Suites in Little Rock. The summit will be an all day meeting with lunch being provided for the first 250 attendees. Joel Ario will be among keynoters. There will be a "101" session at 8:30 am for those not familiar with Exchanges.

We have one planning member attending the Consumer User-Friendly Exchange Face meeting in San Francisco today, and two other Arkansans will be attending the final planning meeting there in September. Other upcoming meetings in September are: CMS Eligibility/Enrollment meeting in Baltimore and National Governor's Association Meeting on Exchanges in Arlington, VA.

DHHS/CMS/CCIIO announced CO-OP grant availability for non-profits wishing to start a new insurance program in their State. It is DHHS's desire to fund at least one CO-OP in each State. The first round of applications is due in October. There will be interim due dates through December 2012. We are not aware of any group planning to apply.

QUESTION: There was a news report that indicated Arkansas will not be requesting additional funding for the planning efforts, is that an error? *Yes, that article addressed Early Innovator (Arkansas never had) and Exchange Planning funds and was confusing to the many readers. Arkansas Insurance Department does plan to apply for Level One funding in September.*

#### Workgroups

**STATE AGENCY**-Joni Jones reported that the group met on August 18, 2011. There were updates and discussion on the Stakeholder Summit (discussion regarding the workshop design), the new regulations (discussion regarding preparation of consolidated comments) and the marketplace/financial model presentations from Powell and Associates and SCIO-Inspire. There were question regarding the formulas used in the models, including What about residents who refuse to enroll? Doubt that 95% to 100% will enroll, How was the PMPM rate calculated for Medicaid? What about dual eligibles? How was uncompensated care factored: Was bad debt calculated at fees or costs? Were access issues figured in? Is regional data available?

**CONSUMER**-Elisabeth Burak reported that the group discussed the marketplace and financial model presentations from Powell and Associates and SCIO-Inspire. The group had questions regarding the

accuracy of the prediction that 95% of Arkansans would choose to participate in the exchange within the first year. There were also questions regarding whether or not the models considered the education level of Arkansans, What will the Exchange do to ensure quality plans for the exchange? How will the Exchange address changing health outcomes? Will the plans be simple and understandable for Arkansans? and What is the intent of CCIIO and the Feds in regard to the timeline restraints? When will we determine issues like whether the Exchange will be an active purchaser or open marketplace model?

**OUTREACH**-Fred Bean reported that 5 or 6 Benefits Brokers were present at the meeting. They shared good questions and suggestions on whether or not people issues were considered in the models that Powell and Associates and SCIO-Inspire have developed. Questions were: What role will human factors play on the model results? What is the prediction in regard to the 89% that will not see a premium decrease? There were also questions on the pricing points.

**HEALTHCARE PROVIDERS** - Ed Choate reported that the group had expressed an interest in how certain organizations are resolving problems with enrollment today. Examples to study would be the Medicaid and Medicare programs. Four organizations were invited to discuss their approach. Joni Jones from DHS County Operations discussed Access Arkansas and described the program as an Eligibility Gateway which is moving toward electronic eligibility determinations. Melissa Simpson discussed the Senior Health Insurance Information Program (SHIIP) which is a Medicare-focused program housed at Arkansas Insurance Department. It interacts with applicants to help identify which Medicare programs they may qualify for. Cynthia Eden discussed MASH, which is a Texas-based program that works primarily with hospitals, but does work with other organizations as well. MASH meets with self pay individuals to try and convert to third party pay accounts through the use of state or federal programs that the individuals may qualify for, especially Medicaid. MASH already has some systems in place and would be open to expanding to take on the Navigator role. Jim Miles discussed Covenant, which is an organization similar to MASH. Covenant is a Jonesboro-based organization that works with self pay individuals to convert them to a third party pay account also through the use of various state and federal programs and limited private insurance connections. Covenant is a small organization but would be interested in expanding to take on the Navigator role. The group also reviewed the actuarial and marketplace models presented to the Steering Committee and forwarded a few questions: What are the specific numbers for people migrating from one insurance category to another? What accounts for the decreased PMPM medical costs? Does the model account for consumer education in start-up? Can the model predict the effect of collective bargaining? When will we discuss the size of small group in 2014 (50 vs. 100)?

**SMALL BUSINESS**-Kenny Whitlock reported that the group discussed ways to gain support of the exchange and planning. There was a suggestion to have some of the community leaders do radio spots or television interviews. There was also a discussion on whether or not to charge a fee for the Stakeholder Summit. The workgroup agreed that there should be a small fee. Questions on the Marketplace and Actuarial models included: Does the model consider medical care fees or costs? Does the model account for gaps in provider coverage? Does the model account for lags in consumer education? Does it factor in hospitals giving up their DSH?

#### **QUESTIONS or COMMENTS**

Did the Consumer workgroup favor active purchaser models? *This is a key question. More discussion is needed.*

Would the post-2014 reimbursement fees be adequate enough to encourage provider participation?

Does the Steering Committee believe that individuals in the workgroups have additional time to meet?

Is there interest in forming a committee to work on more specific issues and report back to the Steering Committee to help move the planning along?

The comment was made that it is time for the Steering Committee to take the lead and start letting the workgroups know what is needed.

The decision-making process needs to be streamlined. Workgroups are spinning their wheels.

It was suggested that each workgroup be given one or two issues to make a decision on and report back to the Steering Committee to make a final decision to move forward with planning. Additionally, workgroups could initiate the questions. *The Commissioner is expecting recommendations from the Steering Committee.*

*The decision was made that the liaisons will facilitate future workgroup meetings. Cindy and Bruce will provide updates prior to the meetings and questions or comments can be presented at the workgroup meeting. There will be two sets of questions presented to workgroups: One will be general in nature (for half the meeting) and the other will be workgroup expertise specific (for half of the meeting). The "general" type discussion for next month will be to review the 2011 Exchange Enabling Legislation. Other issues for discussion include: preventing adverse selection, Inside/Outside Exchange Issues, Market Competition versus Active Purchasing for Exchange plans, open enrollment periods, and definition of small business for 2014: 50 or 100 and under?*

#### New Business

**Program Integration** - Kathy Grissom with First Data provided a handout on the results from the key informant interviews. There were a total of 11 entities interviewed. The goal was to understand existing programs and the processes that are currently in place that may support the Exchange. The slide presentation is on the HBE website.

**Community Outreach/Evaluation** - Debbie Hopkins with Arkansas Foundation for Medical Care provided handouts of these draft reports. AFMC was charged with developing recommendations for an evaluation plan for the exchange and recommendations for the communication, education, and outreach plan. The recommendations are based on research and experience from other states. A massive education-outreach effort is critical to gain support from the state and facilitate Exchange enrollment. The goal for the outreach communication is to increase the number of insured Arkansans. The goal is to reach 75% of eligible residents in the first year, 90% within the second year. The first phase would be to create an overall brand awareness; the second phase would include information about the importance of health insurance, who is eligible, etc. The third phase would take place when the exchange launches and would be a statewide media effort to let people know how to enroll, where they can go to enroll and provide updates about the exchange. Outreach needs to include Hispanic speaking and hearing impaired. AFMC recommended that the Navigator role be developed as a guide, advocate and an educator but not an enroller in the Exchange. The recommendation includes that the Navigator role be filled primarily by some type of grass root, community based organizations. AFMC also made recommendations of an online certification and training process for Navigators. A grant program was recommended for payment of the Navigators with certain criteria to determine the payment amount and expected deliverables.

#### **QUESTIONS or COMMENTS**

How much will the Education Outreach cost? *Estimated costs are in the draft document.*

There should also be a certification process for producers that would enroll clients on the Exchange.

Blue Cross Blue Shield reports that 85% of their individual market currently self-enrolls via their website.

Have we reviewed the Utah Navigator model—which realized increased enrollment when agents became Navigators and began to encourage Exchange enrollment?

#### Next Meeting

We will discuss the Evaluation plan and NW Arkansas Agents Association paper in a future meeting. Send any additional discussion items for the Steering Committee agenda to Cindy Crone at [Cynthia.Crone@arkansas.gov](mailto:Cynthia.Crone@arkansas.gov).

Next meeting is September 6, 2011 at 3-5 PM in AID Hearing Room.

## CCIIO Update - August 23, 2011

- I. Newest set of proposed regulations released 8/12/11 on Premium Tax Credits, Medicaid/CHIP and ACA, and Exchange Eligibility and Employer Standards. There is a 75 day comment period from the date of official release.

See [www.HealthCare.gov/news/factsheets/exchanges08122011a.html](http://www.HealthCare.gov/news/factsheets/exchanges08122011a.html) to access materials.

- II. Remember to submit any comments you want included in Exchange Planning response regarding first set of regulations to [Bruce.Donaldson@arkansas.gov](mailto:Bruce.Donaldson@arkansas.gov) by September 9, 2011.
- III. CCIIO awarded \$185 million to 13 more states and Washington DC for Exchange Development Level One Grants on Friday, August 12<sup>th</sup>. Arkansas is still on schedule to request Level One funding in September.
- IV. Kansas became the second state to return Early Innovator Funding to DHHS.
- V. DHHS Listening Session on Proposed Exchange Regulations is in Denver 8/24. Bruce Donaldson is attending.
- VI. Exchange Grantee meeting is in Arlington, VA September 19-20.
- VII. It was announced that there is limited funding for Federal Exchange Development (as opposed to State Exchange funding).

## Grant Activity Update

- VIII. We plan to initiate Small Business outreach/education activities in September (ACHI will lead).
- IX. State Chamber of Commerce has elected to support development of an Arkansas HBE as an economic development issue.
- X. Remember to mark your calendars for October 11, 2011 Exchange Planning Stakeholder Summit.
- XI. We continue our UX 2014 participation to assist with design of a user-friendly Exchange E/E prototype.

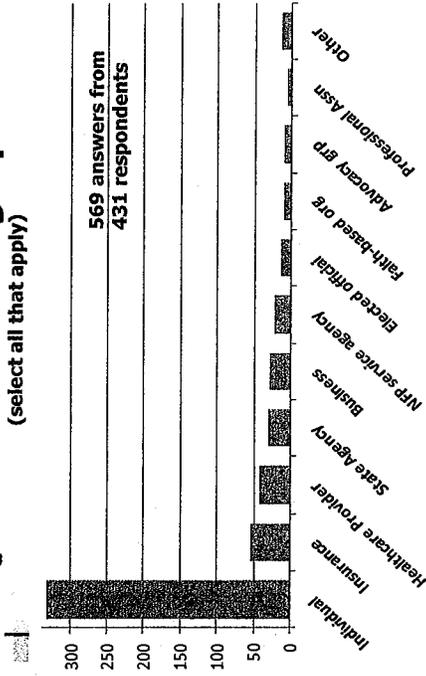
# Arkansas Health Benefits Exchange

One page Summary of Preliminary Results from the Web-based Survey

8/23/11

## Question 1: Demographics

(select all that apply)

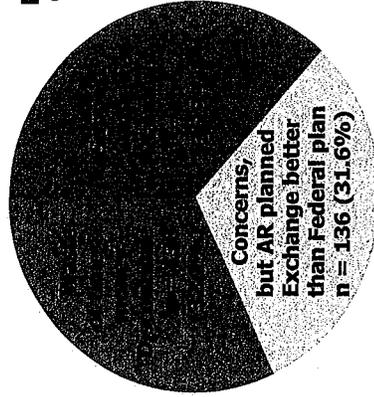


569 answers from 431 respondents

8/23/11

## Q2. How respondent feels about the planning effort

N = 431  
(1 missing)



8/23/11

## Respondents

Viewed Survey = 1,305

Started Survey = 681

Completed Survey = 470

Valid Responses = 431

Planning should be stopped = 138

Supports continued planning = 292

8/23/11



**State of Arkansas**  
**Arkansas Insurance**  
**Department**

**Arkansas Health Benefits Exchange**  
**Planning Project**

**Program Integration**

**Version 3.0**

**August 22, 2011**



**First Data™**  
beyond the transaction

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## Document History

This document is controlled through the Document Management Process. To verify that the document is the latest version, please contact the First Data Team.

Date	Version	Responsible	Reason for Revision
August 16, 2011	1.0	Kathy Grissom/J. P. Peters	Initial Submission
August 17, 2011	2.0	Kathy Grissom	Comments from HBE Planning Team
August 22, 2011	3.0	Kathy Grissom	Additional comments from HBE Planning Team

Table 1: Document History

# 1 Introduction

According to the Exchange Establishment Grant requirements for program integration, states are to demonstrate that coordination has been established with the State Medicaid Agency (which includes the State Children's Health Insurance Program [SCHIP]), state insurance department, and other health and human services programs as needed for the operation of the Exchange. This agency coordination is essential as the State makes decisions on coverage, eligibility, enrollment, health plan certification, outreach and other aspects relating to the operation of the Exchange. The State's decisions will have implications for all these state government agencies as well as other health and human services programs in terms of oversight and regulation of health plans and insurers.

As part of the program integration, states are to assess their current agency capabilities and resources to identify the necessary steps to satisfy these requirements. Some of the activities involved interviews with key governmental agencies and organization leaders, which were identified by the Health Benefits Exchange (HBE) Planning Staff, to ascertain the following with regards to the development and operation of the Exchange:

- Insights into the various functional components of each agency,
- Role and responsibilities,
- Risks and/or issues,
- Assets to leverage,
- Changes to policy, procedures, routine functions of agency,
- Financial/resource impact,
- Benefits of the Exchange in terms of agency/organization and State, and
- Comments on the Navigator role.

This Program Integration Plan describes First Data's approach, activities, findings and recommendations after reviewing available documentation and interviewing selected staff. These activities were designed to gain an understanding of existing programs, systems and processes that will support or be impacted by the operation of the Exchange. Additionally, it is intended to show how the information gathered can be leveraged to design, develop and implement Arkansas's Health Benefits Exchange.

## 2 Approach

### 2.1 Identify Agencies/Organizations

Using the list of State agencies identified in the Request for Proposals (RFP) as its base, the HBE Planning Staff expanded the list and broadened the scope beyond State agencies to include a representative of the Governor’s Office, two insurance plans and a university healthcare provider. Those agencies/organizations whose staff participated in the interviews were:

- Arkansas Insurance Department (AID),
- Arkansas Department of Human Services (ADHS),
- Arkansas Office of Health Information Technology (OHIT),
- Arkansas Department of Health (ADH),
- Arkansas Department of Information Services (DIS),
- Arkansas Center for Health Improvement (ACHI),
- Employee Benefits Division (EBD), Arkansas Department of Finance and Administration (DFA),
- State of Arkansas, Office of the Governor,
- Arkansas Blue Cross/Blue Shield,
- Delta Dental of Arkansas, and
- University of Arkansas for Medical Sciences (UAMS).

Findings in Section 3 are listed by agency/organization in the order displayed above.

### 2.2 Review of Existing Documentation

Prior to and as follow up to the interviews, First Data staff reviewed numerous documents and websites regarding each entity and their organization, programs and regulations. The list below is representative of the information reviewed:

Agency	Document/Website
Arkansas Insurance Department (AID)	<a href="http://www.insurance.arkansas.gov">http://www.insurance.arkansas.gov</a> <a href="http://hbe.arkansas.gov">http://hbe.arkansas.gov</a> One Year Later: The Benefits of the Affordable Care Act for Arkansas Health Benefits Exchange Survey Planning for the Arkansas Health Benefits Exchange

Agency	Document/Website
	<p>Arkansas Insurance Department 2009 Annual Report Arkansas Insurance Department Organizational Chart (rev. 3/11)</p>
<p>Arkansas Department of Human Services (ADHS)</p>	<p><a href="http://humanservices.arkansas.gov/">http://humanservices.arkansas.gov/</a> Access Arkansas Website <a href="https://access.arkansas.gov/Welcome.aspx">https://access.arkansas.gov/Welcome.aspx</a> Medicaid Eligibility Quick Reference Guide Medicaid Application Form SNAP Eligibility and Benefit Information SNAP Quick Reference Guide Arkansas Medicaid Program Overview SFY 2010 Governor Beebe’s Proposal on Transforming Arkansas Medicaid Transforming Arkansas Medicaid Arkansas Health System Reform &amp; Medicaid Transformation “Transforming Arkansas Health Care” Draft Work plan—May 2011 How to use Direct Data Entry to Verifying Eligibility – PPT Presentation HP Arkansas Medicaid Arkansas Department of Human Services Organizational Chart, January 2011 State Medicaid Health Information Technology Plan (SMHP) Arkansas Medicaid Enterprise (rev. March 4, 2011)</p>
<p>Arkansas Office of Health Information Technology (OHIT)</p>	<p><a href="http://ohit.arkansas.gov/Pages/default.aspx">http://ohit.arkansas.gov/Pages/default.aspx</a> Health Information Exchange Council (HIE) HIT Task Force HIE Summary of Strategic and Operational Plans, February 18, 2011 HIE Maps: Broadband and Wireline Access by Arkansas Counties</p>
<p>Arkansas Department of Health (ADH)</p>	<p><a href="http://www.healthy.arkansas.gov">www.healthy.arkansas.gov</a> Guide to Program and Services, Fiscal Year 2010 Arkansas Department of Health Annual Report 2008</p>

Agency	Document/Website
	<p>Arkansas Department of Health Brochure – Working hard everyday to make your life better.</p> <p>Statewide Pocket Guide and Fast Facts Brochure</p> <p>Top 10 Health Achievements in the Decade of the 21st Century</p> <p>Arkansas Department of Health Organizational Chart (rev. March 2011)</p>
Arkansas Department of Information Services (DIS)	<p><a href="http://www.dis.arkansas.gov/">http://www.dis.arkansas.gov/</a></p> <p>Enabling Legislation</p> <p>Preparing to Implement HITECH – A State Guide for Electronic Health Information Exchange</p> <p>Arkansas Department of Information Services 2010 Annual Report</p> <p>Arkansas Department of Information Services Quarterly Report to the Legislature Period Ending March 2011</p>
Arkansas Center for Health Improvement (ACHI)	<p><a href="http://www.achi.net">www.achi.net</a></p> <p><a href="http://www.arhealthnetworks.com/index.php">http://www.arhealthnetworks.com/index.php</a></p> <p>2010 Annual Report – Arkansas Center for Health Improvement</p> <p>Arkansas Center for Health Improvement Organizational Chart</p>
Employee Benefits Division, Arkansas Department of Finance and Administration (EBD)	<p><a href="http://www.dfa.arkansas.gov/offices/employeeBenefits">http://www.dfa.arkansas.gov/offices/employeeBenefits</a></p> <p>Performance Audit, December 2010</p>
State of Arkansas, Office of the Governor	<p><a href="http://governor.arkansas.gov/">http://governor.arkansas.gov/</a></p> <p><a href="http://www.thebenefitbank.com/About">http://www.thebenefitbank.com/About</a></p>
Arkansas Blue Cross/Blue Shield	<p><a href="http://www.arkansasbluecross.com">http://www.arkansasbluecross.com</a></p>
Delta Dental of Arkansas	<p><a href="https://www.deltadentalar.com">https://www.deltadentalar.com</a></p>
University of Arkansas for Medical Sciences (UAMS)	<p><a href="http://www.uams.edu">http://www.uams.edu</a></p>
Miscellaneous	<p><a href="http://portal.arkansas.gov/Pages/default.aspx">http://portal.arkansas.gov/Pages/default.aspx</a></p>

Table 2: Existing Documentation Review

## 2.3 Structured Interviews

### 2.3.1 Those Selected for Interview

The HBE Planning Staff contacted each agency/organization to arrange the interviews, asking that the spokesperson reserve one hour for this purpose. One agency (Department of Human Services) asked that two separate interviews be scheduled with different representatives. Others chose to have additional staff participate during their agency/organization's allotted time. A total of twelve interviews were conducted between July 5, 2011 and July 14, 2011. Those interviewed were:

Name of Agency	Interviewee(s)
Arkansas Insurance Department (AID)	<b>Jay Bradford</b> , Commissioner
Arkansas Department of Human Services (ADHS)	<b>Joni Jones</b> , Director, Division of County Operations
Arkansas Department of Human Services (ADHS)	<b>Dawn Jaycox Zekis</b> , Director of Policy and Planning, Office of the Director
Office of Health Information Technology (HIT)	<b>Ray Scott</b> , State Coordinator
Arkansas Department of Health (ADH)	<p><b>Mary Leath</b>, Deputy Director for Administration (leaving agency on 07/15/11)</p> <p><b>Randy Lee</b>, Director, Local Public Health Services</p> <p><b>Glen Baker</b>, Director, Public Health Laboratory</p> <p><b>Lee Clark</b>, Manager, Reimbursement Services</p>
Arkansas Department of Information Systems (ADIS)	<p><b>Claire Bailey</b>, Director &amp; Arkansas Chief Technology Officer</p> <p><b>Kym Patterson</b>, State Chief Security Officer</p>
Arkansas Center for Health Improvement (ACHI)	<b>Joe Thompson</b> , Director and Arkansas Surgeon General
Arkansas Department of Finance and Administration, Employee Benefits Division (EBD)	<b>Jason Lee</b> , Executive Director
State of Arkansas, Office of the Governor	<b>Frank Scott</b> , Deputy Director of Policy

Name of Agency	Interviewee(s)
Arkansas Blue Cross Blue Shield	<p><b>P. Mark White</b>, President &amp; CEO</p> <p><b>Cal Kellogg</b>, Sr. Vice President &amp; Chief Strategy Officer</p>
Delta Dental of Arkansas	<b>Ed Choate</b> , President & Chief Executive Officer
University of Arkansas for Medical Sciences (UAMS)	<b>David Miller</b> , Vice Chancellor & Chief Information Officer Information Technology

**Table 3: Structured Interviews**

Appendix A lists each person interviewed in the order they were interviewed. The Appendix also provides contact information and the name of the person designated by the agency/organization to assist with the development and operations of the Exchange.

### 2.3.2 The Interviews

All those interviewed were asked the following questions.

1. Please provide a brief overview of your agency/organization and its various functional components.
2. What do you envision as your agency/organization’s role and responsibility with the Health Benefits Exchange?
3. What risks or issues have been identified for your agency/organization with respect to the development and operation of the Health Benefits Exchange?
4. What assets does your agency/organization have that will assist in the development and operation of the Health Benefits Exchange?
5. What significant changes to your agency/organization’s organization, policies, routine functioning do you anticipate when the Health Benefits Exchange is operational?
6. What financial/resource impact do you expect the Health Benefits Exchange to have on your agency/organization?
7. How will the Health Benefits Exchange benefit your agency/organization?
8. How will the Health Benefits Exchange benefit the state of Arkansas?
9. Has your agency/organization designated someone to take the lead in matters related to the development and operation of the Health Benefits Exchange? If so, please provide the name and contact information for that person.

The list of questions and a background document on the Affordable Care Act (ACA) were sent to each interviewee via email prior to the interviews for their review and to facilitate

maximum use of the interview hour. (A copy of the ACA background document is included in Appendix B.)

In addition to the questions listed above, interviewees were asked their opinion on setting up the Navigator program.

All interviews were conducted by two First Data team members, J. P. Peters who was in the room with the interviewee and Kathy Grissom who was on the telephone. In some instances they were joined by additional First Data team members.

## 3 Findings

At some time during each interview a comment was made about the “unknowns” of how Arkansas will organize and operate their Exchange. In general, respondents see themselves as able to assist in the development of the Exchange but are waiting for additional information and/or direction as well as the formal authorization to establish a state Exchange.

After consultation with the HBE Planning Staff, the First Data Team organized the interview responses into the following areas.

### 3.1 Anticipated Role/Responsibilities with Establishment of the Exchange

Each interviewee was asked to describe what roles/responsibilities they envisioned for their agency/organization after the Exchange is operational. Their responses are listed below.

- The **Arkansas Insurance Department** will have responsibility for regulating the Exchange, the health insurance plans and the Navigators. However, AID does not see itself in the role of operating the Exchange.
- The **Arkansas Department of Human Services** indicated they should be in “lock step” as a true partner because both the Exchange and ADHS will be using the same enrollment tools, portals and other resources. ADHS identifies as a key role that of the “eligibility doorway” for the expanded adult Medicaid population that will be created by the ACA. Another role ADHS identified is to assist with outreach and education.
- The **Office of Health Information Technology** expects to collaborate on interfaces and interdependencies. The respondent stressed the need to start talking specifics soon so the agency can plan appropriately and in a timely manner. OHIT also expects SHARE to be of significant support to the Exchange.
- The **Arkansas Department of Health** believes their staff should serve as Navigators for the Exchange. Through their case management services, ADH has experience navigating recipients to needed resources.
- The **Arkansas Department of Information Services** anticipates its role will be the same as for many other initiatives – involved in strategic planning and supporting operations. However, they do expect to see demand for their support and services to increase with the establishment of the Exchange.
- In discussions with the **Surgeon General** who is also the director of the **Arkansas Center for Health Improvement**, the roles were carefully delineated as follows:

- ✓ ACHI's role is to support and assist AID with best implementation and wrap around services to ensure all the policy questions are identified and all options considered, especially things that involve AID, ADHS and OHIT.
- ✓ ACHI believes they will serve a "troubleshooting" role for HBE, advising as needed.
- ✓ The Surgeon General's role is to advise the Governor on the best strategy for the state to take regarding the Exchange.
- The only role the **Employee Benefit Division of the Department of Finance and Administration** expects to have is as an administrative consultant to HBE because of their experience with similar Exchange operations.
- The **State of Arkansas, Office of the Governor** will work with business and industry leaders to garner support for the Legislative authorization of the Exchange as well as to educate the public about the benefits of the HBE. Their policy staff will also assist in developing policy for the Exchange.
- The **Arkansas Blue Cross/Blue Shield** indicated their role in the operation of the Exchange is severely limited by ACA to being a producer of products (insurance plans). However, they do see it as their role to be a source of information about the insurance industry in Arkansas during the HBE planning process. As deemed appropriate, they can also assist with outreach and education.
- **Delta Dental of Arkansas** indicated they are working with the various committees and workgroups to assist in the development of the Exchange. Their national corporation is also working with CMS as it clarifies the requirements around the pediatric dental coverage.
- The representative for the **University of Arkansas for Medical Sciences** does not see a role for that organization in the operation of the Exchange. He does believe UAMS can assist individuals to enroll through the HBE and recognizes that UAMS will benefit from HBE as more individuals seeking healthcare services from UAMS will have insurance.

