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ARKANSAS: BASELINE REPORT

**State-Level Field Network Study
of the Implementation of the
Affordable Care Act**




June 2015

**Rockefeller Institute of Government
State University of New York**

The Brookings Institution

**Fels Institute of Government
University of Pennsylvania**

Field Research Associates

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Contents

Part 1 – Setting the State Context	1
1.1 Decisions to Date	1
Overview	1
Health Care Environment	1
Political Environment	2
1.2 Goal Alignment	3
Health Insurance Marketplace Decision Process	3
Medicaid Expansion.	5
Part 2 – Implementation Tasks.	7
2.1. Marketplace Priorities.	7
2.2. Leadership – Who Governs?	8
2.3. Staffing	9
2.4. Outreach and Education; 2.5. Navigational Assistance	10
2.6. Interagency and Intergovernmental Relations	11
2.7. QHP Availability and Program Articulation	12
Part 3 – Supplement on Small Business Exchanges	14
3.1. Organization of Small Business Exchanges	14
Part 4 – Summary Analysis	15
Endnotes	16

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State-Level Field Network Study of the Implementation of the Affordable Care Act

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ARKANSAS: BASELINE REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

Editor's note: The Arkansas report has a special place among the state-level field network studies examining the rollout of the Affordable Care Act. The lead author, Dr. Joe Thompson, was actively involved in decisions that influenced the state's response to the Affordable Care Act, serving as Arkansas's surgeon general from 2005 to 2015 in the administrations of Republican Governor Mike Huckabee and Governor Mike Beebe, a Democrat.

Part 1 – Setting the State Context

1.1 Decisions to Date

Overview

Health Care Environment

Arkansas's approach to the implementation of the Patient Protection and Affordable Care Act (ACA) through early 2015 has been marked by political volatility and, in the midst of this volatility, both innovation and flexibility. To a large degree, Arkansas has used the ACA as a tool to achieve comprehensive health care system transformation in a state with nearly three million citizens and one of the lowest median household incomes in the nation.

During the ten years prior to passage of the ACA, average annual health insurance premiums nearly doubled for Arkansas families, pushing the statewide rate of uninsured working-age

adults to 26 percent, with some counties approaching 40 percent.¹ Prior to 2014, an estimated 550,000 Arkansans lacked health care coverage.² A generally unhealthy population with health risks and a disease burden near the top of most national indicators had strained Arkansas's delivery system to a tipping point.

For some populations, Arkansas Medicaid has been a lifeline, offering coverage for children in families earning up to 200 percent of the federal poverty level (FPL) through both traditional Medicaid (ARKids A) and the State Children's Health Insurance Program (ARKids B). Medicaid eligibility for low-income adults, however, has been among the most restrictive in the nation. Eligibility was primarily limited to the aged, disabled, and parents earning less than 17 percent of the FPL, offering no Medicaid coverage for nondisabled adults without children.

Political Environment

Arkansas's legislature is comprised of a 100-member House of Representatives and a 35-member Senate. Legislators meet biennially in odd years to consider substantive legislation and in even years for a fiscal session in which they consider only appropriation bills. In recent years, voter-initiated term limits have taken a toll on more tenured legislators, resulting in great turnover among legislative leadership at the capitol in Little Rock.

A longtime Democratic legislator and state attorney general, Mike Beebe, succeeded Republican Governor Mike Huckabee in 2007. By 2011, Beebe and fellow Democrats enjoyed small majority margins in both chambers.

For the first time since Reconstruction, Republicans gained a majority in both chambers in the 2012 elections, with messaging focused largely on opposition to the ACA and its implementation in Arkansas. When the United States Supreme Court struck down the Medicaid expansion mandate in June 2012, it became unlikely that expansion would be approved by the 89th Arkansas General Assembly during the 2013 legislative session.

Two features of Arkansas law are particularly noteworthy here, given the party change in legislative control and an impending Medicaid budget deficit. First, state law requires a balanced budget, prohibiting the state from deficit spending. Second, Arkansas's constitution requires a supermajority vote, i.e., three-quarters in both chambers, to pass appropriations. Consequently, a small minority can block any appropriation.

Despite enjoying wide popularity across the state, Beebe faced a difficult battle in 2013 to advance his agenda, which included health care coverage expansion. His administration needed a bipartisan policy solution and effective conservative messaging. In this effort, he was aided by the ascension of two more moderate Republican members to leadership roles — Senate President Pro Tempore Michael Lamoreux and House Speaker Davy Carter. With millions of federal dollars available to help 250,000 low-income Arkansans achieve health care coverage and, on the other

hand, the possibility of draconian cuts to the existing cash-strapped state Medicaid program, the political stage was set.

1.2 Goal Alignment

Prior to and during the federal crafting of the ACA and coverage expansion, there were discussions within public and private sectors in Arkansas about how to address what many viewed to be a broken health care system. Against this backdrop — and with looming congressional intervention that many states, including Arkansas, anticipated would be ill-fitting to address state-specific issues — the state launched the Arkansas Health System Improvement Initiative (AHSII) in 2010. Directed by Beebe's executive branch and Arkansas Surgeon General Dr. Joe Thompson, the AHSII focused on five areas:

- **Payment innovation:** What began as a means of bending the rising cost curve in the Medicaid program became a multipayer restructuring of the health payment system to incentivize quality