## 3.2 Impact on Existing Business Processes (Risks and Issues)

Agency/organization responses to the impact on their existing business processes are listed below. Concerns identified by each agency/organization are not prioritized but do represent the current thinking of those interviewed.

- The **Arkansas Insurance Department** does not see any risks to the agency but is very concerned with factors outside their control (e.g., Federal court cases, the presidential election)
- The **Arkansas Department of Human Services** shared as their high level concerns:
  - ✓ Anxiety about the unknowns – Federal regulations as well as how the state will set up the Exchange.
  - ✓ Biggest challenge is funding the new requirements

- ✓ Grey areas where it is unclear who is responsible, e.g., customer service for new adult Medicaid population
- ✓ Making sure to maximize but not jeopardize Federal funding by careful adherence to matching requirements
- ✓ The current lack of a “rules engine”
- ✓ “Churning,” particularly in the new adult Medicaid population
- ✓ Much of the self reported data will be matched to old information which could mean a high number of misses. What is the recourse? Will ADHS need to add staff to verify eligibility; need to add staff for quality assurance (QA) and fraud detection? How often will families be re-evaluated if their circumstances change?
- ✓ Can the state’s IT infrastructure support the increase in users/system needs?
- ✓ If all are to use the same web portal (Medicaid and non-Medicaid), clarification is needed
- The **Office of Health Information Technology** identified as concerns:
  - ✓ Data privacy and security – health information is the new currency in the healthcare market place
  - ✓ Multiple initiatives going on in the state at the same time. Tremendous stress on resources. So much change at one time creates “reform fatigue”.
- The **Arkansas Department of Health** identified the following risks and/or issues.
  - ✓ ADH clinics are “non-traditional” providers – how will they be affected if the non-insured people they currently serve become insured? Will they still come to the clinics or go elsewhere?
  - ✓ “Churning” as individuals go back and forth between insurance and Medicaid
  - ✓ Risk of destabilizing the current medical delivery system. Private providers de-emphasize the value of ADH as a provider.
  - ✓ Concerned that there will not be enough healthcare providers for those with insurance
  - ✓ Concerned that the HBE will not be user friendly, requiring additional staff to assist those seeking to use the system
  - ✓ “Any change is a risk to us”
- The **Arkansas Department of Information Services** –
  - ✓ Risk if the state does not control the data. If the state does not maintain control, it will cost the state.
  - ✓ Increase in the combined workload (volume) across DIS agency could be a risk but DIS has access to additional resources (staff) that should allow them to manage the increase

- ✓ Concern that state executives have bought into the plan for an Exchange but are not communicating adequately with other staff in their agencies to assure their support
- ✓ Unsure how to tie the Exchange data to the Master Person Index
- ✓ Essential that there be a clear timeline for implementation of the Exchange and that all tasks are managed to completion
- ✓ State executives are committed to “One View – One Arkansas” on the web and must make sure this is coordinated with HBE
- There were no risks identified for the **Arkansas Center for Health Improvement** as an agency but some were identified for the state.
  - ✓ ACHI is very concerned about so many major healthcare initiatives for the state being undertaken at the same time
  - ✓ ACHI sees a risk for the state if all options for operation of the Exchange are not fully considered.
  - ✓ There are political risks for the state if the Exchange is not authorized and if the Exchange does not come about in the best way possible for Arkansans.
  - ✓ ACHI sees the Exchange as a financial drain on all state agencies (including ACHI) as in-kind and staff resources are used to assist AID in its development and operation.
- The **Employee Benefit Division of the Department of Finance and Administration** identified as concerns:
  - ✓ Confusion in the insurance market with all the changes
  - ✓ Unfounded perception by the employees EBD serves that they could get better and cheaper insurance if they were allowed to participate in the Exchange
  - ✓ The importance of the Exchange not having the appearance of being owned or controlled by an insurance carrier
- The **State of Arkansas, Office of the Governor’s** respondent stated that the biggest risk is ceding control to the Federal government because Arkansas citizens would have to deal directly with them.
- **Arkansas Blue Cross/Blue Shield** identified the following concerns:
  - ✓ Tremendous amount of unknowns
  - ✓ If the HBE design is not efficient/effective, it will increase cost.
  - ✓ How will health plans on and off the Exchange operate? Will the two markets compliment or compete with each other? Need a balance.
  - ✓ Hard to really predict but may be hard to stay in the black; expect margins to be thinner if they exist at all

- **Delta Dental of Arkansas** identified:
  - ✓ Level and scope of the pediatric dental benefit is unknown and will impact affordability
  - ✓ Concern about how benefit choices be portrayed on the Exchange portal; whether people will be able to choose dental separate from medical
  - ✓ Concerned about forcing families to have split coverage because of the way the dental benefit is offered
  - ✓ Rate review process will be something new for dental insurance
- The **University of Arkansas for Medical Sciences** did not identify any impact on existing business processes.

### 3.3 Opportunities for Resource Sharing

One purpose of interviewing representatives of these agencies and organizations was to identify resources that could be used to support various functions of the Exchange and thus reduce the cost of creating all new functionality. However, with much of the Exchange functionality not fully defined by CMS and without a finalized governance structure in place for the Arkansas Exchange, it was not possible to identify specific processes or systems that can be used or replicated. Instead, agencies/organizations discussed their willingness to share experience, expertise and staff to help plan and implement the Exchange.

#### 3.3.1 Assistance with Planning and Implementation

- The **Arkansas Insurance Department** has regulation structures in place that will be needed for both qualified health plan (QHP) and Navigator licensing/certification. AID also has a good working relationship with the U. S. Department of Health and Human Services.
- The **Department of Human Services** has tremendous experience/insight in the areas of eligibility and enrollment; the knowledge and systems associated with the ACCESS Arkansas portal. ADHS has experience converting case records from paper to electronic and has recently opened a new processing center that may be of benefit to the HBE. Additionally, ADHS is developing an interactive voice response (IVR) system to answer the most common questions received. It is slated for operation in September 2011 and could provide some lessons learned as HBE develops its call center.
- The **Office of Health Information Technology** has staff that can share “lessons learned” since their initiative is ahead of HBE in terms of development, including ways to do things cheaper and faster. Also, OHIT is developing the Master Person Index that may be their most important asset for HBE.
- The **Arkansas Department of Health** has extensive knowledge of and contacts with communities throughout the state that will be of assistance with HBE outreach and education efforts.

- The **Arkansas Department of Information Services** has strategic and operational expertise on single point of entry portal; customer call centers; state IT architecture; and maximizing mobile functionality (social media). DIS also has access to research and staff augmentation resources that could be used by HBE.
- The **Arkansas Center for Health Improvement** can provide policy expertise during planning and operation of the Exchange. Additionally, ACHI has legislative authority over the All Claims Database which will assist the rate review component of the HBE. When HBE is operational, ACHI can provide data analytics for needed oversight (rate review, etc.) and may be able to assist with public reporting of data.
- The **Employee Benefit Division of the Department of Finance and Administration** will provide access to their operating procedures and staff experienced with their school program which has many similarities to HBE. Additionally, by the end of the year all their technology will be in the public domain.
- The **State of Arkansas, Office of the Governor** will provide their policy advisor to help coordinate and reduce duplication of efforts.
- **Arkansas Blue Cross/Blue Shield** identified several areas where they have knowledge and expertise to share as part of the planning process. These include the local market place (including “land mines” to avoid); actuarial data and knowledge; IT resources; outreach capabilities; electronic data transfer capabilities; and experience with online eligibility.
- **Delta Dental of Arkansas** offered their staff’s knowledge and expertise as well as information from their national corporation and resources to support community outreach and education (funds and contacts)
- The **University of Arkansas for Medical Sciences** will continue their participation on several planning committees.

### 3.3.2 Financial Resources

A few agencies/organizations identified financial support for the Exchange:

- The **Arkansas Insurance Department** spokesman sees the growth in the number of QHPs as generating enough tax revenue to fund HBE operations. He also sees the need to maximize grants and other funding sources, particularly during the planning and start-up phase.
- The **Arkansas Department of Human Services** pledged to capitalize on every opportunity to draw down Federal funds to assist in development and operation of the Exchange.
- **Delta Dental of Arkansas** indicated that it has funds available to assist with community outreach and education efforts regarding the Exchange.

### 3.3.3 Financial Liabilities

Two agencies clarified that the services to the HBE after it is operational must be paid for by the HBE.

- The **Office of Information Technology** expects the Exchange to pay for needed services as others do.
- The **Arkansas Department of Information Services** stated that it charges for all services provided. DIS has master service agreements with other state agencies and creates service orders for services provided.

### 3.4 Impact on Policies, Procedures and/or Organization

In general, the agencies and organization indicated that they needed to wait for CMS clarification/direction as well as final decisions on how the Arkansas Exchange will be developed before fully understanding what changes are needed. However, based on available information, respondents did identify areas where they knew changes would need to be made.

- The **Arkansas Insurance Department** spokesman indicated that the operation of the Exchange could impact their Customer Service activities as it will increase the amount of their business. He anticipated that policy changes will be needed but said it is not yet clear what they are.
- The **Arkansas Department of Human Services** spokespersons stated some redesign of their policies and procedures will be needed to address the new Medicaid population. They anticipate that others will also need modification but cannot define the extent until how the HBE will operate is known. ADHS stated to plan on at least four months to make the needed changes to policies, procedures and corresponding staff training.
- The **Office of Health Information Technology** identified the need for more and different interfaces although the specifics are not yet known. Important to begin defining the specifics as soon as possible to allow sufficient time to prepare and test.
- The **Arkansas Department of Health** identified several changes to be made:
  - ✓ Expand their billing staff in anticipation that more people they serve will have insurance.
  - ✓ Expect to see the Ryan White program (for HIV/AIDS) grow as more people have insurance
  - ✓ Modify policies and procedures to accommodate the changes brought about by HBE but stressed that they do not yet have any specifics on this because of a lack of information

- The **Arkansas Department of Information Services** spokesperson said that the changes their agency will have to make depends on the HBE platform chosen. They also expect that the ongoing work on the portal could change because of HBE.
- The **State of Arkansas, Office of the Governor** must assure interoperability which may require some structural changes
- **Arkansas Blue Cross/Blue Shield** identified several areas to modify:
  - ✓ Policies will change once all requirements are known
  - ✓ Customer service because some things will be handled by HBE and some by QHP but clarification is needed from HBE before making changes
  - ✓ Focus will change from identifying risk up front to identifying risks after enrollment and how best to manage the risk
  - ✓ Change in marketing and sales approach; the need for agents and the cost of their commissions will decrease
- **Delta Dental of Arkansas** anticipates making changes in at least the following areas:
  - ✓ Branding of their product since decisions currently being made by employers will be made by individuals through the HBE
  - ✓ The shift from small group plans to individual buyers will cost the organization more to administer
  - ✓ Expect to have higher advertising costs but that will be offset by the absence of agent commissions
- The **University of Arkansas for Medical Sciences** expects to develop a process that links uninsured individuals seeking services from UAMS with the HBE

### 3.5 Impact on Interagency Agreements

Across the board agency respondents indicated that modifying or creating interagency agreements can be done as needed in a timely manner. At this point, they have no firm idea of what the needs are in this area and will not until the Exchange's governance model is established and more specifics are known about its organization and operation.

### 3.6 Benefits of Health Benefits Exchange

- The **Arkansas Insurance Department** represents the interests of the consumer and sees HBE as having significant benefits for consumers by expanding insurance coverage.
- The **Arkansas Department of Human Services** identified a number of benefits:
  - ✓ HBE should help reduce some of the stigma associated with Medicaid

- ✓ Because all citizens are required to have insurance, the indigent care and uncompensated care that providers now experience will be significantly reduced
- ✓ Because of the emphasis on preventative care, access to insurance for all will improve the health care system and overall wellness of Arkansans
- ✓ ADHS will have access to a rules engine
- ✓ Anticipate the HBE will be efficient and will provide meaningful outreach to assure that more people are enrolled and have insurance
- The **Office of Information Technology** listed as benefits:
  - ✓ SHARE will support HBE which will bring more value to SHARE
  - ✓ The HBE may open the door for SHARE to have a role with private insurance
  - ✓ HBE will be a huge benefit for the state; many currently uninsured people will have opportunities that they aren't even aware of
- The **Arkansas Department of Health** notes that the operation of HBE will increase opportunities for preventative healthcare for Arkansans.
- The **Arkansas Department of Information Services** sees HBE as an opportunity to create one-stop shopping creating transparency for the consumers in that they can make comparisons between insurance plans
- The **Arkansas Center for Health Improvement** believes that HBE will support choice for the citizens of the state
- The **Employee Benefit Division of the Department of Finance and Administration** stated that providing citizens with choice is good but also noted that the HBE could broaden the state's insurance pool.
- The **State of Arkansas, Office of the Governor** identified the greatest benefit as creating competition in the insurance market which should lead to reduced cost and increased benefits. He also noted that HBE will provide citizens with one central place to look at benefits.
- **Arkansas Blue Cross/Blue Shield** identified several benefits:
  - ✓ HBE will create a new way to market insurance
  - ✓ Many Arkansans will qualify for subsidies which will increase enrollment
  - ✓ The number of underinsured and uninsured will be reduced
  - ✓ The amount of uncompensated care for providers will be reduced
- **Delta Dental of Arkansas** indicated that:
  - ✓ More people will have access to coverage and health care
  - ✓ HBE will foster a lower cost/more efficient buying process

- The **University of Arkansas for Medical Sciences** stated that HBE will improve health care for the citizens of the state

### 3.7 Comments on the Navigator Role

- The **Arkansas Insurance Department** is emphatic that Navigators need to be licensed so that AID can monitor their performance and enforce the rules and qualifications for the position
- The **Arkansas Department of Human Services** had several comments on Navigators:
  - ✓ Navigators should assist in navigating the system, not limit their role to assisting with choosing an insurance plan and walk away
  - ✓ Navigators should be a collaboration of public and non-profit
  - ✓ Navigators should be a source of reliable information on many areas not limited to choosing an insurance plan
- The **Office of Health Information Technology** did not comment on Navigators.
- The **Arkansas Department of Health** wants their staff to serve as Navigators.
- The **Arkansas Department of Information Services** did not comment on Navigators.
- The **Arkansas Center for Health Improvement** did not comment on Navigators.
- The **Employee Benefit Division of the Department of Finance and Administration** shared two thoughts:
  - ✓ Navigators should be paid in a grant environment
  - ✓ Anyone but insurance carriers would be the best Navigators
- The **State of Arkansas, Office of the Governor** shared the following:
  - ✓ HBE must hold the Navigator responsible for their actions; get correct information to them and insist that they communicate the information in a fashion that individuals can understand.
  - ✓ Used the Benefit Bank program as an example of what not to do. That program used volunteers and got “volunteer” results.
  - ✓ Monitoring and oversight is essential as is good training for the Navigators.
- **Arkansas Blue Cross/Blue Shield** believes it will be very difficult to find someone with influence but who is independent to be a Navigator. Suggested that church organizations and “all kinds of different folks” be considered.
- **Delta Dental of Arkansas** believes the insurance industry would make the best Navigators
- The **University of Arkansas for Medical Sciences** did not comment on Navigators.

### 3.8 Other

- The **Arkansas Department of Human Services** indicated that they are involved in a new initiative that may impact the HBE – the Payment Reform Effort being led by the Surgeon General. There may be opportunities for collaboration.
- The **Arkansas Department of Health** is routinely involved in Home Town Health Coalitions throughout the state which could serve as avenues for outreach and education efforts.
- The **Arkansas Center for Health Improvement**
  - ✓ Discussed ARHealthNetwork as it is a program listed on the agency’s website. It is a Medicaid waiver (4 yrs old) administered by NovaSys that provides basic insurance coverage for small businesses (usually 1 to 3 employees). It has been in operation for four years and has approximately 15,000 enrollees. There is rich enrollment experience and utilization information that could help with actuarial steps for HBE. ACHI is preparing to evaluate the program and data may be available for use within 3-6 weeks.
  - ✓ Raised the issue of requiring insurance companies who are in the HBE to cover the entire state versus allowing them to cover only certain areas. There are many factors to consider before making this decision.
- The **Employee Benefit Division of the Department of Finance and Administration** spokesperson stated “There is nothing that is in the Exchange that we can’t do.” He went on to discuss his fear that EBD will be directed to operate it without adequate resources or time to prepare.
- **Arkansas Blue Cross/Blue Shield** believes that Arkansas needs to look at where the state’s insurance market is now and where it needs to go so it can support gradual or incremental change without too much of a shock.
- **Delta Dental of Arkansas** noted that they financially support twenty free dental clinics for adults around the state in underserved areas. This effort is coordinated through ADH’s Office of Oral Health and is another viable outreach avenue.

## 4 Recommendations

### 4.1 Opportunities to Incorporate Business Processes of Others into the Development and Operation of the Exchange

A key tenet in the development and operation of the HBE is capitalizing on existing resources and assets to the extent feasible. Based on interviews and documents reviewed, the First Data Team identified the following broad areas where it appears that there is knowledge, experience and replicable processes that would benefit the HBE.

- **Enrollment** – Using the CMS published guidelines for HBE, work intensely with the Department of Human Services, the Employee Benefit Division and Blue Cross/Blue Shield to understand their individual enrollment process, focusing on web based enrollment, to determine what is applicable for the HBE enrollment function. For each, investigate the business rules, the tools, the staff required to support the activity and the volume of enrollees. The goal is to identify the most efficient, effective way to facilitate enrollment through the HBE and to establish linkages to ADHS (Medicaid) and private insurance as appropriate.
- **Eligibility** – Work with the Department of Human Services to identify opportunities to integrate processes, operation and tools between ADHS and HBE. The goal is to create a comprehensive, efficient method of determining/recertifying eligibility for those accessing health insurance through the Exchange.
- **Outreach and Education** – Three agencies/organizations are noted to have the potential to be especially helpful in the area of outreach and education. The Department of Human Services and the Department of Health have a presence in every county in the state. They have regular contact with many individuals who will be using the HBE. They also have experience initiating new programs and outreach to identify individuals who would most benefit from their programs. It is important to ask what worked and what did not work as plans are made to share information about HBE. Additionally, Delta Dental of Arkansas has pledged monetary support for outreach and education activities. HBE staff needs to solidify that offer to help fund needed activities.
- **Customer Service** – While all agencies/organizations interviewed have existing customer service functionality, there are three that should be explored in depth because their customers are many of the same demographic that will be contacting the HBE. The Arkansas Insurance Department works with insurance providers and can provide profiles of their concerns. The Department of Human Services and the Department of Health interact on a regular basis with many of the individuals who will be seeking insurance coverage through the HBE. Their experience in this area is vital in determining how best to set up a call center, an interactive voice response (IVR) system, an online assistance system as well as the type and number of staff needed to support this functionality.

One other agency with vital information in this area is the Department of Information Services, which can provide the technological support for needed customer service activities.

- **Master Person Index** – The Office of Health Information Technology is developing a Master Person Index. HBE staff must determine how this tool will benefit their enrollment activities and how best to link to the Index.
- **Insurance Plan Design** – When considering the insurance plans to be offered through the HBE, the best source of unbiased information is the Employee Benefits Division. They are continuously researching the market and seeking out the best coverage for their constituents. Tapping into their experience could save the HBE staff a lot of time and effort.
- **Navigators** – There are two agencies with experience connecting individuals to needed services, the Department of Human Services and the Department of Health. Each noted that some efforts have been more successful than others. Accessing their experience, staff training materials and customer service information will create a good baseline for developing the criteria to be a Navigator, identifying both initial and on-going training needs, and the type of support needed from the HBE.

The Arkansas Insurance Department feels strongly that individuals serving in the Navigator position must be regulated and monitored to help protect the integrity of the Exchange.

A final organization to have input into the Navigator role is Blue Cross/Blue Shield of Arkansas as a representative of the insurance industry. Their experience with enrollment and customer service will help provide a certain perspective as to what Navigators may encounter as they assist individuals in accessing insurance coverage.

- **Financing** – The HBE staff is prepared to capitalize on grant funds available from CCIIO. However, there are two other potential funding sources that require early exploration to assure the HBE's readiness to take advantage of them. The Department of Human Services has pledged to assist in efforts to draw down Federal funds. The HBE staff needs to understand the requirements for each opportunity and also be assured that state matching funds are available. A continuous source of funding identified by the Arkansas Insurance Department is the growth in taxes due to an increase in insurance plan enrollment. For operational budget planning, the HBE staff needs to work with the AID staff to convert these expectations into actual projected revenue.

To determine the extent to which the assets identified in these areas can be of use by HBE, ongoing planning is needed. In order to complete this work and begin developing the Exchange, the First Data Team recommends that the Arkansas HBE Planning Staff begin staff expansion. We recommend the immediate hiring of three individuals as the core operations staff for the Exchange.

- Under the direction of the HBE Planning Director, the first new staff member's responsibility will be to facilitate overall development of the HBE's operation.
- The two additional individuals will be assigned specific functional areas to coordinate HBE business processes with existing processes/programs and, when necessary develop HBE specific processes to meet the unique functions of the Exchange.

Given the Federal government's aggressive timeline for development of a state Exchange, additional staff dedicated to Exchange implementation and eventual operation must begin work for the HBE establishment as soon as possible.

## 4.2 Mitigating Risks and Issues

- **Lack of specifics on the Exchange** - When reviewing the risks and issues identified during the agency/organization interviews, many fall under the broad category of "few specifics are known about how the Arkansas Exchange will operate". Without a clear understanding of how Arkansas will establish and operate the HBE, other agencies and organizations cannot begin to plan how they will be affected and how they will work with the HBE. Making these decisions and beginning a planned, logical development of the HBE will result in the alleviation of much anxiety while also allowing the identification of specific issues to be addressed and resolved.
- **Federally mandated timeline for HBE** - Coupled with the need for decisions regarding the formation of the HBE are concerns about the federally mandated implementation timeline and the knowledge that failure to comply will result in ceding control of Arkansas's Exchange to the Federal government. Consensus is that this would not be in the best interest of Arkansans. Therefore, moving forward with decisions and establishment of the HBE in an organized, efficient manner is of paramount importance to all agencies and organizations interviewed.
- **Multiple statewide initiatives** - Another broad area of concern is the multiple statewide initiatives being undertaken concurrently. This is seen as causing a huge resource drain on many state agencies and, in some instances, putting a strain on the state's IT infrastructure. Those interviewed voiced concern that these efforts must be orchestrated, when possible, to support each other. An initial step to doing this would be for the leaders of each initiative to share their tasks and timelines in an effort to identify stress points that could be adjusted without jeopardizing any one initiative. The specific initiatives cited in addition to the Exchange are:
  - ✓ State Health Alliance for Records Exchange (SHARE),
  - ✓ Healthcare Payment Reform, and
  - ✓ MMIS Replacement Project.
- **Churning** - An issue raised by a number of interviewees was the prediction that there will be extensive "churning," individuals moving back and forth between Medicaid and private insurance plans. Such churning would be detrimental to the individuals whose insurer and coverage could change frequently. It would also

increase the administrative burden of ADHS, the HBE and the insurance carriers. When more information is known about the uninsured in Arkansas, this issue needs careful consideration to determine what viable alternative exists to minimize churning and the disruption it will cause.

- **Need to validate self-reported information** - One agency raised the issue of HBE enrollment being based on self-reported information verified electronically against non-current data (income tax returns). The concerns identified are whether additional staff will be needed for verification if the self reporting was not consistent with the tax returns; for additional fraud and abuse monitoring; to become involved when individuals had sudden changes in financial status and needed to change their insurance; or other activities that could require a case worker's intervention. In the absence of direction from CMS on these areas, it is difficult to anticipate staffing needs, work flow or business rules. These are issues that will need consideration in the plan for staffing and operation of the HBE.
- **Possible negative impact on current medical care** - One agency voiced concern that the projected increase in insured individuals may have a detrimental effect on Arkansas's current medical delivery system. If more individuals seek medical care, are there enough providers to serve them? The HBE staff may decide that this warrants further study in an effort to confirm or alleviate this concern.
- **Anxiety within the insurance industry** - A concern voiced by a representative of the insurance industry is the fear that so much change (e.g., creation of the Exchange) may create anxiety in the insurance marketplace. To mitigate this, the HBE Planning Staff can begin providing accurate, up-to-date information at the earliest opportunity to insurance carriers, brokers and others associated with the industry. Using the means independent of any insurance carrier, the HBE can establish comprehensive lines of communication with the industry.

### 4.3 Resource Sharing

Most of the resource sharing identified consisted of staff expertise for planning purposes and is discussed in Section 4.1 above. However, it bears noting that the Employee Benefit Division is currently operating their Teacher Insurance program in a fashion very similar to the Exchange. The leadership of that Division has the most comprehensive knowledge of such an operation and has offered not only their advice but also their policies and procedures to be used as models for those that must be developed for the Exchange.

### 4.4 Policy and Procedure Revision/Creation

All agencies/organizations agreed that changes would be needed to their policies, procedures and, in some cases, staffing and organization. While some known needs are in the discussion stage, much of the specific work cannot be done until establishment of the HBE is further along. The timeline for the HBE development needs to take into consideration that some state agencies require at least four months to finalize policy changes.

## **4.5 Need to Change or Create Interagency Agreements**

The agencies interviewed stated that creating or changing interagency agreements is a very easy, quick process and they do not envision any issues. The key, however, is that the governance model chosen for the HBE must have the authority to enter into interagency agreements. In the interim, AID should consider the need for interagency agreements to confirm planning activities for the HBE. This would enable efficient and effective use of federal planning grants for the Department of Human Services, Health Information Exchange and Health Benefits Exchange.

## 5 Program Integration Plan

In order to capitalize on the knowledge and experience available from these agencies and organizations, Arkansas must decide on their governance model and secure additional dedicated staff to begin establishing the HBE operation. This staff must be authorized to coordinate with other state agencies as they work to meet the Federal standards for HBE. Daily oversight must assure that staff is properly allocated and tasks are completed on time. There must also be an individual or a small group of individuals in place to make decisions in a timely manner to assure that the implementation can progress without roadblocks.

The Operations Plan will contain a comprehensive timeline with specified tasks and known dependencies. The timeline will incorporate all the plans and will include at least these critical dates:

- Level One Grant Applications may be submitted September 30, 2011 or December 30, 2011. It is the intent of Arkansas AID to meet the September 30, 2011 submission date.
- Level Two Grant Applications may be submitted December 30, 2011; March 30, 2012; or June 29, 2012. It is strongly recommended that Arkansas AID meet the March 30, 2012 submission Date
- Open Enrollment in the Exchange for consumers must begin by October 1, 2013.
- Each HBE will be evaluated and a decision made by January, 2013 as to whether or not the State is judged able to fully implement an Exchange by January 2014.
- Fully operational Exchange, January 2014

## 6 Appendix A – Interviewee Contact Information

Date of Interview	Name of Agency	Interviewee(s)	Lead Contact Person
07/05/11	Arkansas Department of Health <a href="http://www.healthy.arkansas.gov">www.healthy.arkansas.gov</a>	<p><b>Mary Leath</b> Deputy Director for Administration (leaving agency on 07/15/11)</p> <p><b>Randy Lee</b> Director, Local Public Health Services Phone: 501-661-2832 <a href="mailto:Randy.d.lee@arkansas.gov">Randy.d.lee@arkansas.gov</a></p> <p><b>Glen Baker, MD,FACP</b> Director, Public Health Laboratory Arkansas Department of Health 201 South Monroe Street Little Rock, AR 72205-5425 Phone: 501-350-9070 Fax: 501-661-2972 <a href="mailto:Glen.baker@arkansas.gov">Glen.baker@arkansas.gov</a></p> <p><b>Lee Clark</b> Manager, Reimbursement Services Phone: 501-661-2377 <a href="mailto:Lee.clark@arkansas.gov">Lee.clark@arkansas.gov</a></p>	Glen Baker, MD,FACP
07/06/11	Delta Dental of Arkansas <a href="http://www.deltadentalar.com">www.deltadentalar.com</a>	<p><b>Ed Choate</b> President &amp; Chief Executive Officer 1513 Country Club Road Sherwood, AR 72120 Phone: 501-922-1600 Wats: 800-462-5410 ext 1600 Fax: 501-992-1601 <a href="mailto:echoate@deltadentalar.com">echoate@deltadentalar.com</a></p>	Ed Choate & Melissa Massengale Phone: 501-992-1666

Date of Interview	Name of Agency	Interviewee(s)	Lead Contact Person
07/06/11	Arkansas Department of Human Services <a href="http://humanservices.arkansas.gov/dco/">http://humanservices.arkansas.gov/dco/</a>	<b>Joni Jones</b> Director, Division of County Operations 700 S. Main P. O. Box 1437, Slot S301 Little Rock, AR 72203-1437 Phone: 501-682-8375 Fax: 501-682-8367 <a href="mailto:Joni.jones@arkansas.gov">Joni.jones@arkansas.gov</a>	Linda Greer Assistant Director 700 S. Main P. O. Box 1437, Slot S301 Little Rock, AR 72203-1437 Phone: 501-682-8257 <a href="mailto:Linda.greer@arkansas.gov">Linda.greer@arkansas.gov</a>
07/07/11	State of Arkansas Office of the Governor <a href="http://governor.arkansas.gov/">http://governor.arkansas.gov/</a>	<b>Frank Scott</b> Deputy Director of Policy Office of the Governor Mike Beebe State Capitol, Suite 124 Little Rock, AR 72201 Phone: 501-683-6462 Fax: 501-682-9499 <a href="mailto:Frank.scott@governor.arkansas.gov">Frank.scott@governor.arkansas.gov</a>	Same
07/07/11	Arkansas Insurance Department <a href="http://insurance.arkansas.gov/">http://insurance.arkansas.gov/</a>	<b>Jay Bradford</b> Commissioner 1200 West Third Street Little Rock, AR 72201-1904 Phone: 501-371-2621	Cynthia Crone, APN Health Insurance Exchange Planning Director 1200 West Third Street Little Rock, AR 72201-1904 Phone: 501-683-3634 Cell: 501-786-9793 Fax: 501-371-2629 <a href="mailto:Cynthia.crone@arkansas.gov">Cynthia.crone@arkansas.gov</a>

Date of Interview	Name of Agency	Interviewee(s)	Lead Contact Person
07/07/11	State of Arkansas Department of Finance and Administration, Employee Benefits Division <a href="http://dfa.arkansas.gov/offices/employeeBenefits/">http://dfa.arkansas.gov/offices/employeeBenefits/</a>	<b>Jason Lee</b> Executive Director 501 Woodlane, Suite 500 Little Rock, AR 72201 P. O. Box 15610 Little Rock, AR 72231-5610 Phone: 501-682-5502 1-800-815-1017 Fax: 501-682-1168 <a href="mailto:jason.lee@dfa.state.ar.us">jason.lee@dfa.state.ar.us</a>	Same
07/08/11	Arkansas Blue Cross Blue Shield <a href="http://www.arkansasbluecross.com">www.arkansasbluecross.com</a>	<b>P. Mark White</b> President & CEO 601 S. Gaines Street P. O. Box 1489 Little Rock, AR 72203-1489 Phone: 501-378-2208 <a href="mailto:pmwhite@arkbluecross.com">pmwhite@arkbluecross.com</a>  <b>Cal Kellogg, Ph.D</b> Sr. Vice President & Chief Strategy Officer 601 S. Gaines Street Little Rock, AR 72201 P. O. Box 2181 Little Rock, AR 72203-2181 Phone: 501-378-3051 <a href="mailto:cekellogg@bluecross.com">cekellogg@bluecross.com</a>	Cal Kellogg
07/11/11	Office of Health Information Technology <a href="http://ohit.arkansas.gov/Pages/default.aspx">http://ohit.arkansas.gov/Pages/default.aspx</a>	<b>Ray Scott</b> Coordinator 1401 West Capitol Avenue, Plaza G Little Rock, AR Phone: 501-410-1999 <a href="mailto:Ray.scott@arkansas.gov">Ray.scott@arkansas.gov</a>	Same  Shirley Tyson for technical piece

Date of Interview	Name of Agency	Interviewee(s)	Lead Contact Person
07/11/11	Arkansas Department of Human Services <a href="http://humanservices.arkansas.gov/">http://humanservices.arkansas.gov/</a>	<b>Dawn Jaycox Zekis</b> Office of the Director, Director of Policy and Planning Donaghey Plaza South 700 Main Street P. O. Box 1437, Mail Slot S201 Little Rock, Arkansas 72203-1437 Phone: 501-683-0173 Fax: 501-682-6836 Cell: 501-231-0653 <a href="mailto:Dawn.zekis@arkansas.gov">Dawn.zekis@arkansas.gov</a>	Same  Note: alternate number for her – 501-212-8711.
07/12/11	Arkansas Center for Health Improvement (ACHI) <a href="http://www.achi.net">www.achi.net</a>	<b>Joe Thompson, MD, MPH</b> Director & Arkansas Surgeon General 1401 W. Capitol Avenue, Suite 300 Little Rock, AR 72201 Phone: 501-526-2244	Joe Thompson (lead for Surgeon General issues)
07/14/11	University of Arkansas for Medical Sciences <a href="http://www.uams.edu">http://www.uams.edu</a>	<b>David Miller, MHSA, FHIMSS, CHCIO</b> Vice Chancellor & Chief Information Officer Information Technology 4301 W. Markham St, #633-1 Little Rock, AR 72205-7199 Phone: 501-686-7609 <a href="mailto:Dlmiller2@uams.edu">Dlmiller2@uams.edu</a>	Same

Date of Interview	Name of Agency	Interviewee(s)	Lead Contact Person
07/14/11	<p>Arkansas Department of Information Systems (DIS) <a href="http://www.dis.arkansas.gov/">http://www.dis.arkansas.gov/</a></p> <p>State Technology Council <a href="http://www.STC.arkansas.gov">www.STC.arkansas.gov</a></p>	<p><b>Claire Bailey</b> Director &amp; Arkansas Chief Technology Officer One Capitol Mall, Third Floor P. O. Box 3155 Little Rock, AR 72203 Phone: 501-682-2701 Cell: 501-416-2381 Fax: 501-682-4960 <a href="mailto:Claire.bailey@arkansas.gov">Claire.bailey@arkansas.gov</a></p> <p><b>Kym Patterson</b> State Chief Security Officer (same address as above) Phone: 501-682-4550 Fax: 501-682-9465 <a href="mailto:Kym.patterson@arkansas.gov">Kym.patterson@arkansas.gov</a></p>	Both

## 7 Appendix B – ACA Background Information

Functional Area	Arkansas Defined Business Processes	ACA Legislative Requirements
Screening and Eligibility Determination	<ul style="list-style-type: none"> <li>• Eligibility Determinations</li> <li>• Eligibility Verification</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid eligibility is expanded to individuals with income up to 133% of the poverty line including adults without dependent children</li> <li>• Single application form for all State health subsidy programs</li> <li>• Secure interface for eligibility determination for all such programs based on a single application through data matching</li> <li>• Eligibility determination for Exchange participation, premium tax credits, reduced cost-sharing and individual responsibility exemptions; and applicants' citizenship/ immigration status, income and family size will be verified against Federal records</li> <li>• Individuals determined to be ineligible for assistance are screened for eligibility for enrollment in plans offered through Exchange as well as premium assistance for the purchase of a plan and, enrolled in plan without having to submit additional application</li> <li>• Inform individuals of eligibility requirements for the Medicaid program, the CHIP program, or any applicable State or local public program and if screening of an application by the Exchange determines individual is eligible for any program, enroll individual</li> <li>• Ensure that individuals applying for Medicaid or CHIP but found ineligible are screened for eligibility in Exchange plans</li> <li>• Exchange may contract eligibility determination to the State Medicaid agency for all subsidy programs</li> <li>• A qualified employer is a small employer that elects to make all full-time employees eligible for one or more qualified health plans offered in the small group market</li> </ul>
Enrollment Management	<ul style="list-style-type: none"> <li>• Enrollment</li> </ul>	<ul style="list-style-type: none"> <li>• All US citizens and legal residents are required to have coverage</li> <li>• Dependents under the age of 26 can remain on their parents' insurance</li> <li>• State is operating no later than January 1, 2014 a website which allows individual eligible for Medicaid or CHIP and also eligible for premium assistance to compare benefits, premiums, and cost sharing</li> <li>• Secretary will develop standardized format for products to present the percentage of total premium revenue expended on nonclinical costs, eligibility, availability, premium rates, and cost sharing</li> <li>• Information required for enrollment: Name, address, DOB for each individual to be covered by the plan, citizenship status –Including SSN and/or attestations</li> <li>• Enable electronic signature for enrollments and re-enrollments</li> <li>• Enroll through such website, individuals who are identified as being eligible for State plan,</li> </ul>

Functional Area	Arkansas Defined Business Processes	ACA Legislative Requirements
		<p>waiver, or child health assistance without any further determination by the State</p> <ul style="list-style-type: none"> <li>• Individuals determined to be ineligible for assistance are screened for eligibility for enrollment in plans offered through Exchange as well as premium assistance for the purchase of a plan and, enrolled in plan without having to submit additional application</li> <li>• Coordinate, for individuals who are enrolled in the State plan or under a waiver and who are also enrolled in a qualified health plan offered through such an Exchange</li> <li>• Start Initial open enrollment period by July1, 2012</li> <li>• If applicant information related to enrollment, premium tax credits and cost-sharing reductions is positively verified, HHS Secretary will notify the Treasury Secretary of the amount of any advance payment to be made</li> <li>• State must develop procedures to assure children found ineligible for Medicaid are enrolled in certified qualified health plans</li> </ul>
Customer Relationship Management	<p>Post enrollment services including:</p> <ul style="list-style-type: none"> <li>• Call centers</li> <li>• Ombudsman</li> <li>• Consumer Advocacy Programs</li> </ul>	<ul style="list-style-type: none"> <li>• Operation of a toll-free hotline to respond to inquiries for assistance</li> <li>• Designate an independent office of health insurance consumer assistance or an ombudsman that responds to inquiries and complaints concerning insurance coverage</li> <li>• The office of health insurance consumer assistance or health insurance ombudsman must help with complaints and appeals filing, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved, and providing information about the external appeal process; collect, track, and quantify problems and inquiries encountered by consumers; educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage; assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and resolve problems with obtaining premium tax credits</li> <li>• Establish a program under which to award grants to "Navigators"</li> </ul>
Reporting		<ul style="list-style-type: none"> <li>• Publish average costs of licensing, regulatory fees and other payments required by the Exchange, as well as administrative costs, moneys lost to waste, and fraud and abuse</li> <li>• Implement data-driven fraud detection protocols</li> <li>• Maintain accurate accounting of all activities, receipts and expenditures; and an annual report must be submitted</li> <li>• Report on quality measures and performance of health plans</li> <li>• Conduct enrollee satisfaction surveys for every plan with more than 500 employees</li> <li>• Within five years of operations, the Comptroller General will conduct an ongoing study of activities and enrollees. The study will review operations and administration, including complaint data and ability to meet goals. It will include observations, operational or policy</li> </ul>

Functional Area	Arkansas Defined Business Processes	ACA Legislative Requirements
		<p>improvement recommendations, the number of doctors not accepting new patients and provider network adequacy, cost and affordability of insurance</p> <ul style="list-style-type: none"> <li>• Qualified health plans must make the same quality reports related to pediatric care that are required of the State Medicaid-CHIP agency</li> </ul>
Plan Management	<ul style="list-style-type: none"> <li>• Plan Payments</li> </ul>	<ul style="list-style-type: none"> <li>• Review, approve or deny certification based on coverage transparency, the accurate and timely disclosure of claims policies and procedures; periodic financial disclosures; enrollment and disenrollment data; denied claims; rating practices; cost-sharing and payments with respect to out-of-network (OON) coverage; enrollee and participant rights</li> <li>• Require health plans seeking certification to submit to the Exchange, the Secretary, the State Insurance Commissioner, and to the Public the following: Claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of denied claims, data on rating practices, information on cost-sharing and payments with respect to out-of-network coverage, information on enrollee and participant rights</li> <li>• Plan seeking certification must allow individuals to learn the amount of cost-sharing under the plan that the individual is responsible for</li> <li>• Review and approve/deny requests for premium rate increases, and take into account excess premium growth outside the Exchange</li> <li>• Provide for timely acknowledgment, response and status reporting that supports a transparent claims and denial management process</li> <li>• HHS Secretary will notify plan issuers of enrollees who are eligible for cost-sharing reductions, and issuers will reduce cost-sharing under the plan</li> <li>• Exchanges must provide access to at least four levels of coverage</li> <li>• Catastrophic plan only for individuals under 30</li> <li>• A licensed health insurance insurer must charge the same premium whether the plan is offered via the Exchange, offered directly or through an agent</li> <li>• Director of the Office of Personnel Management shall contract to offer at least 2 multi-State plans through the Exchange</li> </ul>
Employer Relations		<ul style="list-style-type: none"> <li>• A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage to be made available to employees through an Exchange</li> <li>• A small employer may continue to participate if it ceases to be a small employer because of an increase in the number of employees</li> <li>• Beginning in 2017, each State may allow issuers in the State’s large group market to offer qualified health plans through an Exchange</li> </ul>

Functional Area	Arkansas Defined Business Processes	ACA Legislative Requirements
		<ul style="list-style-type: none"> <li>• Transfer to the Secretary of the Treasury, the name and taxpayer identification number of each individual who was an employee but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage; or the employer provided minimum essential coverage which was determined to either be unaffordable or not provide the required minimum actuarial value</li> <li>• Transfer to the Secretary of the Treasury, the name and taxpayer identification number of each individual who notifies the Exchange that they have changed employers or have ceased coverage</li> <li>• Provide to each employer the name of each employee who ceases coverage under a plan</li> <li>• “Offering employer” is one who offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and who pays any portion of the costs</li> </ul>
Outreach	<ul style="list-style-type: none"> <li>• Consumer Outreach and Education</li> </ul>	<ul style="list-style-type: none"> <li>• States may allow agents and brokers to enroll individuals in any plan on an Exchange in the State, and to assist applications for premium tax credits and/or cost sharing reductions</li> <li>• States may establish rate schedules for broker commissions paid by health plans</li> <li>• Exchanges shall establish grants (out of operational funds) to support health care Exchange "navigators"</li> <li>• Navigators: Individuals and organizations who will help employers, employees, consumers and self-employed individuals understand and enroll in plans via the Exchange</li> <li>• Navigators should be qualified and regulated and may include trade, industry and professional associations, community and consumer-focused non-profits, chambers of commerce, licensed insurance agencies and brokers, etc.</li> <li>• Navigators may not be health plans or receive any considerations from health plans</li> <li>• Consult and coordinate with external stakeholder groups</li> </ul>
State and Federal Coordination		<ul style="list-style-type: none"> <li>• Transfer applicant-provided information to HHS Secretary for verification</li> <li>• Data matching program will be primary mechanism for establishing, verifying and updating eligibility</li> <li>• Verification and determination amongst Federal agencies will be completed online, and Secretary will notify Exchange of results; Secretary may delegate some verification responsibility to the Exchange</li> <li>• Exchange must provide to the Secretary of the Treasury and to the taxpayer relating to any Exchange plan, any information provided to the Exchange, including change in circumstances necessary to determine eligibility, and the amount of the premium assistance tax credit; name, address and TIN of the primary insured, and the name and TIN of each individual covered under the policy; total premium, excluding applicable premium</li> </ul>

Functional Area	Arkansas Defined Business Processes	ACA Legislative Requirements
		<p>assistance tax credit or cost-sharing reductions; level of coverage provided, and the period of coverage; aggregate amount of any advance payment; information needed to determine if taxpayer received excess advance payment</p> <ul style="list-style-type: none"> <li>• If applicant-provided information related to enrollment, premium tax credits and cost-sharing reductions is positively verified, HHS Secretary will notify the Treasury Secretary of the amount of any advance payment to be made; also, if applicant-provided information relating to exemption from individual responsibility requirement is verified, HHS Secretary will issue a certification of exemption</li> <li>• Exchange must also transfer to the Secretary of Treasury the name and TIN of: Those issued an exemption from the individual mandate; each individual who has an employer but was determined eligible for the premium tax credit; each individual who notifies the Exchange that they have changed employers; each individual who ceases coverage during the year</li> <li>• State may authorize Exchange to contract with an eligible entity to carry out Exchange responsibilities</li> </ul>
Financial	<ul style="list-style-type: none"> <li>• Plan Payments</li> <li>• Premium Collection</li> <li>• Cost Allocation</li> <li>• Cost Sharing</li> </ul>	<ul style="list-style-type: none"> <li>• Electronic calculator to determine actual cost of coverage after the application of premium tax credits</li> <li>• Exchange must provide the following information to the Secretary of the Treasury and to the taxpayer: Total premium for the coverage, excluding applicable premium assistance tax credit or cost-sharing reductions</li> <li>• Standard out-of-pocket maximum limit reductions: <ul style="list-style-type: none"> <li>○ 100%-200% FPL: reduced by 2/3rds</li> <li>○ 200% -300% FPL: reduced by 1/2</li> <li>○ 300% -400% FPL: reduced by 1/3rd</li> </ul> </li> <li>• The plan's share of total allowed costs of benefits would be increased to: <ul style="list-style-type: none"> <li>○ 94% for those 100-150% FPL</li> <li>○ 87% for those 150-200% FPL</li> <li>○ 73% for those 200-250% FPL</li> <li>○ 70% for those 250-400% FPL</li> </ul> </li> <li>• Calculation of premium credit should take into consideration premium assistance amounts, coverage months, minimum essential coverage, unaffordable coverage under an employer-sponsored plan, applicable 2<sup>nd</sup> lowest cost silver plan, adjusted monthly premium for such plan, applicable %,and advance payment of credits</li> <li>• The Secretary of HHS will notify the Exchange and the Secretary of Treasury, and the Secretary of Treasury will make the necessary payments to the insurer, who must reduce the individual's premiums and cost-sharing</li> <li>• States may provide subsidies in addition to the Federal subsidies</li> </ul>

Functional Area	Arkansas Defined Business Processes	ACA Legislative Requirements
		<ul style="list-style-type: none"> <li>• If Secretary notifies Exchange that enrollee eligible for premium credit or cost-sharing reduction due to lack of minimum essential coverage through an employer (or unaffordable coverage), the Exchange must notify employer (and employer may be liable for tax)</li> <li>• In the case of an eligible small employer, there shall be a small employer health insurance credit for any taxable year</li> <li>• The aggregate cost of applicable employer-sponsored coverage should be included in W2</li> <li>• Levels of coverage are defined as               <ul style="list-style-type: none"> <li>○ Bronze: 60% of the full actuarial value the plan</li> <li>○ Silver: 70% of the full actuarial value the plan</li> <li>○ Gold: 80% of the full actuarial value the plan</li> <li>○ Platinum: 90% of the full actuarial value the plan</li> </ul> </li> <li>• Health insurance issuers are to consider all enrollees in all health plans offered by the issuer in the individual market (except grandfathered plans) to be members of a single risk pool; Also all enrollees in all health plans offered by the issuer in the small group market (except grandfathered plans) to be members of a single risk pool</li> <li>• The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015 and 2016</li> <li>• Each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans</li> <li>• Reward quality through market based incentives</li> <li>• States must ensure the Exchange is self-sustaining by January 1, 2015</li> <li>• Exchange may charge assessments or user fees to participating health plans, or to otherwise generate funding</li> <li>• Administrative and operational funds cannot be used to fund retreats, promotional giveaways, etc.</li> <li>• Pay for new spending, in part, through spending and coverage cuts in Medicare Advantage</li> <li>• Grants to be made available to States for planning and activities related to establishing an Exchange. Grants may be renewed</li> </ul>



**State of Arkansas**  
**Arkansas Insurance**  
**Department**

**Arkansas Health Benefits Exchange**  
**Planning Project**

**Evaluation Plan**

**Version 3.0**

**August 22, 2011**



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## Document History

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August 22, 2011	3.0	Amy Schrader/Debbie Hopkins	Additional comments from HBE Planning Team

**Table 1: Document History**

# 1 Introduction

In developing this evaluation plan, we have tried to simultaneously take two perspectives. Our first perspective is that of the policy maker who wants to know whether the Exchange, as established in Arkansas, satisfactorily performs what lawmakers have termed “essential functions.” The second perspective is broader. We sought to also develop an evaluation plan that would address whether the Exchange was able to meet its public policy goals and whether any publicly anticipated or feared consequences were observed.

This proposed evaluation plan is designed to be a comprehensive assessment of Arkansas’s new health insurance exchange. Evaluation is focused on three primary components: implementation, outcomes, and efficiency. Implementation evaluation focuses on the process of Exchange introduction to the public. A solid implementation evaluation serves as the foundation for outcomes and efficiency evaluations since the latter depend on successful implementation.

However, as a policy instrument, the Exchange is expected to have far-reaching consequences on the broader health care system. An outcomes evaluation centers on the policy objectives of the Exchange. Thus, this evaluation plan also aims to address various policy-relevant potential effects of the new Exchange.

Finally, in a time of constrained resources, efficiency is the critical third pillar of comprehensive evaluation. Efficiency evaluations identify whether the Exchange was implemented with minimal waste and whether the health outcomes were achieved in the most cost-effective manner.

It is essential that cooperative partnerships occur in the measurement of the implementation, outcomes and efficiency of the Exchange in order for the impact to be successful and for the Exchange to experience the most in cost-effectiveness. The measures presented in this evaluation plan are designed to track many aspects of health care, including satisfaction with care, quality of care, access to care, utilization of care, and cost of care. Although funding for an evaluation requires a financial commitment upfront, the benefits result in health improvement for Arkansans and a cost-effective and efficient health system which lead to potentially greater cost savings long-term.

To measure the HBE implementation effectiveness, we **recommend** conducting a population-wide survey of all Arkansas residents to capture awareness and use of the HBE as well as calculating enrollment and re-enrollment, tracking disenrollment and gaps in coverage.

To ensure that enrollees are satisfied with their healthcare coverage purchased through the HBE, we **recommend** conducting the CAHPS Health Plan survey to measure enrollee satisfaction. Since Navigators and licensed insurance producers are predicted to play an instrumental role in consumers accessing the HBE, we **recommend** surveying consumers at the time of enrollment to capture whether they used a Navigator or licensed producer and how satisfied they were with their Navigator or producer.

With a predicted increase in consumers accessing care, we **recommend** surveying providers to see if they feel they can adequately meet the needs of their existing patients and deliver care to new patients.

Tracking the number of uninsured Arkansans as well as crowd-out will be one aspect of measuring the success of the HBE. Also, the calculation of quality measures will measure whether enrollees’ are receiving quality and timely care. We also recommend measuring access to care to determine if problems arise after more people access healthcare services as well as measuring utilization of care to determine if enrollees are accessing preventive services, not accessing the emergency department for non-urgent care and are not being readmitted to the hospital. Tracking the costs of care by plan and issuer will help identify any outlier expenditures.

## 1.1 Abbreviations and Definitions

<b>ACA</b>	The Affordable Care Act, which refers collectively to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act
<b>AHRQ</b>	Agency for Healthcare Research and Quality
<b>AID</b>	Arkansas Insurance Department
<b>Applicant</b>	An individual who is seeking an eligibility determination to enroll in a health plan through the Exchange, to receive advance payments of the tax credit, or to receive other State benefits per §1312(f)(1)
<b>CCIIO</b>	Center for Consumer Information and Insurance Oversight
<b>CAHPS</b>	The Consumer Assessment of Healthcare Providers and Systems
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CPM</b>	Committee on Performance Measurement
<b>Enrollee</b>	A qualified individual or qualified employee who has enrolled in a qualified health plan, per ACA §1312(f)(1)
<b>HBE</b>	Health Benefits Exchange
<b>Health Plan</b>	A discrete combination of benefits and cost-sharing, also known as a “qualified health plan” or “QHP” per ACA §1312(f)(1)
<b>HEDIS®</b>	Healthcare Effectiveness Data Information Set, a set of standardized performance measures developed and maintained by NCQA
<b>Issuer</b>	ACA & the CCIIO use the term “issuer”, not “carrier” to refer to “the entity offering coverage”. For the sake of consistency, we adopt the same term throughout this proposal for Exchange evaluation.
<b>MCPSS</b>	Medicare Contractor Provider Satisfaction Survey
<b>NCQA</b>	National Committee for Quality Assurance, a not-for-profit organization committed to assessing, reporting on and improving the quality of health care
<b>NQMC</b>	National Quality Measures Clearinghouse
<b>Qualified Individual</b>	One who is already determined eligible to participate in an Exchange, per ACA §1312(f)(1)

Table 2: Abbreviations and Definitions

## 2 Approach

In developing the evaluation plan, we have relied upon the cause-and-effect logic implicit in ACA and subsequent rules and proposed rules. We have proposed measures that are directly tied to one or more of the stated objectives of ACA or to one of the mechanisms by which ACA is believed to achieve its policy goals. When a measure is required or proposed to be required, we have noted that in the text.

Our evaluation secondarily draws on a review of the experiences of early adopters of Exchanges, a review of existing evaluation plans for current or planned Exchanges and other changes to health insurance programs, and conventional measures of health system effectiveness. Our intent with this approach was to identify objectives and methods that were relevant to Arkansas and its unique population needs rather than imposing federal or non-comparable state standards.

### 2.1 Review of Other State Exchanges

Currently, only two states (Massachusetts and Utah) have functional state Exchanges. Both states require legislative revision to their existing state exchange authorization to be in compliance with the Patient Protection and Affordable Care Act (ACA). During the 2011 legislative session, ten states passed laws to establish Exchanges. Several other states either passed legislation or had executive orders signed that expressed the intent to develop a state-run Exchange.

Table 3 shows the status of Exchange development in states that have taken action to developing their own exchanges.

Type of Action	States
Existing Exchange	Massachusetts, Utah
Authorizing Legislation	California, Colorado, Connecticut, Hawaii, Maryland, Nevada, Oregon, Vermont, Washington, West Virginia
Intent-to-Establish Legislation	Illinois, Indiana, North Dakota, Virginia
Feasibility Study	Alabama, Mississippi, Wyoming

**Table 3: Progress Toward Creating Exchanges**

Source: Adapted from Table 1 of "Establishing Health Insurance Exchanges: An Update on State Efforts."

(<http://www.kff.org/healthreform/upload/8213.pdf>)

Of the states listed, legislative review focused on West Virginia because it is the most similar to Arkansas in terms of rural composition and socioeconomic variables. More of West Virginia's population (54%) resides in rural areas than Arkansas (47%). However, with exception of Vermont, it is the only heavily rural state to adopt Exchange legislation. There is no statistical difference in educational attainment or median household income between West Virginia and Arkansas.

The objectives of feasibility studies for Alabama and Mississippi were examined for guidance on evaluation topics, again because of their similarity to Arkansas in rural composition and socioeconomics. Alabama's rural population is 45%, while Mississippi's is 51% (2000 US Census). Socioeconomic profiles focused on educational attainment and income. Arkansas's percent of high school graduates (82.4%) has a statistically equal proportion to Alabama's 82.1% and Mississippi's 80.4%. Mississippi has a median household income that is about \$1,200 less than Arkansas's. Alabama incomes are about \$2,700 higher. Both differences are significant.

Most early-adopting states have a high urban population, are relatively affluent, and have a low uninsured population relative to the US as a whole. However, where these states are similar to Arkansas on key health system features, their enabling legislation and statements by policy-makers were reviewed in a highly focused manner.

## 2.2 Review of Existing Evaluation Plans and Related Literature

State-developed plans for Exchange evaluations were difficult to find. This is not surprising given that most states are only in the early phases of Exchange development.

Most information about evaluation exists for the Massachusetts exchange. As the first of the states to attempt universal coverage through the private insurance market, Massachusetts attracted a great deal of outside research interest. Thus, a large proportion of the evaluation of the Massachusetts exchange have been conducted by non-state entities with little state oversight or input.

A secondary area of interest is the evaluations that have been conducted of other programs to expand health insurance coverage. The programs have focused mainly on Medicaid and its various State waiver programs. We reviewed the funded evaluation programs for coverage expansion programs identified by the State Health Access Data Assistance Center (SHADAC), an initiative of the Robert Wood Johnson Foundation.

The most common concerns in existing evaluations are the degree of enrollment change and especially barriers to enrollment. Other areas of interest are changes in the cost of care specifically as they relate to reimbursement for newly covered services.

## 2.3 Sources of Established Measures

In many cases, there are established methods for capturing the measures we propose in this evaluation. We **recommend** relying on these measures when possible because they have been previously validated and are generally well-accepted in the industry.

Most validated measures of health system quality and efficiency are publicized through the National Quality Measures Clearinghouse (NQMC). Our measures rely upon two main measurement sets, Healthcare Effectiveness Data Information Set® (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Most commercial

issuers have experience with these measures, so their collection should not represent a new administrative burden.

The HEDIS® is a set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS® is one of the most widely used set of health care performance measures used in the United States. HEDIS measures, while inclusive of some outcomes, generally are focused on the process of care. For example, the Breast Cancer Screening measure reports the percentage of women 40 to 69 years of age who had a mammogram to screen for breast cancer.

NCQA's Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, health care providers and policy makers, oversees the evolutions of the measurement set. Several Measurement Advisory Panels (MAPs) provide clinical and technical knowledge required to develop the measures. Additional HEDIS® Expert Panels and the Technical Advisory Group (TAG) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

The CAHPS program is overseen by the United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ) and includes a myriad of survey products designed to capture consumer and patient perspectives on health care quality.

### 3 Evaluation Measures and Methods

#### 3.1 Implementation Effectiveness

“Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each state has the opportunity to establish an Exchange(s) that: (1) facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other requirements specified in the Affordable Care Act.”

Implementation evaluation focuses on the process of Exchange introduction to the target population. Outcomes and efficiency evaluations must be interpreted in the context of how successfully implementation occurred. Therefore, a solid implementation evaluation serves as the foundation for all subsequent evaluations. The key measures by which the Exchange implementation process will be judged are its adoption by consumers and the continued use of the exchange.

Table 4 summarizes suggested measures of implementation effectiveness and potential sources. This list may be expanded later to comply with federal rules that are not yet finalized.

Potential Data Sources						
	Survey	Website	Call Center	Insurance Issuers	Medicaid Data	Exchange
Use of the Exchange	X	X	X			
Enrollment	X			X	X	X
Re-enrollment				X	X	X
Disenrollment				X	X	X
Gaps in Coverage	X			X	X	X

Table 4: Summary of Implementation Measures

##### 3.1.1 Use of the Exchange

Use of the Exchange reflects two components: consumer awareness of the HBE as an option for purchasing health insurance and the ease with which the various HBE interfaces may be used. To date, discussions with the Arkansas Insurance Department and the Exchange workgroups have indicated that consumers will have multiple ways to accessing the HBE. There are multiple ways to access the Exchange including a federally-mandated call center and website as well as walk-in and by mail.

We **recommend** a population-wide survey of all Arkansas residents. This data collection method enables evaluators to ask residents specifically whether they are aware of the Exchange and separately whether they have tried to use it. Because the HBEs are new, no national survey tools are currently available to measure awareness and use. While this may change between now and when the HBE is implemented in Arkansas, we **recommend** that plans for evaluating awareness and use include development of a new survey tool designed

specifically to capture awareness and use. We **further recommend** that an updated review of tools be made before developing a new statewide survey tool since significant time and expense is involved in this process.

An **alternative recommendation** is to use relatively easy to capture statistics that are specific to the method of contact and established within that industry. An example of a use measure is the “bounce rate” or the number of times a consumer visits a website but leaves without visiting a threshold number of pages on that site. We **recommend** that no measures be finalized until authorizing legislation has passed and AID has set up appropriate administrative structures.

### 3.1.2 Enrollment and Re-enrollment through the Exchange

An Exchange is intended to be a method by which consumers can access Medicaid or health insurance they otherwise could not have purchased. Enrollment through the exchange is arguably one of the most important measurements of implementation success. Just because insurance is available through the Exchange, it is not guaranteed that all individuals who are eligible for Medicaid or subsidized premiums will elect to enroll or purchase coverage.

Currently, 47.1% of employers in Arkansas offer health insurance to at least some of their employees. In general, about 83.6% of employees at firms that offer insurance are eligible for coverage. The “take-up” rate, or the percentage of eligible employees actually electing to enroll in the company’s plan, is 77% in Arkansas. We believe that 77% should be viewed as a baseline “take-up” measure before implementation of the Exchange. Therefore, with additional outreach efforts, we believe 90% should be the minimum threshold for enrollment of qualified individuals in the Exchange.

The premium subsidies for insurance coverage through the Exchange will be substantial relative to what many employers offer, especially for family coverage. For example, the average Arkansan with employer-based coverage pays about 20.2% of the total cost of the premium for employee-only coverage and 26.6% of the premium for family coverage (analogous to a subsidy of 79.8% and 73.4%, respectively). Exchange premium subsidies for families making less than 400% of FPL will range from 35% to 96%, depending on income.

There are additional incentives to purchase insurance through the exchange. First, lower income families will also be eligible for cost-sharing subsidies that may not be available through an employer, thus the total premium + cost-sharing cost of health insurance may be lower through the exchange. Second, most (66%) of the projected enrollment for the exchange will come from people who are currently uninsured and may not have access to insurance, but would like to purchase it. Finally, there will be individual fines for not maintaining health insurance coverage. All of these factors may contribute to a higher take-up rate than is currently observed for employer-offered insurance in Arkansas.

Among states that already have an insurance exchange or have passed authorizing legislation, Arkansas has no peers in take-up rate. Indeed, in states with similar employer

subsidies to Arkansas, the take-up rate is generally lower than that observed in Arkansas. This may indicate that people in Arkansas may be more likely to respond to premium subsidies. The many unknowns surrounding this issue underscore the importance of studying the enrollment rate.

We **recommend** measuring enrollment as the number of enrollees divided by the number of qualified individuals, expressed as a percentage. Because not all potential qualified individuals will actually apply for coverage through the HBE, we **further recommend** measuring enrollment as the percentage of potentially eligible individuals.

Re-enrollment is defined as maintaining QHP coverage through the HBE from one benefit year to the next. Re-enrollment is an important measure of effectiveness because it indirectly captures the value consumers place on the HBE. We **recommend** measuring re-enrollment as the number of enrollees in the current benefit year who have had any previous enrollment through the HBE divided by all current enrollees, expressed as a percentage.

### 3.1.3 Disenrollment and Gaps in Coverage

For the purposes of this evaluation proposal, disenrollment is any enrollee-driven termination of coverage through HBE. Under the 45 CFR §155.430, there are six reasons for termination of coverage. Since we are looking at disenrollment categories that would cause an enrollee to leave the Exchange, we are interested in the following four categories of reasons for termination of coverage: (1) voluntary termination, (2) loss of eligibility, (3) failure to pay premiums, and (4) rescission. Under current proposed rules, HBEs must “establish maintenance of records procedures for termination of coverage, track the number of individuals for whom coverage has been terminated and submit that information to HHS on a monthly basis” (45 CFR §155.430, proposed). The remaining two disenrollment categories include: the QHP terminates or is decertified by the HBE and the enrollee changes from one QHP to another. For the purpose of this evaluation, we do not recommend tracking these reasons since these categories of termination do not involve the enrollee leaving the HBE, but simply switching to other plans within the HBE.

We **recommend** that the HBE track reasons for termination of coverage over time with particular attention paid to whether there is a trend in the percentage of enrollees voluntarily terminating or failing to pay their premiums. We **further recommend** that this analysis be carried out with respect to subsidy and benefit level. Because the proposed rules will require the HBE to maintain termination records, we **do not anticipate new data collection or surveys for this measure**.

A gap in coverage occurs when an enrollee moves from one class of coverage to another (e.g. a Medicaid to QHP) and this move results in a period of uninsurance for at least one day. If proposed rules are finalized, gaps in coverage should be rare because of a provision that allows for special enrollment periods of 60 days when an individual has a loss of coverage and a provision for continued Medicaid until the private plan assumes coverage. Specifically, the regulations state that individuals “will not be required to be uninsured

prior to receiving a determination of eligibility for a special enrollment period.”  
ACA§9801(f), 45 CFR§155.420.

However, it is likely that many individuals losing coverage will not take advantage of the ability to obtain an eligibility determination before losing their current coverage. Therefore, we **recommend** that the HBE monitor the actual time elapsed between when an individual loses the current type of coverage they have (employer, QHP, or Medicaid) and when they subsequently gain coverage through the HBE (in a QHP or Medicaid).

The date of lost coverage will be known to the HBE because of the 60-day enrollment period. The date of enrollment in a QHP or Medicaid will also be part of the HBEs standard record-keeping process. Therefore, this recommendation **does not represent new data collection, but rather analysis of what will be existing administrative data.**

Finally, we **specifically recommend** that analysis of gaps in coverage focus on QHP enrollees and Medicaid beneficiaries who are close to the Medicaid threshold since these individuals may be especially prone to changes in eligibility. The HBE should determine whether individuals with one or the other type of coverage delays switching to the other type for close to the 60 day limit. Additional clarity within federal regulations will further define how to handle QHP enrollees switching to Medicaid and Medicaid beneficiaries gaining coverage through a QHP to accommodate gaps.

### 3.1.4 Navigator Education

Given the central role envisioned for Navigators, we **recommend** assessing whether they feel they received appropriate and sufficient training and had sufficient technical assistance to be able to answer consumer questions. We **additionally recommend** that Navigators be asked whether they feel the HBE is supporting the role of a Navigator and whether the HBE could make administrative changes that would enable Navigators to more effectively serve consumers.

We **recommend** that these surveys take place each six months in the first and second year of implementation, with possible subsequent surveys if identified issues are not resolved. We **further recommend** that, given the nature of the domains of interest, the surveys should be qualitative and open-ended rather than guided response.

### 3.1.5 Federally-Required Measures

Planning for and development for Exchanges is in its early days. To date, the CCIIO has focused its efforts on disseminating information about goals and objectives for Exchanges and the appropriate functions and governance thereof. CCIIO has not published any guidelines for measuring Exchange effectiveness. This is subject to change.

We **recommend** regularly reviewing the guidance, proposed rules, and final rules published in the *Federal Register* for updated information on standards for Exchange evaluation. In the interim, related proposed and final rules should be reviewed to determine the potential direction CCIIO may take in establishing any rules for evaluation.

Specifically, **we recommend** reviewing all materials released relating to Exchange implementation, Qualified Health Plan (QHP) standards, and risk adjustment.

At a minimum, a review of existing federal rules should be made before any evaluation is undertaken to ensure that compliance is maintained. This in no way precludes evaluation if no federal rules are in existence. The recommended clearinghouse for this information is the Regulations & Guidance webpage of the Implementation Center, currently accessible through <http://www.healthcare.gov/center/>.

### 3.2 Enrollee Satisfaction

We **recommend** the HBE or a designated contractor administer CAHPS Health Plan surveys to measure enrollee satisfaction in the following areas: Navigators, HBE website, health plan, issuer, medical provider, and agent. The surveys should be administered to a random sample. When selecting the random sample of enrollees for the CAHPS survey, **we recommend** following current CAHPS sampling methodology to ensure that the sample size is sufficient to draw conclusions about relevant groups and subgroups.

Although not all of the measures below are currently captured on the CAHPS 4.0 Health Plan surveys, supplemental questions will be designed to measure enrollee satisfaction in the areas listed in Table 5. For questions that are captured on the national CAHPS Health Plan survey, national benchmarks will be available for comparison.

	National Survey	Custom Questions	Benchmark Available?
With Navigators		X	
With Exchange Website		X	
With Health Plan	X		X
With Issuer	X		X
With Provider	X		X
With Agent		X	

Table 5: Summary of Enrollee Satisfaction Measures

#### 3.2.1 Navigators

There is no current national survey tool to measure satisfaction with a Navigator. We **conditionally recommend** that if a national Navigator-specific survey tool is developed and validated before HBE implementation such a tool should be used. However, at this time, **we recommend** that the HBE or a designated contractor develop a new survey tool that measures (1) ease of access to a Navigator, (2) how often the navigator gives the enrollee the information or help they need, (3) how often the navigator treats the enrollee with courtesy and respect, and (4) how often the enrollee rates the navigator an 8 or above on a 0 to 10 scale where 0 represents the worst navigator possible and 10 represents the best navigator possible. These proposed dimensions are patterned after the CAHPS survey.

To capture enrollees’ satisfaction with a Navigator when they are most likely to recall the experience, we **recommend** asking these questions within six months of their enrollment. A follow-up survey could also be conducted at re-enrollment to determine if there were any changes in the enrollee’s satisfaction with the Navigator. We **further recommend** that applicants be pre-screened for inclusion in the Navigator survey at the time of benefit eligibility determination so that only applicants who used a Navigator are selected for this survey.

### 3.2.2 Exchange Website

Using the CAHPS Health Plan survey tools as a model, we **recommend** that questions be developed to evaluate the Health Exchange Website to measure how often a consumer has utilized the website within a specified timeframe, how often the website provided information the consumer needed about how their health plan works and how the consumer rates the Health Exchange Website on a 0 to 10 scale where 0 represents the worst website possible and 10 represents the best website possible.

### 3.2.3 Issuer

Enrollee satisfaction surveys are mandated under ACA §1311(c)(4). Proposed federal rules are that the HBE must maintain a website that provides enrollees with up-to-date information about satisfaction survey results. At this time, no federal guidelines give the nature and content of these enrollee satisfaction surveys. However, the proposed 45 CFR Part 155 states specifically that HHS will be issuing further rules with respect to this topic. We make several recommendations below that we believe will likely be compliant with eventual guidance. However, **we caution that all recommendations of specific enrollee satisfaction measures are subject to change** pending eventual federal regulations.

The proposed 45 CFR Part 155 suggests that an insurance issuer or the HBE may be the entity which conducts the enrollee satisfaction survey. This is one of the areas subject to additional clarification. Therefore, Table 6 lists the potential entities that may have collection responsibility.

Measure	Potential Data Sources			Suggested Benchmark(s)
	Insurance Issuer	Outside Evaluator	State or Exchange	
Overall Rating	X	X	X	National average Exchange average
Information on Costs	X	X	X	Exchange average
Claims Processing	X	X	X	Exchange average
Customer Service	X	X	X	National average Exchange average

Table 6: Measures of Enrollee Satisfaction and Collecting Entities

Because of the ACA collection requirement, we do not envision the need to conduct additional surveys explicitly for evaluation, as long as sufficient sample sizes were collected when the regulatory requirement to conduct a survey was met. For this reason, **we recommend** close cooperation between survey operations for the Exchange's consumer information piece and the evaluation piece. Indeed, having one entity responsible for both may be the most cost-efficient way to meet the regulatory requirements and conduct a strong evaluation.

We **recommend** using existing national measures to capture an enrollee's satisfaction with their health plan collected through CAHPS Health Plan surveys which include: Rating of Health Plan, Plan Information on Costs, Claims Processing and Customer Service. It is worth noting here that the CAHPS use of "health plan" refers to that entity which is defined as an "issuer" in this text and by ACA and CCIIO.

The Rating of Health Plan measure asks the enrollee to rate their health plan on a scale from 0 to 10 where 0 represents the worst health plan possible and 10 represents the best health plan possible. Ratings of 8 and above will be calculated out of all ratings for comparison as well as each health plan's average rating.

The Plan Information on Costs measures how often the enrollee is able to find out from their health plan how much they will have to pay for a health care service or equipment as well as prescription medicines. This measure is calculated by taking the percent of consumers who responded "Always" or "Usually" out of all responses: "Never", "Sometimes", "Usually" and "Always".

The Claims Processing measures how often the enrollees' claims are handled quickly and correctly by the health plan. This measure is calculated by taking the percent of enrollees who responded "Always" or "Usually" out of all responses: "Never", "Sometimes", "Usually" and "Always".

The Customer Service measures how often the health plan's customer service gave the enrollee information or help they needed and treated them with courtesy and respect. This measure is calculated by taking the percent of enrollees who responded "Always" or "Usually" out of all responses: "Never", "Sometimes", "Usually" and "Always".

### 3.2.4 Health Plan

It is envisioned that ACA will provide consumers with choice of health plans to fit their needs. Under ACA, a health plan "is defined as a discrete combination of benefits and cost-sharing that is offered by a health insurance issuer and in which an individual or group can enroll." All health plans sold through the Exchange must be "qualified health plans" (QHPs). Each issuer may offer multiple QHPs.

This proposed section of the evaluation will determine whether there are systematic differences in enrollee satisfaction across issuers by benefit levels. Benefit levels are classified under ACA as bronze, silver, gold, and platinum. Catastrophic coverage is available to those 30 or younger, provided certain conditions are met. Since it is not known

whether there will be sufficient numbers of enrollees in the catastrophic QHPs, we do not recommend analysis at this benefit level without statistical assessment of sample size first.

We **recommend** measuring enrollee satisfaction with QHPs by the same measures as those collected under the issuer survey. This prevents the need to conduct a separate survey, which should additionally moderate evaluation costs.

We recommend comparing QHP satisfaction between those enrollees with and without a Navigator or Agent. We recommend capturing this measure by stratified analysis of CAHPS survey results based on a gateway question “Did you use a Navigator to select your QHP?” and “Did you use an Agent to select your QHP?” within the questionnaire. Therefore, the Exchange will be able to measure the effectiveness of the Navigator or Agent by comparing satisfaction scores between groups of enrollees who used and did not use a Navigator or Agent.

It is well-known that enrollee satisfaction varies with health status. Because of the potential for healthier enrollees to self-select into different levels of coverage than sicker enrollees, risk-adjustment is critical before statistically valid comparisons can be made across benefit levels. Therefore, we **recommend** that the Exchange choose one of the federally-mandated risk-adjustment measures as a tool for calibration in order to provide a fair assessment of satisfaction and allow for comparison between the QHPs. The relevant rule is 45 CFR Part 153 Subpart D.

### 3.2.5 Provider

We **recommend** using the CAHPS 4.0 Health Plan survey tools to also measure four components related to the enrollees’ medical providers. Specifically we recommend the following CAHPS composites and ratings be used: How Well Doctors Communicate, Shared Decision Making, Rating of Personal Doctor and Rating of Specialist.

The How Well Doctors Communicate measures how often doctors listen, explain things, spend enough time with and show respect for what the enrollees have to say. The Shared Decision Making measures how often enrollees are included in their health care decisions by their providers. Standardized responses are “Never”, “Sometimes”, “Usually”, and “Always”. We **recommend** that the evaluation follow CAHPS protocol and use a combination of the “Always” and “Usually” responses as a gauge of success.

The Rating of Personal Doctor measure asks the enrollee to rate their personal doctor for a specific timeframe on a scale from 0 to 10 where 0 represents the worst personal doctor possible and 10 represents the best personal doctor possible. The Rating of Specialist measure asks the enrollee to rate the specialist they saw most often for a specific timeframe on a scale from 0 to 10 where 0 represents the worst specialist possible and 10 represents the best specialist possible. We **recommend** that the evaluation follow CAHPS protocol and calculate the percent of enrollees who rated the item an 8 or higher.

### 3.2.6 Agent

There is no current national measure for an agent, however, we **recommend** that the state measures (1) ease of access to an agent, (2) how often the agent gives the consumer the information or help they need, (3) how often the agent treats the consumer with courtesy and respect, and (4) how the consumer rates their agent on a 0 to 10 scale where 0 represents the worst agent possible and 10 represents the best agent possible.

## 3.3 Provider Perceptions

With an expected increase of consumers accessing care, it is important to measure if providers' still feel they can adequately meet the needs of their existing patients and deliver care to new patients. These surveys are not intended to compare carriers or health plans or judge providers' opinion of ACA. The goal of this measure is to determine whether the provider has noticed an increase in patients and an increase in health care service utilization with a specific focus on whether either of these has impacted care delivery. In essence we are measuring access to care from the providers' perspective.

At this point, we cannot predict whether the QHPs will be existing plans or will be new plans developed under the HBE. If specially developed QHPs are designed so that providers can recognize that these plans were purchased through the HBE, then we **recommend** measuring provider satisfaction by plan and issuer for QHPs purchased through the HBE.

We **recommend** using questions from a national survey tool in order to measure provider satisfaction. Provider surveys should be short in length and straightforward in order to engage the provider quickly.

## 3.4 Insurance Coverage

One of the stated goals of ACA is to achieve universal health insurance coverage through a mix of market-based reforms. As a federal priority, measurement of increased insurance coverage will likely be a necessity in the future. However, it should be a priority for the state as well.

Most people recognize the financial burden the uninsured place on the healthcare system. For a poor state like Arkansas, this burden is particularly difficult to pay. Nationally, the number of physicians providing charity care fell to 68% in 2004-2005 from 76% in 1996-1997. Arkansas faces a restricted supply of physicians and safety-net clinics. This means that care is shifted to hospitals' emergency departments or inpatient facilities if the uninsured delays care long enough. This may help explain Arkansas's higher-than-average supply of hospital beds.

Lacking health insurance also places individual Arkansans and their families at substantial health and financial risk. Because uninsured Arkansans often forego preventive care, they may miss out on screenings and hence be diagnosed in later stages of diseases, including

cancer, and die earlier than those with insurance. Medical bills can keep the uninsured from being able to pay for basic necessities such as housing or food.

Of the currently uninsured, more than 75% are either employed or the children of employed parents. Amongst this group, the majority (90%) will qualify for some sort of subsidy of insurance premiums through the exchange. However, it is possible that the exchange will not completely eliminate the number of uninsured in Arkansas due to lack of enrollment and employer crowd-out (when private industry quits providing a service once government assumes that function).

Table 7 shows what data sources we **recommend** HBE to use in order to measure the number of uninsured Arkansans and, the state’s crowd-out rate.

Proposed Data Source			
	Survey of Arkansans	Survey of Business	National Data
Number of Uninsured			
• By Income	X		X
• By Age	X		X
Crowd-Out		X	X

Table 7: Summary of Insurance Measures

### 3.4.1 Reducing Number of Uninsured Arkansans

In 2009, the most recent year with data available, 82.9% of Arkansans had health insurance. This was below the national rate of 84.6%. This reflects the effect of Medicare coverage in the elderly population though. Amongst the non-elderly population, 80.4% had insurance and amongst non-elderly adults, the percent with coverage falls still further to 74.8%. This places Arkansas amongst the list of states with the lowest insurance coverage for adults under the age of 64.

There has been a national trend toward declining insurance coverage in recent years. It is likely that this trend is reflected in Arkansas as well. To control for trends outside of policy changes related to ACA, we **recommend** that state-level measurement of insurance coverage for the specified groups below begin as soon as possible. When possible, these groups are constructed to reflect current national measurement, which will allow for meaningful benchmarking.

In some cases, no national benchmark exists. For example, the Marshallese minority group has a significant presence in Arkansas, but their experience is not tracked nationally. Another exception is geographic areas within Arkansas, which are defined by Arkansas’s Department of Health public health regions. The counties within each region are defined in Table 8. Measurement can still take place and be tracked over time without a benchmark.

Domain	Sub-Group	National Benchmark Exists?
Household Income	<100% of Federal Poverty Level 138% of FPL and less (newly Medicaid eligible) 139% to 250% of FPL (premium subsidy + cost-sharing subsidy) 251% to 399% of FPL (premium subsidy only)	✓ ✓ ✓ ✓
Race and Ethnicity	White, Non-Hispanic Black, Non-Hispanic Hispanic Asian/South Pacific Islander Multi-racial American Indian/Alaska Native Marshallese	✓ ✓ ✓ ✓ ✓ ✓
Age	0 to 18 years 19 to 25 years 26 to 34 years 35 to 44 years 45 to 54 years 55 to 64 years 0 to 64 years 65 years and older	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
Geographic Area	<b>Central:</b> Faulkner, Garland, Grant, Lonoke, Perry, Pulaski and Saline counties. <b>Northeast:</b> Clay, Cleburne, Craighead, Crittenden, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, Stone, White and Woodruff counties. <b>Northwest:</b> Baxter, Benton, Boone, Carroll, Conway, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Pope, Scott, Searcy, Sebastian, Van Buren, Washington and Yell counties. <b>Southeast:</b> Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Jefferson, Lee, Lincoln, Monroe, Phillips, Prairie and St. Francis counties. <b>Southwest:</b> Calhoun, Clark, Columbia, Dallas, Hempstead, Hot Spring, Howard, Lafayette, Little River, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier and Union counties.	

**Table 8: Proposed Sub-Group Analyses**

In the absence of a State-level survey, measures of insurance cannot be reliably obtained in a timely fashion. Therefore, we **strongly recommend** that the State conduct or obtain through contract a state-wide annual survey of insurance following nationally-recognized and statistically valid methods for measuring insurance enrollment.

### 3.4.2 Crowd-Out

“Crowd-out” is an economic term that refers to the phenomenon of private industry ceasing to provide a service or produce a good once government assumes that function. In the context of the new Exchange, there is the potential that some small employers who currently offer insurance coverage will cease to provide health insurance. If this happens, their low-wage employees will be shifted to Medicaid. Mid-wage employees will qualify for insurance subsidies and can purchase through the Exchange. High-income employees however may be left to purchase insurance in the traditional individual market or may become uninsured. Nationally, there is little evidence for an extensive crowd-out effect amongst low-income adults who newly qualify for Medicaid. For example, a report by the Center for Budget and Policy Priorities found that “in the 12 states that have expanded Medicaid to cover adults with incomes at or above the poverty line, an average of 23 percent of individuals with incomes eligible for Medicaid have private coverage. In the states that haven’t expanded Medicaid, a nearly identical share — 22 percent — of the same population has private coverage.” This is because such a small proportion of low-income families have access to private insurance. Given Arkansas’s economic profile, this may mean that the Medicaid expansion would have little effect here. There is more evidence of switching to subsidized insurance when it is offered. For example, when CHIP was expanded to include children beyond the poverty level, the CBO found that up to 50% of children had previously had private insurance. Information on whether this was employer-provided or purchased on the individual market by parents was not available.

The extent to which crowd-out will occur in Arkansas is unknown. Because there has never been a program exactly like this before, projections rely heavily on state expansions of Medicaid eligibility and CHIP. We were not able to identify any such studies that looked at Arkansas specifically. Table 9 shows our recommended measures of crowd-out effects.

Measure	Enrollment Documents	Enrollee Survey	Employer Survey	National Benchmark
Ceasing insurance offer			X	
Switching		X		✓
<ul style="list-style-type: none"> <li>• To Medicaid</li> <li>• To private exchange plan</li> <li>• By health plan</li> <li>• By subsidy level</li> </ul>	<ul style="list-style-type: none"> <li>X</li> <li>X</li> <li>X</li> <li>X</li> </ul>			
Reason for switching				
<ul style="list-style-type: none"> <li>• More affordable</li> <li>• Better coverage</li> <li>• Employer no longer offered</li> </ul>		<ul style="list-style-type: none"> <li>X</li> <li>X</li> <li>X</li> </ul>		

Table 9: Measures of Crowd-Out

As of 2009, 47.1% of employers in Arkansas offered some form of health insurance to their employees. These appear to be primarily large employers because 83.3% of employed Arkansans work at companies that offer health insurance. However, a sizable portion,

16.4%, of employees at Arkansas firms that offer health insurance are not eligible for the insurance offered.

When the fine for having an employee purchase through the exchange is less than the amount the employer contributes to the health insurance premium, employers have an incentive to cease offering insurance. Due to the already sub-average number of firms and employees with employer-provided private insurance in Arkansas, we **strongly recommend** that this number be closely tracked on an annual basis through an employer survey. Surveys should begin before the Exchange becomes an option to control for any trend due to changing economic conditions.

Where offered, Arkansas employees generally paid about 20% of the premiums for their health insurance for single coverage and about 27% of premiums for family coverage. Where subsidies for the purchase of insurance exceed current employer coverage, there is the potential for switching. Therefore, we **also recommend** a survey of enrollees in the exchange to ascertain whether they are switching and the reason why. This should be analyzed by the level of subsidy and type of health plan purchased. Variables for sub-group analysis can be obtained by enrollee survey or from enrollment documents, the latter likely being the more reliable source. Analysis should be conducted using statistically-robust methods that adjust for exogenous trends, such as changes in economic conditions.

### 3.5 Quality of Care

If a large percentage of consumers is not receiving a treatment or preventive service that national guidelines call for, this tells us – medical professionals, payers and the general public – that something needs to change. This may mean: changing the way care is delivered, establishing or refining processes so that critical steps are not missed, helping healthcare providers stay current on the latest guidelines, educating Arkansans about the importance of preventive healthcare, improving access to healthcare providers in medically underserved areas, and helping doctors and patients communicate effectively.

Table 10 shows the data sources for quality measures that we recommend. These quality measures are described in their sections below

	Survey	Chart Review	Claims Data	Statistical Analysis
Technical and Process Measures <ul style="list-style-type: none"> <li>Comprehensive Diabetes Care</li> <li>Cardiovascular Conditions</li> </ul>		X	X X	
Health Outcome Measures	X	X	X	X
Variation in Measures <ul style="list-style-type: none"> <li>by Health Plan</li> <li>by Issuer</li> </ul>				X X

Table 10: Summary of Quality of Care Measures

### 3.5.1 Technical and Process Measures

While there are over seventy HEDIS® measures, we **recommend** that the Health Exchange focus on areas of greatest need within Arkansas as well as the demographics of the consumers. HEDIS® measures are often reviewed, edited, retired and created by NCQA's CPM to ensure that all measures accurately reflect current medical practices, codes and technologies. Therefore, the list of measures are recommended, but not limited to, the measures below:

**Comprehensive Diabetes Care:** For the more than 212,000 Arkansans who have diabetes, preventive care is critical for preventing complications such as kidney disease, blindness and amputations. Regular hemoglobin A1c testing can indicate a need for better blood-sugar control. Annual fasting lipid profiles track control of cholesterol and triglyceride levels, which are important in preventing diabetes-related vascular disease. Annual dilated eye exams can identify early signs of diabetic retinopathy, and early detection followed by laser treatments can dramatically reduce the risk of blindness. For the Arkansas Medicaid population, the rates of Hemoglobin A1c testing, LDL-C screening and Dilated eye exams were consistently lower than the national Medicaid rates from SFY2003 to SFY 2007.

**Cardiovascular Conditions:** Heart disease and stroke, the first and third leading causes of death in the United States, are the most common cardiovascular diseases. Heart disease accounted for 27 percent of deaths in Arkansas in 2005, while stroke caused 7 percent of deaths. In 2007, 31 percent of adults in Arkansas reported having high blood pressure (hypertension) and 40 percent of those screened reported having high blood cholesterol, which puts them at greater risk for developing heart disease and stroke. Currently, there are three HEDIS® measures that focus on Cardiovascular conditions: Cholesterol Management for Patients with Cardiovascular Conditions, Controlling High Blood Pressure, and Persistence of Beta-Blocker Treatment After a Heart Attack.

### 3.5.2 Outcome Measures

Over 600 evidence-based quality measures exist through the NQMC, a database sponsored by AHRQ to promote widespread access to quality measures by the health care community.

Due to the large number of quality measures, we **recommend** that the Exchange commission a needs assessment and meet with key stakeholders, agencies and leaders to determine which areas of health outcomes should be the primary focus for the HBE and which data elements are currently collected or required under ACA. After determining which outcome measures are most relevant for Arkansas and existing data sources and gaps,, the Exchange in consultation with key stakeholders can choose the desired outcomes measures accordingly and adapt the evaluation plan at that time.

Data collection methods will vary depending upon which measures are chosen by the Exchange. Some measures require claims data, a survey, chart review, or a combination of data collection methods. Valid statistical methods should be used to compare trends or to test for differences between health plans.

### 3.5.3 Variation by Plan and Issuer

One of the explicit goals of the ACA is to provide consumers with information to make informed decisions about the best private health insurance options for them and their families. Specifically, consumers will be able to “directly compare available private health insurance options on the basis of price, quality, and other factors.” Quality ratings assigned to QHPs described in section 1311(c)(3) of the Affordable Care Act (pg 42).

Selected quality of care measures should be calculated annually for each health plan and issuer. Reports should highlight where significant differences exist between health plans and issuers in order to ensure consumers are accessing quality health care.

### 3.6 Access to Care

One focus of the health benefits exchange is to improve a consumer’s access to health care. Since many of the consumers likely to join the health exchange will have not been previously covered by a health plan or had minimal coverage through a health plan, they will have access to health care they previously would not have had.

To measure the consumer’s access to health care, we **recommend** a CAHPS-like survey be administered to capture the following measures: perceived access to services, wait time for primary care visit, miles traveled for primary care, affordability of insurance, affordability of care and affordability of prescriptions.

	Custom Survey	Existing Survey	GIS Software
Perceived Access to Services <ul style="list-style-type: none"> <li>• Enrollees</li> <li>• Arkansans</li> </ul>		X	
Wait Time for Primary Care Visit		X	
Miles Traveled for Primary Care	X		X
Referrals to Specialists	X	X	
Affordability of Insurance	X		
Affordability of Care	X	X	
Affordability of Prescriptions	X	X	

Table 11: Summary of Access Measures

#### 3.6.1 Perceived Access to Services

The objective of this measure is to learn the extent to which the Health Exchange has had a positive impact on the consumer’s ability to obtain health care services. We **recommend** the survey ask about the consumer’s experiences before enrolling in the Health Exchange and their experience since enrolling in the Health Exchange. The survey should not be

conducted for consumers who have been enrolled less than six months. The following measures will, but are not limited to, compare a consumer's access to health care services: improved access to a primary care provider, prescription medication and emergency or urgent care.

- To measure improved access to a consumer's primary care provider, the survey should determine the level of problem accessing a primary care provider prior to enrollment and compared to at least six months post enrollment.
- To measure improved access to urgent care from a doctor's office or the emergency room, the survey should determine the level of problem accessing urgent care from a doctor's office or the emergency room prior to enrollment and compared to at least six months post enrollment.
- To measure improved access to a consumer's prescription medication, the survey should determine the level of problem accessing prescription medication prior to enrollment and compared to at least six months post enrollment.

Although these measures are not nationally available, the measures could be compared by health plan to determine where consumers are experiencing the greatest improvement in access to health care services. Statistical tests should be conducted to determine whether the changes in access to health care prior to enrollment and post enrollment are significant.

### 3.6.2 Wait Time for Primary Care Visits

Access to health care is multi-dimensional. There is the access to the system that insurance grants a person. As noted before, only about 68% of physicians will see patients who are uninsured. However, it is equally important to measure another dimension of access — timeliness of care.

As previously mentioned, Arkansas's supply of active physicians is far below the national average. Each active physician in Arkansas serves an average of 581 Arkansans. Nationally, physicians serve about 455 U.S. residents. Numbers that apply specifically to primary care doctors in Arkansas were not available, but it is reasonable to expect that they generally serve more patients than their peers in other states. There is also a relative shortage of safety-net clinics in Arkansas. There are only 4 FQHCs per 100,000 Arkansans living below 200% of the FPL. The national average is 7 FQHCs per 100,000 people below 200% of the FPL.

Of the states with existing Exchanges or with legislation authorizing an Exchange, Utah and Nevada are most like Arkansas with respect to physician supply. Three states currently studying the feasibility of operating a state-run Exchange (Alabama, Mississippi, and Wyoming) also have similar physician supply profiles to Arkansas.

We **recommend** measuring wait time for primary care visits on two dimensions: (1) how often the consumer gets care as soon as they thought they needed it and (2) how often the consumer sees a primary care provider within 15 minutes of their appointment time.

Table 12 shows entities that might collect the information on primary care access. ACA section 1311(c)(1)(D)(i) requires that all QHPs be accredited with an outside accrediting organization (e.g., NCQA), which HHS is interpreting, per 45 CFR §156.275 (proposed), to mean QHP issuers must be accredited. If the accreditation organization requires some form of timeliness measurement, the State could simply require that each QHP issuer submit this information annually during its recertification process. A method for doing so is outlined in the proposed rule. However, from an evaluation perspective, all accreditation organizations would have to use the same measures of timeliness. As HHS has not yet released final regulations on which organizations may accredit QHP issuers, we cannot offer guidance on whether this is a feasible strategy.

As an alternative, we **recommend** using two validated measures of timeliness, available through NCQA. The “Getting Care Quickly” measure is captured through the CAHPS 4.0 survey and measures the consumer’s access to timely urgent and non-urgent care. “Wait time” includes time spent in the waiting room and exam room. This measure captures how often consumers see a primary care provider within 15 minutes of their appointment time and is captured through the Clinician and Group CAHPS survey.

Dimension	Data Sources		
	Insurance Issuer	Outside Evaluator	State or Exchange
Getting Care Quickly (CAHPS for consumers)	X	X	X
Time in Waiting Room (Clinician & Group CAHPS)	X	X	X

**Table 12: Collection of Primary Care Access Data**

The measures for timely access to needed care are well-established, so the primary concern with this area is who will collect and analyze the data. Many QHP issuers will likely already conduct the CAHPS survey. Given this, the State could require CAHPS survey data to be submitted to the Exchange or a designated contractor for statistical analysis of differences by issuer and for meta-analysis to determine aggregate effects. The strength of this approach is that the State will know how the existence of the exchange has affected care for those in and outside its operation. There is the added benefit of reduced data-collection costs.

Alternately the State could take a more restricted view and the State, the Exchange, or a designated contractor with strong survey experience could conduct a CAHPS survey of just Exchange enrollees.

Regardless, we believe that given the sensitive nature of this topic and ACA more generally, an outside evaluator should play a central role. While issuer-level data may be submitted by the QHP issuer or its accreditor, at a minimum we advise that a broad benchmark survey be conducted by an outside evaluator so any outlier issuers can be identified. This is a critical quality-control tool.

### 3.6.3 Travelling for Primary Care

Apart from being able to get an appointment with a primary care doctor, Arkansans also need to be able to reach their doctors. One concern that has been raised is that increased access to coverage will cause additional caseload burdens to be placed on physicians who may subsequently decide to stop providing care. While there is no compelling evidence to support the link between the Exchanges and the number of physicians practicing, we believe that the evaluation should address some of the concerns of critics.

If the supply of physicians declines, we expect that Arkansans will have to travel further than they do now for care. Long travel times can discourage people from seeking primary care as much as long wait times. In a rural state, such as Arkansas, monitoring travel distance and time is particularly important.

We **recommend** one of two measurement methods. We believe both methods of measurement are valid; the preferred method will depend largely on the Exchange's ability to secure data-sharing agreements and willingness to make long-term financial commitments.

Option 1 for measuring travel distance and time is a consumer survey. Because there is no currently validated question or set of questions to assess this, the Exchange would need to contract with an outside agency that is experienced with developing and testing new survey questions to create a question that accurately captures this data. Through the consumer survey tool, a supplemental question will be developed to measure the one way distance or miles the consumer travels to visit their primary care provider. The new question(s) could then be added to an existing survey and administered annually.

Option 2 is to use consumer and provider ZIP codes to approximate travel distance and time. Commercially available software, such as GeoAccess-GeoNetworks, has been widely used by health insurance companies to calculate distances and approximate travel times when assessing network adequacy. While we do not endorse a particular software program, GeoAccess is one of the most well-known programs in this class of software and is used by the GSA (Contract #GS-35F-0027W). Using this approach would require obtaining 5-digit enrollee ZIP codes and the ZIP code of the enrollee's primary care provider. 5-digit ZIP codes are HIPAA protected and would require a formal data-sharing agreement with each issuer authorized to sell through the new Exchange. Specific primary care provider IDs would not need to be disclosed for this method.

### 3.6.4 Referrals to Specialists

Another aspect in measuring satisfaction of care involves measuring whether consumers are receiving care from specialists in a timely matter and how difficult it was to get an appointment with a specialist. The CAHPS 4.0 Health Plan survey tools have a section designed to measure the specialist that the consumer saw most often in a specific timeframe. These measures are nationally recognized and provide a means of comparison against national benchmarks. Such questions include whether the consumer tried to make

an appointment to see a specialist, how often it was easy to get appointments with specialists, and how many specialists the consumer saw. Although the CAHPS 4.0 Health Plan survey tools do not contain questions about referrals, supplemental questions could be developed to measure if the consumer needed a referral in a specified timeframe and how often they got a referral to see a specialist as soon as they needed.

### 3.6.5 Affordability

We **recommend** measuring affordability across three dimensions: insurance premiums, cost-sharing for medical care, and prescription drug costs. While not exhaustive, we believe that this list will present an accurate picture of how costs to the consumer are changing over time in Arkansas. Monitoring the affordability of healthcare is vital to ensuring that consumers are accessing needed care and preventive screenings to prevent higher costs and chronic illness later.

One supposition of the ACA is that “companies will compete for business on a level playing field, driving down costs.” It is believed by the authors of the ACA that this will occur through many mechanisms. For example, “Exchanges will give individuals and small businesses the same purchasing clout as big businesses.”

The Exchange evaluation should determine the extent to which premium reductions for individual and small business purchasers actually occurs. Ideally, this includes a baseline assessment of what the average cost of coverage for different family configurations in the individual and small business market pre-Exchange implementation.

Further, the evaluation should determine whether premiums are declining overall, or whether coverage is simply more affordable to enrollees due to the presence of subsidies. This latter investigation necessitates the need for analysis by subsidy tier and by benefit level (i.e., bronze, silver, gold, or platinum).

Affordability also covers whether insured persons can pay for the medical treatment that they need. There is currently evidence that the cost of medical care is a substantial barrier to access. Nationally, of those reporting difficulty accessing care, 44.7% cited cost as the main reason they did not get treatment. Insurance does not immediately remove this barrier. Amongst the non-elderly with private insurance, 29% cited cost as a barrier and amongst the publicly insured, 42.1%. Lower income households will qualify for reductions in cost-sharing if they purchase insurance through the Exchange. It is therefore logical that the Exchange monitor the extent to which cost-sharing subsidies are effective at keeping medical care affordable.

While national surveys exist that measure these important domains, the data are generally only available on a substantial lag and cannot be analyzed at the granular level required for state policymaking. Therefore, we **recommend** the evaluation of the Exchange include the development of a new consumer survey tool.

Questions for the new consumer survey tool should be developed to assess the level of financial burden placed on the enrollee by (1) the monthly insurance premium and (2) any

relevant cost-sharing relative to their annual household income. We further propose that this new survey tool assess (1) whether the enrollee chose to delay care due to out-of-pocket costs, (2) not access care due to the out-of-pocket costs, and (3) go without any prescription medication due to the out-of-pocket cost of the medicine.

### 3.7 Utilization of Care

As a large number of Arkansans gain access to health insurance and are able to access the health system in new ways, we expect that patterns of health care use will change. National studies indicate that most enrollees in the Exchange will have been uninsured and that there is substantial pent-up demand for health care services.

For example, it is projected that more than one third of Exchange enrollees will have gone two or more years since their last preventive check-up. Further, over 25% of enrollees will have had no interaction with the health system at all in the year before their enrollment. Given this, it is logical to expect immediate and dramatic differences in utilization of some health care services (preventive care and non-urgent emergency department) and long-term declines in others as chronic health conditions are diagnosed earlier and better managed over the course of the disease (certain hospitalizations).

	Hospital Data	Claims Analysis	Issuers	Survey
Preventive Services		X	X	X
Emergency Department	X	X	X	X
Hospitalizations	X	X	X	X

Table 13: Data Sources for Utilization of Care

#### 3.7.1 Preventive Services

We **recommend that** receipt of a specific set of evidence-based preventive services should be measured annually due to high economic value. Also, ACA regulations expanded prevention coverage for women’s health, immunizations, aspirin use to prevent cardiovascular disease and smoking cessation. Women’s health preventive services include breast cancer screening, Chlamydia screening, and cervical cancer screening. Since ACA is recommending specific preventive services to be covered under the Exchange, we recommend at least measuring these preventive services to determine if enrollees through the Exchange are being screened in order to prevent the onset of further complicated conditions or health deterioration.

Other important preventive measures include access to dental care, adult BMI assessment, and adults’ access to preventive/ambulatory health services. We **recommend** that these measures should be calculated for each health plan and by issuer. We **recommend** these rates should be compared to the national benchmark to determine whether the plans and/or issuers exceed or need improvement within these areas.

Women's Health: Preventive care for women – mammograms, cervical cancer testing and Chlamydia screening – is in need of increased attention and focus. Mammogram rates are falling nationally and here in Arkansas. Screening for Chlamydia – one of the most common and easily cured sexually transmitted diseases – has fallen in recent years in Arkansas, even as national rates have climbed. The percentage of women receiving Pap tests, which can detect precancerous changes in cervical cells, has also fallen in Arkansas while national rates have risen slightly.

Colorectal Cancer Screenings: Although the colorectal cancer screening is likely to affect a small subset of older adults, colorectal cancer is the third most common type of non-skin cancer in men and in women and it is the second leading cause of cancer death in the U.S. after lung cancer.

Medical Assistance with Cessation Smoking: This measure is captured in the CAHPS 4.0 Health Plan survey. It measures the percentage of smokers and tobacco users who were advised by their provider to quit smoking or using tobacco, recommended cessation medications and provided cessation methods or strategies.

Flu Shots for Adults Ages 50-64: This measure is captured in the CAHPS 4.0 Health Plan survey. It measures the percentage of adults' age 50 to 64 who receives an influenza vaccination during a specific timeframe.

Aspirin Use: The CAHPS 4.0 Health Plan survey also includes a subset of questions on the adult survey that is used to measure the percentage of adults who are currently taking aspirin.

Discussing Aspirin Risks and Benefits: Within the subset of questions mentioned above, the survey also measures the percentage of adults who discussed the risks and benefits of using aspirin with a doctor or other health provider within a specified timeframe.

Annual Dental Visit: This HEDIS® measure calculates the percentage of enrollees who had at least one dental visit during a specific timeframe.

Adult BMI Assessment: This HEDIS® measure calculates the percentage of enrollees who had an outpatient visit and who had their body mass index (BMI) documented within a specific timeframe.

Adults' Access to Preventive/Ambulatory Health Services: This HEDIS® measure calculates the percentage of enrollees who had an ambulatory or preventive care visit within a specific timeframe.

The preventive services listed as examples here are targeted toward adults. We have selected them because current projections are that adults aged 19 to 64 years will account for about 80% of Exchange enrollees. We **recommend** strong Exchange involvement in the choice of which preventive care measures will ultimately be used.

### 3.7.2 Emergency Department for Non-Urgent Care

Use of the emergency department (ED) for non-urgent care may be an inefficient use of health system resources. Specifically, if care provided in the ED could be provided in primary care clinics, it is generally less expensive for treatment to be provided outside of the ED. More troubling, high use of the ED for non-urgent care may indicate lack of access to primary care, especially in medically underserved areas and populations.

We **recommend** that the Exchange evaluate whether non-urgent ED use changes over time and whether there is a different pattern of non-urgent ED use amongst different benefit levels and in different regions of the state. As part of this evaluation, the Exchange should determine a valid method for measuring non-urgent ED care. Our assessment is that any method will be claims or electronic medical record (EMR)-based and therefore will require the Exchange to enter into a data-sharing agreement with the QHP issuers or with the various hospitals in the state.

Each data source has its own strengths and weaknesses. Relying on claims data from the QHPs only provides information about Exchange enrollees, with no ability to benchmark to a broader population. Additionally, claims data is generally only available on a lag and is restrictive in the amount of clinical information available. However, the use of claims data allows for standardization (since a fixed set of fields are collected for all claims).

EMR data is more immediate and allows for a greater set of clinical adjustments. Additionally, the Exchange would be able to capture data from a broad range of patients, rather than just enrollees. However, it is not clear how feasible separating out the Exchange enrollees from others would be. Also, given the number of hospitals in the state, there is a potential large number of different EMR systems. Also, the required number of technical support personnel to ensure smooth transitions of data from various hospital systems into one central analysis location is likely to be substantial.

### 3.7.3 Hospitalizations

Two classes of hospitalizations should be examined to judge the long-term effectiveness of insurance expansion through the Exchange. The first is a measure of whether enrollees are able to access the care they need for follow-up treatment after an initial hospitalization. The second is a measure of whether enrollees are getting better care for chronic health conditions.

There is evidence that the uninsured are more likely to be readmitted to the hospital because they have greater difficulty getting needed follow-up care. We **recommend** monitoring 30-day readmission rates for Exchange enrollees to help assess whether they are able to get all required post-hospitalization care.

While the adults who are expected to enroll in the Exchanges have significantly lower self-assessed physical health status than those who currently have private health insurance, they paradoxically have fewer diagnosed chronic health conditions. This can be explained

by the lack of contact with primary care providers who perform regular screenings for chronic health conditions. Without regular contact with primary care, a person may not find out he or she has a chronic condition until a complication arises and hospitalization occurs.

These types of hospitalizations belong to a class called hospitalizations for “ambulatory care sensitive conditions” (ACSCs) and are generally thought to be avoidable with adequate management. The Agency for Healthcare Research and Quality (AHRQ) has developed a validated algorithm for tracking hospitalizations for ACSCs. The Prevention Quality Indicators (PQIs) have a component that focuses specifically on chronic conditions. We **recommend** using the Chronic PQI composite rate to track long-term changes in care for chronic conditions. As a nationally developed and tracked measure, a benchmark is available to judge performance.

Data for these measures will be derived from claims and may be reported by the issuers if supplied with appropriate guidelines. The AHRQ software runs on SAS, a statistical package for which not all health insurance companies will have a license. Issuers likewise may not have the in-house expertise working with these measures to regularly report on them. Therefore, we strongly recommend that discussion of data sharing take place so that the Exchange or a qualified contractor could perform calculations.

At a minimum, we believe analysis by health plan is necessary. However, statistical validity is of paramount concern with single-year rates because they may be highly volatile in small populations. It is highly recommended that, if rates are issuer-reported, a trained statistician will review calculations to determine reliability.

### 3.8 Cost of Care

Our proposed affordability measures were targeted to the enrollee. The measures of cost take a system-wide perspective. In this measurement area, health care costs are relevant, regardless of who pays them. Data on the cost of care is vital to an understanding of health system efficiency.

It is no secret that health care costs in the U.S. are rising and healthcare costs in the U.S. are significantly higher compared to other developed countries. Currently, the U.S. spends about \$7,400 per person on healthcare each year. One of the goals of ACA is to reduce the cost of health care. The rationale for how this will happen is not as clearly delineated as it is for other goals of the law. Additionally, the public does not have much confidence that this will be the ultimate outcome of the new reforms; 28% of the public overall believes that costs will “get better”. Amongst independents and Republicans, the belief that costs will decrease is even lower, 19% and 9% respectively.

We **recommend** that the Exchange calculate the cost per enrollee for each health plan and issuer annually. The data necessary for this analysis is already mandated as reportable to the Exchange and HHS under 45 CFR §153.520. Data will be submitted by QHP issuers in a standardized HHS-mandated format. Under 45 CFR §153.510, HBEs are required to make

transfer payments from issuers with the lowest risk pools to the highest risk pools through a risk corridor beginning 2014. The amounts due to or from each issuer will be determined based on the aggregate allowed amounts. We **recommend** using these allowed amounts as a proxy for expenditures.

### 3.8.1 Expenditures by Plan

Examination of expenditures by health plan is intended to identify systematic differences in the cost of health care across benefit levels (i.e. bronze, silver, gold, platinum). Due to the reporting structure mandated by HHS, it will be possible to stratify each issuer's expenditures by benefit level. We **recommend** that the HBE calculate the costs per enrollee annually for the different benefit tiers across issuers. Because healthier individuals may select plans with higher cost-sharing requirements to get the benefit of a lower premium, valid actuarial risk-adjustment methods **are required**, consistent with 45 CFR §153.320.

We **recommend** that this analysis be conducted by a healthcare economist, or other individual similarly trained, with the goal of identifying expenditure-benefit pairings that could indicate large numbers of enrollees are selecting coverage that does not sufficiently meet their needs.

### 3.8.2 Expenditures by Issuer

The HBE should calculate the risk-adjusted expenditures per enrollee for each issuer annually and compare to the all-issuer average expenditure per enrollee to determine if one issuer is significantly more or less than other issuers. Issuers with lower than average costs and higher satisfaction or quality scores should be identified and may serve as a learning model for other plans.

### 3.8.3 Trends in Health Expenditures

It is hypothesized that aggregate health expenditures may potentially decrease because insurers will face greater competition and hence exert more pressure on providers for cost-efficient care as a means to lower the premiums they are able to charge.

We **recommend** examining statewide trends in health expenditures as a measure of the effect, if any, that expanded insurance coverage through the HBE has on aggregate health expenditures. We emphasize that while trends analysis may be used to supplement annual health plan or issuer analyses, the trend analysis proposed here specifically takes a macro view, **including those insured through sources outside the HBE and those who remain uninsured.**

We **recommend** that this analysis be conducted by a health economist, or other individual similarly trained to conduct statistically valid observational studies that can control for the myriad other causes of changes in expenditures (e.g. an aging population).

### 3.8.4 Contrast Between Private Issuers and Medicaid

We anticipate that there will be different health cost experiences between those who enroll in private QHPs and those who access Medicaid through the Exchange. Additionally, we expect that the trends in health expenditures will vary over time across the two sources of insurance coverage (private and Medicaid). Therefore, we propose that the evaluation include an assessment of the degree to which costs differ in the base-year (2013) and how costs change over time between private issuers, as a group, and Medicaid.

We **do not advise** singling out any particular QHP, benefit level, or issuer for direct Medicaid comparison. However, it will likely be instructive to divide the private QHP enrollees by income. For all analysis, we **recommend** valid risk-adjustment measures be used, as established by regulation.

### 3.9 Summary of Evaluation Measures

Note: No measures should be considered final until appropriate administrative structures are set up.

The “X” in the columns of Table 14 designate whether the recommendation is a measure of implementation, outcomes, or efficiency or whether the recommendation refers to methodology.

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
3.1.1	Population-wide survey of all Arkansas residents on awareness of HBE	X			
3.1.1	Survey will be custom tool to capture awareness and use	X			
3.1.1	Review available tools before design in case one exists at time of implementation Or capture bounce rate on HBE website	X			
3.1.2	Measure enrollment and re-enrollment as defined	X			
3.1.3	Track reasons for termination of coverage at subsidy and benefit level.	X			
3.1.4	Analysis of gaps in coverage focus on QHP enrollees and Medicaid beneficiaries	X			

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
3.1.4	Assess Navigator satisfaction with their training and support from the HBE	X			
3.1.5	Regularly review proposed rules in Federal Register and all materials released relating to Exchange implementation	X	X	X	
3.2	Administer CAHPS surveys to measure enrollee satisfaction and follow CAHPS protocol and methodology		X	X	
3.2.1	Develop new survey tool to capture enrollee satisfaction with Navigator at time of enrollment	X	X	X	
3.2.1	Applicants should be pre-screened for inclusion in survey				X
3.2.1	Compare QHP satisfaction between enrollees with and without a Navigator, conduct stratified analysis of CAHPS survey results based on if enrollee had a Navigator.		X		
3.2.2	Use CAHPS questions as model to measure Exchange website satisfaction		X		
3.2.3	Use of existing national measures to capture enrollee's satisfaction		X		
3.2.4	Measure enrollee satisfaction with QHPs by same measures collected in issuer survey		X	X	
3.2.4	Choose one of the federally-approved risk-adjustment measures published in Federal Register for OHP satisfaction		X	X	
3.2.5	Use CAHPS composites		X		

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
	and ratings to measure enrollee satisfaction with providers; follow CAHPS protocol				
3.2.6	Measure enrollee satisfaction with their Agent	X			
3.3	Measure provider perceptions since HBE implementation	X			
3.4	Measure number of uninsured Arkansans and state's crowd-out rate				X
3.4.1	Begin state-level measurement of insurance coverage as soon as possible	X	X		
3.4.1	Collect level of insurance coverage through survey				X
3.4.2	Track state crowd-out measure annually through employer survey		X		
3.4.2	Survey enrollees to determine whether they are switching coverage and why		X		
3.5.1	Calculate HEDIS measures that focus on greatest need within Arkansas		X	X	
3.5.2	Commission a needs assessment to decide areas of health outcomes to measure		X		
3.5.3	Calculate quality of care measures annually for each health plan and issuer		X	X	
3.6	Conduct CAHPS-like survey to capture enrollee access to care		X		
3.6.1	Questions asking enrollee about access to care prior to coverage through HBE and since acquiring coverage through HBE		X		X
3.6.2	Measure wait time for PCP		X		X

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
	through CAHPS survey measures				
3.6.3	Recommend two methods for enrollee's traveling for primary care: 1) through survey measure 2) approximate travel distance through zip code analysis		X		X
3.6.4	Measure access to specialist through CAHPS survey		X		X
3.6.5	Measure affordability through three dimensions as defined in text		X	X	X
3.6.5	Measure affordability through new consumer survey tool		X		X
3.7.1	Calculate HEDIS measures for preventive services by health plan and issuer and compare to national benchmarks		X		
3.7.2	Evaluate whether non-urgent ED use changes over time and track patterns among different benefit levels and geographic regions		X	X	
3.7.3	Monitor 30-day readmission rates for enrollees to ensure that they are able to get all required post-hospitalization care.		X	X	
3.7.3	Use Chronic PQI composite to track long-term changes in care or chronic conditions		X	X	
3.8	Calculate cost per enrollee for each health plan and issuer annually			X	
3.8	Use allowed amounts as proxy for expenditures				X
3.8.1	Calculate cost per enrollee annually for different benefit tiers across issuers				X

Section	Recommendations	Measures			Methods
		Implementation	Outcomes	Efficiency	
	and analysis should be conducted by healthcare economist				
3.8.2	Calculated risk-adjusted expenditures per enrollee for each issuer annually and compare to all-issuer average expenditure per enrollee			X	X
3.8.3	Examine trends in health expenditures including those insured outside of HBE and the remaining uninsured; Analysis should be conducted by a health economist to control for myriad causes of changes in expenditures				X
3.8.4	Valid risk-adjustment measures be used for all analyses as established by regulations				X

Table 14: Summary of Evaluation Measures

## 4 Estimated Budget

After accounting for all measures required through the Department of Health and Human Services regulations and all recommended measures as defined in this evaluation plan, we propose the following amounts as an estimated budget for this evaluation.

Evaluation Component	HHS Required	Estimated Sample Size	Estimated Amount	Recurring Expenses
Annual Enrollee Satisfaction Surveys	Yes	22,000	\$240,000	\$240,000
Annual Provider Satisfaction Surveys	No	2,000	\$46,000	\$46,000
Measurement of Enrollment and Re-enrollment	No	N/A	See staff time	Recurring staff expense
Measurement of Disenrollment and Gaps	No	N/A	See staff time	Recurring staff expense
Annual HBE Website Survey and Analysis	Yes (proposed)	N/A	\$18,000	\$18,000
Conducting Annual Navigator Education Survey	No	750	\$23,000	\$23,000
Enrollee Navigator Satisfaction Survey and Analysis (includes development)	No	Unknown	\$36,000	\$25,000
Qualitative Navigator Interviews	No	5 focus groups	\$5,000	\$0
Staff Time (data entry, analysis and reporting)	N/A	N/A	\$365,000	\$365,000

**Table 15: Estimated Budget**

Additionally, staff time will be required to complete data entry, conduct all analyses and reporting related to implementation effectiveness, access to care, utilization of care, and costs. We estimate the annual expense for this component to be \$365,000. Therefore, total estimated costs to effectively implement the proposed evaluation plan are projected to be \$733,000.

## 5 Required Tasks and Timeline

In this section, we outline required tasks for evaluation and when they should occur in order to meet deadlines set by HHS or to best facilitate evaluation. Unless otherwise noted, the time indicated in the timeline is simply our recommendation to facilitate evaluation. Additionally, some tasks in the timeline below are not evaluation tasks, but are present to provide some reference to other major HBE events that are evaluation-related.

Our timeline is presented as a series of calendar year tables divided by quarters. An “X” in a quarter column indicates that the task is ongoing through that quarter. If a quarter column is the final one marked, the task must be complete by the end of that quarter. **If a specific date applies, the column contains a number in parentheses** that refers to a list directly below the table.

### 5.1 For Calendar Year 2012

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
Data Warehouse Development (supports HBE tracking of enrollment, QHP choice, issuer choice, and termination reason)	Yes	Related				(1)
Measurement of Enrollment and Re-enrollment <ul style="list-style-type: none"> <li>Determine if measurement will be internal to HBE or contracted <ul style="list-style-type: none"> <li>If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> </ul>	Yes	Evaluation				(2)
Measurement of Disenrollment and Gaps <ul style="list-style-type: none"> <li>Determine if measurement will be internal to HBE or contracted <ul style="list-style-type: none"> <li>If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> </ul>						(2)
Survey Question Development <ul style="list-style-type: none"> <li>Development of Navigator and agent satisfaction questions</li> <li>Validation of questions</li> </ul>		Evaluation		X X	X X	X (3)
Website Development	Yes	Related				(2)

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Select federally-approved risk-adjustment method	Yes	Both				(2)
<p>HBE Awareness and Use Measurement</p> <ul style="list-style-type: none"> <li>• Determine whether awareness and use will be assessed jointly or if use only will be measured through HBE website</li> <li>• If awareness and use <ul style="list-style-type: none"> <li>○ Review available tools and proceed to next steps if unavailable</li> <li>○ Obtain contract for survey question development</li> <li>○ Develop awareness and use questions</li> <li>○ Validate awareness and use questions</li> <li>○ Administer awareness survey</li> <li>○ Analyze awareness results</li> <li>○ Present awareness results to HBE board</li> <li>○ Administer use survey</li> <li>○ Analyze use results</li> <li>○ Present use results to HBE board</li> </ul> </li> <li>• If use only <ul style="list-style-type: none"> <li>○ Select contractor to measure appropriate metrics for website usefulness (e.g. bounce rate, industry standard web-based survey)</li> <li>○ Administer survey via HBE website</li> <li>○ Analyze use results</li> <li>○ Present use results to HBE board</li> </ul> </li> </ul>		Evaluation	X			
<p>Assessment of Insurance Coverage</p> <ul style="list-style-type: none"> <li>• Select vendor if not conducted by HBE</li> <li>• Conduct baseline pre-HBE survey of coverage and employer-offer</li> </ul>					X	X
<p>Enrollee Satisfaction Survey</p> <ul style="list-style-type: none"> <li>• Verify CAHPS is acceptable tool</li> <li>• Select and contract with CAHPS administrator</li> </ul>	Yes	Evaluation	X	X	X	X X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Quality of care measurement <ul style="list-style-type: none"> <li>Select contractor, if used, for quality assessment and analysis</li> </ul>	Yes	Evaluation				X
Measure Navigator and agent satisfaction <ul style="list-style-type: none"> <li>Select vendor if not conducted by HBE <ul style="list-style-type: none"> <li>If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> </ul>						X X
Enrollee Satisfaction Survey <ul style="list-style-type: none"> <li>Verify CAHPS is acceptable tool</li> <li>Select and contract with CAHPS administrator</li> </ul>	Yes	Evaluation	X	X	X	X X
Assessment of access to care <ul style="list-style-type: none"> <li>Select vendor if not conducted by HBE <ul style="list-style-type: none"> <li>If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> </ul>	Yes	Evaluation				X X
Assessment of Insurance Coverage <ul style="list-style-type: none"> <li>Select vendor if not conducted by HBE</li> <li>Conduct baseline pre-HBE survey of coverage and employer-offer</li> </ul>					X	X
Assessment of expenditures <ul style="list-style-type: none"> <li>Select vendor if not conducted by HBE <ul style="list-style-type: none"> <li>If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> <li>Secure data use agreement with data providers</li> </ul>	Yes					X X X
Assessment of affordability <ul style="list-style-type: none"> <li>Select vendor if not conducted by HBE <ul style="list-style-type: none"> <li>If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> </ul>		Evaluation				X X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Assessment of expenditures <ul style="list-style-type: none"> <li>• Select vendor if not conducted by HBE                             <ul style="list-style-type: none"> <li>○ If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> <li>• Secure data use agreement with data providers</li> </ul>	Yes					X X X
Assessment of use of services <ul style="list-style-type: none"> <li>• Select vendor if not conducted by HBE                             <ul style="list-style-type: none"> <li>○ If contracted, select contractor and sign security agreements that meet federal standards</li> </ul> </li> <li>• Secure data use agreement with data providers</li> </ul>	Part  Yes  Yes	Evaluation				X  X  X

**Table 16: HBE Evaluation and Related Tasks - 2012**

2012 Notes:

1. This is an information technology (IT) task. Because it supports an essential function of the HBE, we anticipate that having a data warehouse in place will be required in order to secure HHS approval of the Arkansas HBE. This approval must be given, by statute, “no later than January 1, 2013”. We have therefore marked Q4 as the completion time. Detailed information should be sought from IT.
2. This component should be completed no later than December 31, 2012 to ensure that agreements are in place before approval is required.
3. October 31, 2012 so that the entities conducting the new survey have sufficient time to train their staff with the new questions.

## 5.2 For Calendar Year 2013

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
First annual enrollment period	Yes	Related				X

HBE Awareness and Use Measurement		Evaluation				
<ul style="list-style-type: none"> <li>• If awareness and use <ul style="list-style-type: none"> <li>○ Administer awareness survey</li> <li>○ Analyze awareness results</li> <li>○ Present awareness results to HBE board</li> </ul> </li> <li>• If use only <ul style="list-style-type: none"> <li>○ Administer survey via HBE website</li> <li>○ Analyze use results</li> <li>○ Present use results to HBE board</li> </ul> </li> </ul>					X	X
					X	X
					X	X
Measure Navigator and agent satisfaction						X
<ul style="list-style-type: none"> <li>• Administer questions</li> </ul>						
Website Satisfaction Survey		Evaluation				
<ul style="list-style-type: none"> <li>• Conduct</li> <li>• Analysis</li> </ul>					X	X
					X	X
Quality of care measurement	Yes	Evaluation				
<ul style="list-style-type: none"> <li>• Conduct baseline needs assessment</li> <li>• Convene stakeholder panels</li> <li>• HBE board selects annual quality priorities</li> </ul>			X	X	X	X
Assessment of access to care	Yes	Evaluation				
<ul style="list-style-type: none"> <li>• Conduct a survey to measure baseline access to care (previous year)</li> </ul>			X			
Assessment of Insurance Coverage						
<ul style="list-style-type: none"> <li>• Conduct baseline pre-HBE survey of coverage and employer-offer</li> </ul>						X

Table 17: Evaluation and Related Tasks – 2013

### 5.3 For Calendar Year 2014

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
First annual enrollment period	Yes	Related	(1)			
Measurement of Enrollment and Re-enrollment	Yes	Evaluation				
<ul style="list-style-type: none"> <li>• Open enrollment report provided to HBE board</li> <li>• Special enrollment report provided to</li> </ul>				X		

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
HBE board <ul style="list-style-type: none"> <li>Re-enrollment report provided to HBE board</li> </ul>				X		X
Measure Navigator and agent satisfaction <ul style="list-style-type: none"> <li>Administer questions</li> <li>Conduct analysis and report results to HBE board</li> </ul>		Evaluation	X	X		
Enrollee satisfaction survey <ul style="list-style-type: none"> <li>Conduct CAHPS</li> <li>Analyze CAHPS results and report to HBE board</li> <li>CAHPS results published to HBE website</li> </ul>	Yes	Evaluation		X	X	(1)
Measurement of disenrollment and gaps <ul style="list-style-type: none"> <li>Disenrollment report provided to HBE board (for previous year)</li> </ul>	Yes	Evaluation	X			
HBE Awareness and Use Measurement <ul style="list-style-type: none"> <li>If awareness and use <ul style="list-style-type: none"> <li>Analyze awareness results</li> <li>Present awareness results to HBE board</li> </ul> </li> <li>Administer use survey</li> <li>Analyze use results</li> <li>Present use results to HBE board</li> <li>If use only <ul style="list-style-type: none"> <li>Analyze use results</li> <li>Present use results to HBE board</li> </ul> </li> </ul>		Evaluation	X  X	X  X X		
Website Satisfaction Survey <ul style="list-style-type: none"> <li>Conduct</li> <li>Analysis</li> </ul>		Evaluation	X	X		
Quality of care measurement <ul style="list-style-type: none"> <li>Measure quality of care by HEDIS® measures or other appropriate sources</li> <li>Conduct analysis of variation in quality by health plan and issuer</li> </ul>	Yes	Evaluation				X  X
Assessment of access to care <ul style="list-style-type: none"> <li>Conduct annual post-HBE implementation access to care survey</li> <li>Analyze and report results of access survey to HBE board</li> </ul>	Yes	Evaluation	X	X		
Assessment of Insurance Coverage <ul style="list-style-type: none"> <li>Conduct annual post-HBE survey of coverage and employer-offer</li> <li>Provide annual coverage report (previous year)</li> <li>Provide 5-year trend report to HBE board (early years will include pre-HBE</li> </ul>		Evaluation	X  X			X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
trends)						
Assessment of expenditures <ul style="list-style-type: none"> <li>Perform analysis of annual expenditures by health plan and issuer (for previous year)</li> <li>Report results of annual expenditures analysis to HHS and HBE board</li> <li>Perform 3-year trend analysis and report to HBE board</li> </ul>	Yes	Evaluation			X	
Assessment of affordability <ul style="list-style-type: none"> <li>Conduct annual post-HBE implementation assessment of health insurance premiums and cost-sharing as a percentage of income</li> <li>Analyze and report previous year's results to HBE board</li> </ul>		Evaluation	X			X

Table 18: Evaluation and Related Tasks - 2014

2014 Notes:

- Annual enrollment for the initial period will extend through February 28, 2014 under the current proposed rule from HHS.

## 5.4 For Calendar Year 2015

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Review of Current Federal Regulations	Yes	Both	X	X	X	X
First annual enrollment period	Yes	Related	(1)			
Measurement of Enrollment and Re-enrollment <ul style="list-style-type: none"> <li>Open enrollment report provided to HBE board</li> <li>Special enrollment report provided to HBE board</li> <li>Re-enrollment report provided to HBE board</li> </ul>	Yes	Evaluation		X		X
Measure Navigator and agent satisfaction <ul style="list-style-type: none"> <li>Administer questions</li> <li>Conduct analysis and report results to HBE board</li> </ul>		Evaluation	X	X		
Enrollee satisfaction survey <ul style="list-style-type: none"> <li>Conduct CAHPS</li> <li>Analyze CAHPS results and report to HBE board</li> <li>CAHPS results published to HBE website</li> </ul>	Yes	Evaluation		X	X	(1)

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
Measurement of disenrollment and gaps <ul style="list-style-type: none"> <li>Disenrollment report provided to HBE board (for previous year)</li> </ul>	Yes	Evaluation	X			
HBE Awareness and Use Measurement <ul style="list-style-type: none"> <li>If awareness and use <ul style="list-style-type: none"> <li>Analyze awareness results</li> <li>Present awareness results to HBE board</li> <li>Administer use survey</li> <li>Analyze use results</li> <li>Present use results to HBE board</li> </ul> </li> <li>If use only <ul style="list-style-type: none"> <li>Analyze use results</li> <li>Present use results to HBE board</li> </ul> </li> </ul>		Evaluation	X	X		
Website Satisfaction Survey <ul style="list-style-type: none"> <li>Conduct</li> <li>Analysis</li> </ul>		Evaluation	X	X		
Quality of care measurement <ul style="list-style-type: none"> <li>Measure quality of care by HEDIS® measures or other appropriate sources</li> <li>Conduct analysis of variation in quality by health plan and issuer</li> </ul>	Yes	Evaluation				X
Assessment of access to care <ul style="list-style-type: none"> <li>Conduct annual post-HBE implementation access to care survey</li> <li>Analyze and report results of access survey to HBE board</li> </ul>	Yes	Evaluation	X	X		
Assessment of Insurance Coverage <ul style="list-style-type: none"> <li>Conduct annual post-HBE survey of coverage and employer-offer</li> <li>Provide annual coverage report (previous year)</li> <li>Provide 5-year trend report to HBE board (early years will include pre-HBE trends)</li> </ul>		Evaluation	X			X
Assessment of expenditures <ul style="list-style-type: none"> <li>Perform analysis of annual expenditures by health plan and issuer (for previous year)</li> <li>Report results of annual expenditures analysis to HHS and HBE board</li> <li>Perform 3-year trend analysis and report to HBE board</li> </ul>	Yes	Evaluation			X	
Assessment of affordability <ul style="list-style-type: none"> <li>Conduct annual post-HBE implementation assessment of health insurance premiums and cost-sharing as</li> </ul>		Evaluation				X

Task and Components	HHS-Required	Evaluation or Related	Q1	Q2	Q3	Q4
a percentage of income • Analyze and report previous year's results to HBE board			X			

**Table 19: Evaluation and Related Tasks - 2015 and ongoing**

2015 Notes:

1. Should be available October 1 of each year in time for open enrollment of the next year.

In general, analyses that are based on claims or will be claims-derived are done on a retrospective basis. These analyses are performed in the 3<sup>rd</sup> calendar year quarter each year, beginning in 2015, for use and expenditures in the previous year. This allows for a 180 day claim lag between the time service occurs, the provider submits the claim, and the issuer processes the claim. While this does not preclude skewed results due to the use of claims, it does substantially reduce the risk.

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**State of Arkansas**  
**Arkansas Insurance**  
**Department**

**Arkansas Health Benefits Exchange**  
**Planning Project**

**Communication/Education/  
Outreach Plan**

**Version 3.0**

**August 22, 2011**

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## Document History

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August 17, 2011	1.0	Deborah Hopkins/Kathy Grissom	Initial Submission
August 19, 2011	2.0	Carol Cassil/ Kathy Grissom	Comments from HBE Planning Team
August 22, 2011	3.0	Carol Cassil/Kathy Grissom	Additional comments from HBE Planning Team

**Table 1: Document History**

# 1 Introduction

The communications, education and outreach for the Arkansas Health Benefits Exchange (HBE) will be critical to the success and sustainability of the Exchange. The audience will include not only consumers of diverse backgrounds, educational levels and cultures, but small business owners, health care providers and other stakeholders across the state. The messages and their delivery must be carefully targeted to match the priorities and communication styles of the intended audience, without alienating other groups.

Such a complex group requires a wide range of messages, delivery systems and approaches. We have identified numerous channels for delivering these messages, while considering cost and feasibility. These channels include social marketing; print, radio and television advertisement; publicity; social media; text messaging; gas pump advertising; and other nontraditional and innovative delivery systems.

We **recommend** a three-phased approach for outreach and communications designed to move the Exchange step by step toward the overall goal of increasing the number of Arkansans with health insurance.

**Recommendations** for the Navigator program are outlined separately, but will work in concert with the communication, education and outreach to expand the reach of the Exchange.

The overall goals of the Communications/Education/Outreach plan include:

- Increase the number of Arkansans with health insurance
- Gain public support of the HBE

Objectives:

- Achieve high levels of public support for the HBE through legislative, coalition, health care providers and partner collaboration
- Within year one, reach 75% of the consumer and small business populations who are eligible to purchase insurance through the HBE with awareness of HBE and overarching messaging
- Within year two, reach 90% of the consumer and small business populations who are eligible to purchase insurance through the HBE with awareness of HBE and overarching messaging
- Drive 90% of the 500,000 eligible Arkansans to contact the HBE to purchase health insurance

## 2 Approach

### 2.1 Input from Stakeholders

In developing **recommendations**, the Arkansas Foundation for Medical Care (AFMC) representatives attended meetings of the various HBE workgroups as well as the steering committee. Though opinions were strong and varied, we were able to ascertain that most members wanted communications to be well targeted for the specific groups and easy to understand, yet detailed enough to provide the needed information at various levels of the Exchange's rollout. Members recommended making use of word of mouth as well as traditional and newer communications methods and outlets. Opinions on the Navigator role leaned toward educator and guide rather than enroller or salesperson.

In an interim report of a web-based survey conducted by UAMS in July 2011, 30% of survey respondents fully support Exchange planning; 38% of respondents felt Exchange planning should be discontinued; and 32% supported the Exchange planning with concerns. More than half of the survey respondents were individuals. Targeted education and outreach are important in gaining further community and consumer understanding and support.

### 2.2 Primary and Secondary Audience Analysis

The primary audiences for the Exchange are Arkansas consumers and small business owners.

Examples of secondary audiences include local chambers of commerce, business associations, community leaders, churches, nonprofit organizations and other potential partners or stakeholders.

#### 2.2.1 Consumers and Subsets

All socioeconomic classes of consumers may be eligible to use the Exchange. However, a large percentage is likely to be lower to middle range in income level. Many will be newly eligible for Medicaid; some will be employed, but have never had health insurance; some will be parents of children currently insured by ARKids First; and some will be employed by small businesses.

Consumers who will use the Exchange are likely to be unfamiliar with insurance terms and processes, and will need information conveyed as simply as possible. No assumption of knowledge or familiarity with the subject matter should be made in planning, drafting and delivering key messages.

According to the 2010 U.S. Census Bureau report, there are 186,050 Spanish-speaking Arkansans, with pockets of other ethnicities increasing across the state, such as the 4,000 Marshallese, living in Northwest Arkansas.

As part of the communication efforts with the Spanish-speaking population, the Exchange should provide materials written in Spanish to the Mexican Consulate, as well as purchase advertising in *Hola! Arkansas*, the bilingual Hispanic newspaper, and *El Latino*, a weekly Spanish newspaper. We **recommend** buying radio spots on the state's eight Spanish-speaking stations.

The different cultural backgrounds, ages and educational levels of the various target audiences will require a variety of message presentations and delivery channels to appeal to their distinctly different priorities and life stages.

We highly **recommend** market research be conducted to design and test messages and their presentation for specific statewide audiences before the campaign is launched.

### 2.2.2 Small Businesses (Consumer Employers)

Small business owners will have different priorities than individual consumers seeking coverage. Employers will seek a resource for adding or continuing insurance coverage for their employees and may expect specially designed programs that offer value, minimize costs and contain features that benefit employees and perhaps their families, while resulting in wellness, reduced absenteeism and a healthy, productive work force.

Messages to small business owners must highlight a “return on investment” and a focus on benefits to their employees, as well as their bottom line.

To effectively reach the small business audience, we **recommend** meeting with and providing a toolkit of information (brochures, fact sheets, Q&A, newsletter articles, website banner ads and other communications tools) to the following groups: local chambers of commerce, Arkansas State Chamber of Commerce, Associated Industries of Arkansas, Arkansas Chapter of the National Federation of Small Businesses, Arkansas Small Business & Technical Development Center and the Arkansas Economic Development Commission's Small & Minority Business Division. A digital tool kit should also be available on the Exchange website.

Additionally, there are various affiliates/chapters in Arkansas of the Human Resource Management Association that should be provided information on the Exchange, or with whom presentations at chapter meetings should be scheduled. These include the Central Arkansas Human Resource Management Association, the Northwest Arkansas Human Resource Association, the North Arkansas Human Resource Association and the West Central Arkansas Human Resource Association.

### 2.2.3 Health Care Providers

We **recommend** providing hospitals, physician offices, clinics and local health units with Exchange educational materials for dissemination to uninsured patients. Forming a partnership with the Arkansas Department of Health's Hometown Health Improvement initiative is **recommended**.

Many physicians are small business owners who can enlist in the Exchange for insurance coverage for their employees.

### 2.2.4 Insurance Brokers

Attendants at stakeholder meetings indicated many producers/brokers/agents are concerned with their role in the Exchange and have expressed their preference for being allowed to serve as Navigators. Opinions from the consumer workgroup differed. While considering both opinions, we must examine the sustainability of the Navigator role and the finances required to support this role. Upon reflection, we **recommend** the Navigator role be one that can be heavily supported by the voluntary sector similar to AID's SHIP program and through small grants to community-based organizations/agencies paid a modest fee for services.

We also anticipate many individuals and small business owners will require services that could be better provided by licensed agents/producers than by Navigators. Communications in the small business tool kit could **recommend** that small business owners might be better served by consulting with an Exchange-certified producer, rather than a Navigator.

Working with producers/agents/brokers will require additional research.

### 2.2.5 Additional Audiences

Partnering with private and public sponsors to increase market penetration is **recommended**. We **recommend** the Exchange work closely with the following groups to develop messages and strategies specific to the audiences likely to be reached through each partner:

- Legislators
- Media (newspapers, radio, TV, magazine)
- Chambers of commerce
- State offices
- Public schools
- Libraries
- Trade associations
- Insurance companies
- Pharmacists
- Retailers
- Churches
- Nonprofit organizations

- Civic groups
- Business associations
- Coalitions
- Unions
- Legal aid offices
- HR departments
- Advocacy groups
- County Extension offices
- County Farm Bureaus
- Community health centers
- Behavioral health providers
- Domestic violence shelters
- Social services offices
- Primary health care providers

## **2.3 Assessment of Existing Resources**

Across Arkansas, numerous organizations, agencies and entities are working to improve health; health care quality, delivery and access; and overall quality of life. Identifying these potential partners and providing them with collateral materials, links and contact information could help promote the Exchange, expand the Navigator network and ultimately increase the percentage of Arkansans with health insurance.

For example, providing brochures or fact sheets to place in waiting areas and other places where people congregate such as state offices, hospitals, physician offices/clinics, pharmacies, retailers, state and county fairs, churches, local health units, and health fairs could reach those who other marketing efforts might miss.

Many organizations also have statewide publications and websites and would welcome content and links that are relevant to their membership or audience.

## **2.4 Research and Benchmarking**

Our **recommendations** are based on findings from the following research:

- Our interpretation of the proposed federal regulations
- The experiences of states that were early innovators of the Benefits Exchange concept or that are currently developing an Exchange
- Input from the HBE workgroups and steering committee

- Our own experiences within Arkansas’ health care community
- Our familiarity with Arkansas socioeconomic, ethnic and cultural diversity
- UAMS Arkansas Health Benefits Exchange Survey and community meetings
- Consultations with the Arkansas Insurance Department’s Senior Health Insurance Information (SHIIP) program manager

The state agencies included in our background research include:

<b>State</b>	<b>Exchange Information</b>
<b>Alabama</b>	Alabama Insurance Exchange <a href="http://medicaid.alabama.gov/news_detail.aspx?ID=5312">http://medicaid.alabama.gov/news_detail.aspx?ID=5312</a>
<b>California</b>	The California Health and Human Services Agency <a href="http://www.healthExchange.ca.gov">www.healthExchange.ca.gov</a>
<b>Colorado</b>	Colorado Health Insurance Exchange <a href="http://www.colorado.gov/cs/Satellite/GovernorsHealthReform/GOVR/1251579721978">http://www.colorado.gov/cs/Satellite/GovernorsHealthReform/GOVR/1251579721978</a>
<b>Connecticut</b>	Connecticut Office of Policy and Management <a href="http://www.ct.gov/opm">www.ct.gov/opm</a>
<b>District of Columbia</b>	The District of Columbia Health Insurance Exchange <a href="http://healthreform.dc.gov/DC/Health+Reform/Insurance+Coverage+Options/Health+Insurance+Exchange">http://healthreform.dc.gov/DC/Health+Reform/Insurance+Coverage+Options/Health+Insurance+Exchange</a>
<b>Georgia</b>	Georgia Governor’s Health Insurance Exchange Advisory Committee <a href="http://Healthcarereform.georgia.gov">Healthcarereform.georgia.gov</a>
<b>Hawaii</b>	Hawaii Health Insurance Exchange <a href="http://myhix.org/hawaii/">http://myhix.org/hawaii/</a>
<b>Illinois</b>	Illinois Department of Insurance <a href="http://Insurance.illinois.gov/hiric">Insurance.illinois.gov/hiric</a>
<b>Indiana</b>	Indiana Health Insurance Exchange <a href="http://indianahealthinsuranceexchange.com/">http://indianahealthinsuranceexchange.com/</a>
<b>Kansas</b>	Kansas Insurance Department <a href="http://www.ksinsurance.org">www.ksinsurance.org</a>
<b>Maryland</b>	Maryland Health Benefit Exchange <a href="http://www.dhmh.state.md.us/healthreform/exchange/pdf/MHBEA_Enrolled.pdf">http://www.dhmh.state.md.us/healthreform/exchange/pdf/MHBEA_Enrolled.pdf</a>
<b>Massachusetts</b>	HealthConnector, an independent state agency <a href="http://www.mahealthconnector.org">www.mahealthconnector.org</a>
<b>Mississippi</b>	Mississippi Health Benefit Exchange <a href="http://search.freefind.com/find.html?id=41301482&amp;pageid=r&amp;mode=All&amp;n=0&amp;query=Mississippi+Health+Insurance+Exchange">http://search.freefind.com/find.html?id=41301482&amp;pageid=r&amp;mode=All&amp;n=0&amp;query=Mississippi+Health+Insurance+Exchange</a>

<b>New Mexico</b>	New Mexico Human Services Department <a href="http://www.hsd.state.nm.us/nher/nherlao.htm">www.hsd.state.nm.us/nher/nherlao.htm</a>
<b>New Jersey</b>	Individual Health Coverage Program <a href="http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcmain.htm">http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcmain.htm</a>
<b>North Dakota</b>	North Dakota Insurance Department <a href="http://www.nd.gov/ndins/consumer/reform/grants/">www.nd.gov/ndins/consumer/reform/grants/</a>
<b>North Carolina</b>	North Carolina Health Insurance Exchange <a href="http://www.ncdhhs.gov/healthit/exchange/">http://www.ncdhhs.gov/healthit/exchange/</a>
<b>Oregon</b>	Oregon Health Insurance Exchange <a href="http://www.oregon.gov/OHA/health-insurance-exchange.shtml">http://www.oregon.gov/OHA/health-insurance-exchange.shtml</a>
<b>Texas</b>	Texas Health Insurance Exchange <a href="http://forinsurancehealth.com/health-insurance/texas-refuses-to-launch-health-insurance-exchange/">http://forinsurancehealth.com/health-insurance/texas-refuses-to-launch-health-insurance-exchange/</a>
<b>Utah</b>	Utah Office of Consumer Health Services <a href="http://www.Exchange.utah.gov">www.Exchange.utah.gov</a>
<b>Vermont</b>	Vermont Health Insurance Exchange <a href="http://myhix.org/vermont/">http://myhix.org/vermont/</a>
<b>Washington</b>	Washington Health Benefit Exchange <a href="http://www.hca.wa.gov/hcr/exchange.html">http://www.hca.wa.gov/hcr/exchange.html</a>
<b>Wyoming</b>	Wyoming Health Insurance Exchange <a href="http://legisweb.state.wy.us/2011/introduced/HB0050.pdf">http://legisweb.state.wy.us/2011/introduced/HB0050.pdf</a>

Table 2: State HBE Research

## 3 Recommendations: Communications, Promotion and Education Strategy

We **recommend** that the education/communications/outreach campaign should take the following three-year phased approach:

1. Phase 1 (2011, 2012, 2013) – Create HBE brand awareness with a broad, overarching message about the upcoming availability of the Exchange, what it is, the legal obligations to purchase insurance and its benefits to Arkansans and small business owners.
2. Phase 2 – (2013) Provide targeted education and communication as the Exchange implementation date draws near (60 to 90 days in advance of launch). Messaging should include information about the importance of health insurance; who is and who is not impacted by the Exchange; the requirements of the law; and opportunities for purchasing insurance.
3. Phase 3 – (2013, 2014) Conduct a statewide media relations effort to announce the launch of the HBE. Drive traffic to the Exchange website; explain consumer access to affordable, quality health plans; provide specific information about eligibility, requirements, how to enroll and how to contact licensed agents and Navigators; provide ongoing updates.

A tactical work plan with timetable is provided in section 3.2.

### 3.1 Tactics

The **recommended** campaign tactics can be grouped in the following categories:

- Stakeholder/community outreach
- Branding/message development
- Market research/message testing
- Partnering with private/public sponsors
- Advertising/marketing/public relations campaign
- Collateral
- Measurements

#### 3.1.1 Stakeholder/Community Outreach

It will be important early on to identify, inform, educate and gain broad support of the HBE from stakeholders that include legislators, government officials, policy makers, business, industry, consumer groups and others. These groups can play a key role in the promotion of the launch of the Exchange. The common goal of these groups should be to maintain high levels of nonpartisan public support for providing increased access to health insurance for

the state's residents. As people are enrolled, it will be important to highlight and communicate the successes of the Exchange. Small group stakeholder meetings/forums are **recommended**.

Community outreach efforts should include town hall meetings throughout the state; presentations to civic organizations and professional associations; and partnerships with grass roots organizations such as the Cooperative Extension Service, Hometown Health Improvement initiatives and County Farm Bureaus.

### 3.1.2 Branding/Messaging

It is important that the name of the Health Benefits Exchange is easy to say and easy to remember. We **recommend** a one- to two-word name for the Exchange (for example, Massachusetts' insurance exchange is called Connector). We **recommend** a professionally produced logo and development of graphic standards. The standards will ensure consistency in look and feel of all collateral, marketing/advertising materials and the website. The website should have a unique, easy-to-remember URL.

Messages that will raise the awareness of the availability of qualified health plans should be developed. Fair and impartial information concerning enrollment should be developed in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

### 3.1.3 Market Research

We **recommend** conducting one-on-one interviews with eligible Arkansans and small business owners to help guide the campaign by knowing how participants respond to various messages, not only by topics of importance, but also in tone. Preferences among diverse and specific demographics (gender, age, ethnicity) will help frame the campaign messages and will better define the preference of channels (Internet, radio, TV, etc.). Research can suggest the messengers who would be most effective in communicating the importance of purchasing insurance, for example, real-life Arkansan consumers, celebrities or actors as spokespersons. Additionally, research can help better understand the attitudes of this key audience and their barriers to enrollment.

### 3.1.4 Partnering with Private/Public Sponsors

The potential for the campaign's success will greatly depend on high public support. We **recommend** the HBE form partnerships and collaborations with businesses, associations, unions and other organizations to gain access to strategic audiences of employees and small businesses, as well as assist with the dissemination of tools, resources, education and other information. An example is partnering with a pharmacy chain or retailer to provide educational materials to their customers. Private-sector partners can provide pro bono and in-kind services.

Partnering with other state agencies such as the Department of Revenue, Department of Finance & Administration or the Department of Motor Vehicles is of equal importance to ensure access to key audiences at minimal or no cost. We **recommend** the HBE provide educational materials for display and/or voluntary distribution (making them available on a nearby table in the waiting area). State agencies and state health providers responsible for enrollment and outreach to individuals such as the parents of children who are eligible for ARKids First will be a valuable resource.

We **recommend** branded kiosks with Internet capabilities and booths at community locations, partner conferences, exhibits and health fairs where security and privacy can be ensured.

### 3.1.5 Advertising Social Marketing /Digital Marketing/Public Relations

The campaign will require a diverse, yet integrated media mix to reach the specific targeted populations. Both traditional advertising (radio, print, newspaper, billboards) along with digital advertising on Google Ad Words, Facebook and Google+ brand pages is **recommended**. We **recommend** search engine optimization and social media (Facebook, Twitter, Google+).

Quick response codes should be included on all print advertising (when possible within size and format constraints) that takes a smart phone user to a designated page designed for mobile phone viewing on the Exchange website.

Other nontraditional media we **recommend** are vehicle wraps, gas pump audio-visual messaging and text messages to the 18- to 30-year-old age market.

Traditional public service announcements and media relations (interviews, editorials, guest opinion pieces, feature stories) are **recommended** and are critical to the success of this campaign.

### 3.1.6 Collateral/Print Materials

Brochures, fliers, fact sheets and Q&As should be developed to support the education and outreach efforts. All should have a unified look and feel of the Exchange and its products. These materials should be part of an outreach tool kit made available by downloading from the website. The website must be designed to be accessed by people with hearing and visual disabilities.

Consumer materials should be written at a sixth-grade level so as to be understood by a broad spectrum of literacy skills. They should be available in both English and Spanish, at a minimum.

Materials should be designed for easy dissemination by state and local government offices, schools, retailers, banks, restaurants, libraries, hospitals, providers, workplaces, insurance agents, community-based organizations and other businesses.

### 3.1.7 Measurements

The Exchange’s success will be measured by one central goal: increasing the number of Arkansas residents with health insurance. Campaign elements can be measured in the following ways:

- At first point of contact ask consumers how they found out about the Exchange for first two years of operation
- Number of stakeholder consultations
- Number of town hall meetings
- Number of civic/community presentations
- Number of group presentations
- Advertising reach and frequency
- Advertising click-throughs on the HBE website
- Media content (unpaid)
- Number of inquiries through call center
- HBE website traffic with email contact
- HBE website chat contact

### 3.2 Key Messages at Key Times

The following table illustrates how we anticipate staggering outreach to move the Exchange step by step toward its goal of increasing the number of Arkansans with health insurance.

No	Tactic	Audience	2012	2013	2014
1	Branding name	Stakeholders, consumers, small businesses			
2	Logo & graphic standards	Stakeholders, consumers, small businesses	X		
3	Website URL	Stakeholders, consumers, small businesses	X		
4	Phase 1 overarching messages	Stakeholders, consumers, small businesses	X		
5	Market research	Consumers, small businesses	X		
6	Identify stakeholders – Group A elected officials, policy makers	Legislators, state policy makers, Governor’s staff, Medicaid staff, AID staff, legal consultants	X		

No	Tactic	Audience	2012	2013	2014
7	Identify stakeholders – Group B Providers	Arkansas Hospital Association, Arkansas Nurses Association, Arkansas Medical Society	X		
8	Identify stakeholders – Group C business groups	AR Nat'l Federation of Small Businesses, Arkansas State Chamber, Ark. Economic Development Commission; AR Small Business & Technical Development Center; HR Management Associations	X		
9	Identify stakeholders – Group D health insurance carriers, producers, brokers and agents	BCBS, United Healthcare, QualChoice, Independent Insurance Carriers of AR, AR Association of Health Underwriters	X		
10	Identify stakeholders – Group E consumer advocacy groups	AR Advocates for Children & Families, American Legion, AARP	X		
11	Identify stakeholders – Group F health care providers	Arkansas Medical Society, Arkansas Hospital Association, Arkansas Department of Health	X		
12	Explore educational partnership opportunities with pharmacies/retailers	Wal-Mart, Walgreens, Dollar Store, USA Drug, Fred's, Target	X		
13	Conduct small group stakeholder meetings	Groups A, B, C, D, E, F	X	X	
14	Presentations to civic clubs/associations	Consumers, small business owners	X	X	
15	Phase 2 messaging	Importance of health insurance, who is and who is not impacted, legal requirements, opportunities	X	X	
16	Conduct statewide community town hall meetings	Local politicians, civic/community groups, small businesses, consumers	X	X	
17	Schedule statewide editorial visits	Newspaper editors, radio talk shows, TV	X	X	
18	Develop HBE website	General public, prospective insurers, stakeholders	X	X	

No	Tactic	Audience	2012	2013	2014
19	Collateral /educational materials (fact sheets, brochures, flyers, Q&As, table top display, kiosk, etc.)	General public, prospective insurers, stakeholders, small businesses	X	X	X
20	Ongoing stakeholder/community outreach to increase high level nonpartisan public support	Civic/community groups, churches, associations, small business groups	X	X	X
21	Phase 3 messaging	Explanation of plans, deadlines, eligibility, how to enroll, updates		X	X
22	Advertising, social marketing, digital marketing, public relations	Radio, newspaper, TV advertising; search engine, Internet, Facebook, Twitter, YouTube; text messaging; PSAs, interviews, editorials, guest opinion pieces, feature stories; vehicle wraps, gas pump audio-visual messaging; trade show exhibits, kiosk	X	X	X
23	Measurements	Primary: number of Arkansas residents with health insurance; number who enroll in HBE  Secondary: number of stakeholder consultations, town hall meetings, small group meetings, presentations, advertising reach and frequency, click-throughs on the HBE website, amount of unpaid media content, inquiries through call center, website chat contact and email contacts	X	X	X

Table 3: Key Messages

### 3.3 Health Literacy

Increasing health literacy – the ability to find, access, understand and apply health-related information and needed services – has become a national priority, as it has been shown to improve health and health care outcomes, and to reduce health care costs. The Exchange

presents both an opportunity and an increased need for health literacy and effective health-related communications.

We **recommend** that an awareness of health literacy be built into every aspect and component of the Exchange, not only in the communications, education and outreach plan. All materials and messaging targeting consumers, as well as wording on the web portal itself, must be presented at the sixth-grade level or lower. (Specific secondary audiences may require slightly higher reading grade levels depending on the complexity of the subject matter.)

We **recommend** encouraging participating health plans to be aware of health literacy and to present materials in keeping with its principles and standards. A tool developed at Emory with Robert Wood Johnson Foundation funding is currently in use with at least 18 health plans. Some health literacy specialists are **recommending** its use for the state benefits exchanges. The tool is available at <http://www.ahip.org/content/default.aspx?docid=29467>.

Navigators could easily help distribute educational materials from the Department of Human Services, the Health Department and other reliable sources on preventive care, well child care, healthy living, management of specific chronic conditions and other topics deemed appropriate by AID, to help increase health literacy in keeping with Health People 2020 and national priorities. Increasing health literacy has been shown to improve health and reduce health care costs.

### 3.4 Cultural Linguistics

Cultural linguistics is the study of the relationship between language, culture and conceptualization. When targeting a culturally diverse audience, this relationship must be carefully considered.

For the purposes of the Exchange – or any project where materials or education is provided in multiple languages and/or to groups diverse in ethnicity, age, culture or environment – it is important to remember that literal translation is not necessarily accurate translation. Idioms can easily be mangled beyond meaning, negative connotations can color or obscure the message, and the spirit of the original may be lost.

Bearing these realities and the concepts of cultural linguistics in minds, we **recommend**:

- Providing all materials and communications in as many languages as possible, to reach populations that may be most in need of assistance with the Exchange
- Actively recruiting navigators who are members of the cultural and ethnic communities they serve, and who can anticipate any cultural barriers to the message and take appropriate steps to overcome them

- Using professional translators and interpreters who are not only bilingual but bi-cultural, and who will translate only from English into their native tongue or dominant language
- Submitting translated materials to a second translator for review and compare (Some experts recommend having translated materials re-translated into the original language and comparing the results to the original)
- Testing all materials with members of the target audience before launching statewide, with every ethnicity, age group and other identified subgroup represented. This testing should apply not only to printed materials, but to the online portal and electronic communications as well, including text and any accompanying graphics or visuals. Focus testing or similar audience review must be built into the deliverable timelines, along with additional time to make needed revisions. While this could entail some additional time and expense, missteps and miscommunication will be much more costly.

### **3.5 Recommendations: Communication/Education/Outreach Plan Summary**

We recommend a three-phased approach for outreach and communications:

1. Phase 1 (2011, 2012, 2013) – Create HBE brand awareness and overarching message: what it is, the legal obligations to purchase insurance and its benefits to Arkansans and small business owners
2. Phase 2 – (2013) Targeted education and communication near “go-live” date: 60 to 90 days in advance of launch
3. Phase 3 – (2013, 2014) Conduct a statewide media relations effort: focus on launch of the HBE. Drive traffic to the Exchange website; explain consumer access to affordable, quality health plans; provide specific information about eligibility and how to enroll; provide ongoing updates
4. Market research is conducted to design and test messages and their presentation for specific statewide audiences before the campaign is launched
5. Meeting with and providing a tool kit of information to small businesses to include brochures, fact sheets Q&A, newsletter article, website banner ads, etc.
6. Targeted consumer outreach to lower to middle income individuals
7. Providing hospitals, physician offices, clinics and local health units with Exchange educational materials for dissemination to uninsured patients
8. Partnering with private and public sponsors to increase market penetration
9. An awareness of health literacy be built into every aspect and component of the Exchange, not only in the communications, education and outreach plan
10. Categorizing campaign tactics in the following groupings:
  - ✓ Stakeholder/community outreach

- ✓ Branding/message development
  - ✓ Market research/message testing
  - ✓ Partnering with private/public sponsors
  - ✓ Advertising/marketing /public relations campaign
  - ✓ Collateral
  - ✓ Measurements
11. Providing all materials and communications in as many languages as possible, to reach populations that may be most in need of assistance with the Exchange
  12. Actively recruiting navigators who are members of the cultural and ethnic communities they serve, and who can anticipate any cultural barriers to the message and take appropriate steps to overcome them
  13. Using professional translators and interpreters who are not only bilingual but bi-cultural, and who will translate only from English into their native tongue or dominant language
  14. Submitting translated materials to a second translator for review and compare (Some experts recommend having translated materials re-translated into the original language and comparing the results to the original)
  15. Testing all materials with members of the target audience before launching statewide, with every ethnicity, age group and other identified subgroup represented. This testing should apply not only to printed materials, but the online portal and electronic communications, including text and any accompanying graphics or visuals. Focus testing or similar audience review must be built into the deliverable timelines, along with additional time to make needed revisions. While this could entail some expense, missteps and miscommunication will be much more costly.

## 4 Navigators

The Navigator's role, compensation, training and other aspects of the Navigator program are being heavily debated nationally and statewide. States face difficult decisions and must take care to keep the consumers' well-being, public perception of the program and long-term sustainability of the Exchange firmly in mind. Our **recommendations** for Navigators are based on research using the Arkansas SHIIP volunteer model, the National Association of Insurance Commissioners whitepaper on the roles of Navigators and Producers, the UAMS Health Benefits Exchange Survey and community meetings data, studies funded by the Robert Wood Johnson Foundation, the NWA Agents for a Better Arkansas Health Benefits Exchange (HBE) recommendations, the National Association of Health Underwriters report on the role of Navigators, the Navigator efforts of other states pursuing an HBE, as well as sustainability considerations and federal funding restrictions.

While this document will address a model for Navigator compensation, it is our **recommendation** that AID hire a consultant to design, develop and implement a Navigator program. We recommend a consultant budget of \$200,000. This figure is derived from the California Health Benefits Exchange Level I Establishment Grant Application, Budget and Budget Narrative with adjustments made to reflect the differences between Arkansas and California.

### 4.1 Roles and Responsibilities

We **recommend** the role of a Navigator in Arkansas should be to raise awareness of the availability of qualified health plans (QHPs) through the HBE and to assist those wishing to enroll in the Exchange. General assistance can be provided in an individual or group setting, but care must be taken to protect personal health information (PHI).

The goal of the Navigator program should be to help guide and educate individuals who will seek health insurance through the Exchange. The primary focus of the Arkansas Navigator Program should be to serve as a guide and educator to highlight the benefits and penalties associated with the Exchange for those citizens who lack the educational, financial and/or technological resources to understand or access the system.

Navigators should be responsible for distributing accurate, fair and impartial information concerning enrollment in QHPs and should serve an educational role with regard to informing individuals and businesses of the availability of premium tax credits and cost-sharing reductions in accordance with federal tax laws. While they will facilitate enrollment, they should not actually enroll those they assist. Enrollment should be completed by individuals through the Exchange portal or by a broker/producer, depending on the preference of the individual consumer.

The Navigator's role should be one of advocate, educator and guide, particularly for those who may not be computer-literate or well-versed in insurance terminology. Many organizations and individuals across the state currently work to help Arkansans find work, navigate the health care system or conduct other personal business. Often these

educators/advocates work as volunteers. Those who are already serving this informal role will now have a chance to receive training, certification and compensation for assisting Arkansans who need help understanding their health coverage options.

Navigators should be easily accessible in as many Arkansas communities as possible. A Navigator must demonstrate to the Exchange that it has or could easily establish relationships with potential enrollees in the area it wishes to serve. We **recommend** actively recruiting suitable individuals or entities to serve specific populations that have historically been difficult to reach or underserved, such as the Hispanic communities or the Marshallese population in Washington County, and in rural or underserved geographic areas. A Navigator serving such populations would ideally be a community member who is perceived as a peer. All information conveyed through a Navigator should be culturally and linguistically appropriate to the needs of the population being served by the Exchange.

A Navigator may serve as a source of consumer assistance for an enrollee with a grievance, complaint or question regarding a health plan, coverage, or determination under such a plan or coverage. Assistance should be limited to referring individuals to the appropriate resources. For instance, complaints or concerns about the Exchange, a specific health plan, the quality of health care under an Exchange-listed health plan or the quality of a Navigator's services should be referred to a "complaints and concerns" section of the online portal and to the call center. This would allow for tracking of complaints or concerns regarding specific plans, Navigators or health care providers. Complaints and concerns could then be referred to the appropriate resources or authorities for investigation and resolution. We **recommend** that the AID utilize its resources and procedures already established for handling complaints and concerns regarding the Exchange, a Navigator or participating health plans.

The Navigator role will be especially critical in the months immediately following the Exchange's launch when enrollment is at its peak and familiarity with the Exchange is low. We predict that the Navigators will be less active after 2015, when the number of new enrollees is likely to drop and Arkansans are more informed about the Exchange. At that point, new enrollees will likely seek help from licensed producers or from family members or friends who are already enrolled or are familiar with the Exchange and the enrollment process. Recruitment and retention of Navigators, except for chronically underserved populations and areas, will be less critical, and the associated costs will likely drop.

## 4.2 Who can be a Navigator?

According to the federal regulations regarding Navigators, a Navigator may be an individual or entity working or serving within the trade industry, commercial fishing industry, ranching and farming organizations, professional associations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration or licensed insurance agents and brokers, as long as a conflict of interest, in pursuant with Section 1311(i) of Accountable Care Act, does not exist.

An agent is an individual appointed by a health insurance issuer to sell, solicit, or negotiate insurance contracts on its behalf. A broker/producer works on the behalf of his/her client’s best interest and sells multiple products from multiple issuers. The AID regulates these entities. They must meet state licensure and educational requirements as well as demonstrate financial responsibility for their actions. These requirements function as a mechanism for protecting consumers.

A Navigator should be a guide and educator, not an insurance enroller and should not serve the same role as a producer. A Navigator should not engage in the types of services or activities that would require licensure for producers, brokers, or agents. These duties are outside the stated goal of the Navigator program and would add unnecessary cost and bureaucracy. A producer who chooses to serve as a Navigator cannot receive reimbursement for both roles when serving the same customers or customer groups. In addition, HBE call center employees cannot be certified as Navigators and be paid for both roles. They will undergo a separate call center training process and will be paid through a different mechanism from Navigators.

The goal of the Exchange is not to blend the role of Navigator and producer but instead to highlight and enhance the way the two roles work together. A Navigator should be trained and certified to assist both individuals and small business owners. However, brokers/agents are likely to have longstanding relationships with small businesses and may be in a better position to offer tailored or customized plans to the small employer as well as to explain the tax and cost-sharing ramifications to a business owner. A Navigator would be best utilized to serve individuals and families who are eligible for the Exchange and do not have complex insurance decision issues.

### 4.3 Training, Certification and Re-Certification

Most work group participants and other states agree that all Navigators and producers enrolling consumers in the Exchange should be trained and receive some type of certification. We **recommend** this training and certification be provided through an online training course. If the Exchange has adequate resources, the online training would be strengthened by an observational “in-person” training component.

The table below outlines the core and supplemental components of a Navigator training and certification program. The following table closely echoes the Arkansas SHIIP volunteer training program.

On-Line Exams (Core)	In-Person Observation (Supplemental)
<ul style="list-style-type: none"> <li>• Using online certification software</li> <li>• Test (to be determined)</li> <li>• Case study included</li> <li>• May allow multiple testing attempts</li> <li>• Open book</li> </ul>	<ul style="list-style-type: none"> <li>• Counseling sessions</li> <li>• Counselor observation standards</li> <li>• Client must agree to be observed</li> <li>• May allow multiple testing attempts</li> <li>• 80% passing grade</li> </ul>

<ul style="list-style-type: none"><li>• 80% passing grade</li></ul>	
An ideal Navigator has: <ul style="list-style-type: none"><li>• The ability to get along well with others</li><li>• A sensitive and caring attitude</li><li>• The willingness to learn and an ability to retain information relevant to health insurance provisions and claims filing procedures</li><li>• Good written and oral communication skills</li></ul> It is also important that a Navigator never promote or degrade one insurance product or policy over another. The Navigator is responsible for being factual and unbiased.	

**Table 4: Navigator Core Components**

The training should be for the purpose of certifying an individual or entity as a “Navigator” or of obtaining a producer/broker/agent “Exchange Certification.” These separate designations should allow producers to competently assist their clients in enrolling in the Exchange and would highlight the differences in the Navigator and producer roles.

A modest certification fee (we **recommend** \$25) will help cover the cost of training without being a financial burden for potential Navigators. The fee would also lend credibility to the certification process. We **recommend** offering a mechanism to pay online with a credit card or electronic bank draft, as well as an option to mail in a check.

Annual continuing education/re-certification requirements, along with a nominal fee for recertification, should be built into the system to ensure that all Navigators/producers are kept up to date regarding changes in the Exchange, regulations or the Navigator role. Changes should also be communicated to Navigators/producers via email and/or direct mail.

We **recommend** that the Exchange create a training/certification structure for both Navigators and producers within the Exchange, and that the current AID licensing structure be considered.

We **recommend** the certification structure include:

- A definition of the actions and responsibilities requiring certification
- Services that can be provided under certification
- A criminal background check and review of the state and federal “excluded provider lists”
- Rules regarding full disclosure of potential conflicts of interest
- Training in providing full disclosure to clients
- Accountability and consumer protection standards, including any requirements for individual or agency/organization Navigator liability coverage
- HIPAA law and protection of personal health information (PHI) training
- Any forms clients will be required to sign before disclosing PHI to a Navigator or producer

- Requirement that producer/Navigator maintain means of electronic communication.

## 4.4 Navigator Payment System

Federal law allows for small grant funding of Navigators; however, the structure of this funding is to be determined by individual states. The role of a Navigator is that of a trusted community resource for education and guidance. The Navigator's role is not envisioned as a full-time position, and compensation should reflect the role of community service. The position should not be presented as a lucrative money-making opportunity by recruiters, but simply a chance to serve the community and be paid a nominal fee.

Because funding from the Exchange will ultimately be raised through fees from insurers, Navigator compensation should be modest. High Navigator compensation could ultimately result in increased premiums for all Exchange enrollees. Navigator compensation should not be so large as to reduce the Navigator's credibility within the population it serves.

Compensation should not vary regardless of the plans or insurers chosen by the enrollees. A Navigator should not receive compensation multiple times for an individual who continually drops in and out of a QHP over a given time period, nor should a Navigator receive a commission for referring enrollees to a producer. The payment of commissions to Navigators from issuers (carriers) is prohibited by the PPACA.

Given these financial constraints and the recommended role of the Navigator as a guide and resource, rather than an enroller, it is likely that a nonprofit organization or a community organization, rather than an individual, would be the most logical entity to serve in the Navigator role. Individuals are not precluded from serving as Navigators, but they must meet all grant criteria. We recommend AID contract with an additional consultant to design and develop all aspects of the navigator program in consultation with the Exchange. This includes the grant criteria for individuals and organizations seeking to serve as navigators.

Navigators will not be enrolling individuals, so some method of tracking successful enrollment after receiving assistance from a Navigator will be necessary in order for Navigators to be appropriately compensated and or monitored. We **recommend** that each Navigator be assigned an identification number (ID) recognized by the online system. Each time a Navigator provides an educational session or assists an individual or employer, the Navigator should register the individuals or groups served/attending session under the Navigator's ID number..

We **recommend** the Navigator program operate and function as a traditional, competitive, grant program with a predetermined funding amount available by a geographic area or method of distribution determined by the Exchange. The Exchange and its consultant will develop criteria and procurement methodology. Payment to the Navigator grantees should be based on performance indicators that take into account outreach and education activities, technical assistance, points of contact, as well as number of consumers enrolled in the Exchange.

This method of payment will help anticipate and control costs of the Navigator Program. An alternative payment method is salaried Navigator positions. In the UAMS Arkansas Health Benefit Exchange survey, salaried Navigators was the most favored payment method. A flat fee was the second most favored method. It is our **recommendation** that a flat fee payment system is better suited for the needs of the HBE. A salaried system would create unnecessary cost and bureaucracy relating to training, housing, supervising, compensating, and providing benefits to these individuals. It also curtails the ability of the Navigator to engage in other community services and activities that build the relationships a Navigator must have with some of the underserved communities within Arkansas.

The amount and mechanism for compensation should be transparent to consumers. We **recommend** this information be presented in writing to potential enrollees working with a Navigator.

The federal regulations state Navigators must not be compensated with federal money. Revenue generated through Exchange operations should eventually supply adequate revenue to fund the Navigator program. To effectively launch the program and ensure prompt and adequate payment for Navigators, we **recommend** AID identify an alternative revenue source for the first six months of the program.

## 4.5 Recommendations: Navigators

Our **recommendations** for Navigators are based on research using the Arkansas SHIIP volunteer model, the National Association of Insurance Commissioners whitepaper on the roles of Navigators and Producers, the UAMS Health Benefit Exchange Survey and community meetings data, studies funded by the Robert Wood Johnson Foundation, the NWA Agents for a Better Arkansas Health Benefits Exchange (HBE) recommendations, the National Association of Health Underwriters report on the role of Navigators, the Navigator efforts of other states pursuing an HBE, as well as sustainability considerations and federal funding restrictions. Recommendations are:

1. The role of a Navigator within the Exchange should be as a guide and educator for those who are not equipped to enroll in the Exchange without assistance, not an insurance enroller.
  - Licensed producers and brokers should be able to be certified as Navigators. However, payment of Navigator fees is subject to all conflict-of-interest clauses within federal regulations pertaining to the Health Benefit Exchange. Navigators may not be paid commissions by carriers.
2. Active recruitment of suitable individuals or entities desiring to serve as Navigators to specific populations that have historically been difficult to reach or are underserved should be a high priority.
  - Community leaders/entities and nonprofit organizations are best suited to serve as Navigators because of their current relationships and capacity to reach these populations.

3. Training and certification should be provided through an online training course for the purpose of certifying an individual or entity as a “Navigator” or of obtaining a producer/broker/agent “Exchange Certification.”
  - Insurers seeking to provide plans through the Exchange must also seek “Exchange Certification.”
  - Certification should call for a nominal fee from individuals and entities seeking certification.
  - AID should utilize its resources and procedures already established for handling complaints and concerns regarding the Exchange itself, a Navigator or participating health plans.
  - If the Exchange has adequate resources, the online training would be strengthened by an observational “in-person” training component.
  - Certification include:
    - ✓ A definition of the actions and responsibilities requiring certification
    - ✓ Services that can be provided under certification
    - ✓ A criminal background check and state and federal excluded provider list
    - ✓ Rules regarding full disclosure of potential conflicts of interest
    - ✓ Training in providing full disclosure to clients
    - ✓ Accountability standards
    - ✓ HIPAA law and protection of personal health information (PHI) training
    - ✓ Any forms clients will be required to sign before disclosing PHI to a Navigator or producer
    - ✓ A mechanism to allow for errors and omissions insurance
4. Each Navigator should be assigned an ID number recognized by the Exchange Portal.
5. We **recommend** AID hire a consultant to help design, develop, and implement the Navigator program structure as a traditional grant program.
  - Consultant budget of \$200,000 to design and develop the program
6. AID should identify an alternative funding source for the first six months of the Navigator program due to federal funding guidelines regarding Navigators.

## 5 Call Center

ACA required the Exchange to provide for the operation of a call center to respond to requests for assistance by consumers; a call center that is accessible via a toll-free telephone number. In Proposed Rules currently available for comment, CMS clarifies that states have significant latitude in how the Exchange call center is structured, but lists at least four areas where capability should be provided:

- Types of QHPs offered by the Exchange;
- Premiums, benefits, cost-sharing and quality ratings associated with OHPs offered;
- Categories of assistance available; and
- The application process for enrollment in coverage.

While the final rule has not been issued, it seems prudent to include these suggestions when considering the design of the call center for the Arkansas Exchange.

The call center's purpose is to support the services provided through the Exchange website and the Navigators. If the website is user-friendly and there are adequate numbers of well trained Navigators to work with the Exchange customers, the call center should receive minimal calls. In the future, we would anticipate a decrease in the need for Navigators and the call center. However, reaching the state of minimal calls will not occur until the Exchange has been in stable operation for several years so we must plan for an effective, efficient call center to serve the customer base.

### 5.1 Existing Capabilities

Several state agencies currently have some call center capability although each is limited in scope and appears to serve a specific, targeted audience.

- The Department of Human Services through its county offices provide customer support primarily regarding eligibility issues. ADHS is also developing an interactive voice response (IVR) system to answer the most common questions received. It is slated for operation in September 2011 and could provide some lessons learned as HBE develops its call center.
- The Employee Benefits Division of the Department of Finance and Administration indicated that much of their customer support is done through their website but they do operate a small call center to support clients, particularly to assist with claims issues.
- The Arkansas Insurance Department also has a small call center, primarily to serve consumers who are having issues with their insurance plan.
- The Department of Information Services has call center infrastructure ready and can provide technical support as needed.

It will be expedient to leverage the experience of these agencies when planning the Exchange call center but it does not appear feasible to expand any one of these to encompass the Exchange functionality. However, it does appear feasible for the AID call center to assume responsibility for complaints against the QHPs in the Exchange and the Navigators. This is compatible with their current focus and will be a natural compliment to AID's role in certifying the QHPs and licensing/certifying the Navigators.

## 5.2 Call Center Design

The key components to a call center operation are:

- A telephone system that is designed to capture statistics (e.g., call volume, length of the call, peak calling time, call abandonment, etc.) and to seamlessly route calls as appropriate. The phone system must have an adequate number of phone lines and must also allow another person (such as a supervisor) to monitor calls real time. Based on current information, we assume the call center will be for inbound calls and will not routinely make out bound calls to customers.
- While all would prefer that each call be answered by a customer service representative (CSR), financial realities and industry standards lead to the recommendation for a self-service IVR with a script that addresses the most frequently requested information and determines the most appropriate way to provide the answers to the caller with minimal or no CSR intervention. The script can also allow the caller to opt out to a CSR at any time if needed. The Exchange staff must be able to modify the script easily and quickly in response to changing information.
- A customer relationship management (CRM) system that allows CSRs to capture basic information about each call. Many CRM systems work in concert with the phone system to capture basic information about the call prior to the CSR engaging the caller. This would include at least a record of the information the caller accessed through the IVR before being connected to the CSR. Exchange staff would determine what basic information is to be gathered via the CRM, realizing that CRM systems can produce reports to assist in managing the call center and also for identifying call patterns that may indicate the need for additional outreach or education efforts, the need for a change to the Exchange website or other needs.
- Seamless access to the Exchange website to assist with enrolling those callers who have that need. We would also recommend a call center information repository for relevant information that is easily accessible to all CSRs. An example of the type information in such a repository would be a list of Navigators and their area of responsibility for those callers seeking Navigator services.
- Operational procedures and staff training materials that are developed and updated as necessary to assure that staff is providing efficient, quality services on a daily basis. Adequate lead time to fully train CSRs before the call center is opened is of paramount importance.

- Call center staff:
  - ✓ The type of staff in the call center should include individuals who reflect the language and culture of those who will be calling. Not only must they speak and understand the language, they must understand the unique heritage of Arkansas's various regions in order to provide appropriate responses.
  - ✓ The number of staff needed in the call center cannot be estimated until there is a more definite estimate of the number of Arkansans who will seek to purchase insurance through the Exchange. Based on prior experience, we also know that the number of calls will be extremely high for the first 60 to 90 days of operations then level off. Calls will also spike during open enrollment periods or if there is a significant change made that effects the customers. Allowances must be made for additional staff and, if necessary, additional phone lines during such peak periods.
- The physical location of the call center must be a secured space with limited access by non-call center staff. Because protected health information (PHI) will be communicated and recorded by the CSRs, adequate attention must be paid to privacy issues.

Proper planning and implementation of a call center operation is essential to customer satisfaction and sets the stage for meeting the Exchange's future customer service needs.

## 5.3 Recommendations

The First Data Team recommends that the HBE Planning Staff engage a consultant to design the Exchange's call center operation. Specify that the consultant complete at least the following tasks:

- Leverage the infrastructure and technical support available through the Department of Information Services in the design and installation of the telephone system and IVR
- Develop job descriptions for the call center managers, CSRs and support staff
- Develop the IVR script
- Develop operational procedures
- Develop the staff training curriculum and materials
- Provide input to the location and design of the call center facility, work stations for CSRs and other needed equipment
- Develop the timeline of activities leading up to call center "go live", assuring that this occurs no later than September 1, 2013, a month prior to the beginning of Open Enrollment of consumers.

## 6 Estimated Budget

### 6.1 Communication/Education/Outreach Budget

We recommend a three-year budget of \$2.25 million (\$750,000/year) for communication/education/outreach.

The budget would be allocated as outlined on the following table:

Function	%	Amount
<b>Project Management</b> – Campaign staff with experience in community outreach to reach statewide lower- to middle-income Arkansans and small businesses	13%	\$292,500
<b>Branding/Creative Development</b> – Creative talent to develop logo, branding, graphics of all collateral, messaging, advertising, digital, and other promotional materials	10%	\$225,000
<b>Market Research</b> – Conducting one-on-one interviews with eligible Arkansans and small business owners to test effectiveness of messaging and preference of channels. Includes travel expenses	2%	\$45,000
<b>Public/Community Relations</b> – Public relations staff to conduct statewide community relations meetings/forums/presentations and to manage media relations. Includes meeting and travel costs	25%	\$562,500
<b>Collateral/Educational Materials</b> – Production/printing of small business tool kits, brochures, fact sheets Q&A fliers and signage	10%	\$225,000
<b>Advertising/Media Buying</b> – Planning/negotiation/purchase of statewide newspaper, radio, television advertising, text messaging campaign, gas pump audiovisual messaging, and mass transit/vehicle wraps	35%	\$787,500
<b>Trade Show Exhibit/Kiosk</b> – Development of trade show/conference exhibit and kiosk signage. Includes exhibit fees	5%	\$112,500

Table 5: Estimated Budget

## 6.2 Estimated Navigator Budget

We recommend AID hire a consultant to design, develop, and implement a Navigator program. We estimate the cost for that consultation to be \$200,000.

Function	Amount
<b>Consultant</b>	\$200,000
<b>Collateral/Educational Materials</b> – Production/printing of small business tool kits, brochures, fact sheets Q&A fliers and signage (included in Outreach/Education budget)	N/A
<b>Design and Development of Training</b>	\$100,000
<b>Certification/oversight (4-6 staff) per year</b>	\$500,000
<b>Grants per year</b>	\$2,250,000

Table 6: Estimated Navigator Budget

## 6.3 Call Center

Estimated costs below are based on development of a call center staffed by 20 CSRs plus 5 supervisory and support staff.

Function	Amount
<b>Start up:</b>	
<b>Consultant</b>	\$100,000
<b>Telephone and IT set up through DIS (80 lines, development, IVR)</b>	\$400,000
<b>CRM automation support cost (included in overall IT costs)</b>	N/A
<b>Staff Training</b>	\$5,000
<b>Work Stations, equipment, physical plant modifications</b>	\$50,000
<b>Annual Costs:</b>	
<b>Telephone maintenance</b>	\$800,000
<b>Staff Salaries</b>	\$850,000
<b>Physical Plant</b>	\$12,000
<b>Staff Training</b>	\$1,000

Table 7: Estimated Call Center Budget

## 7 Attachment A: References

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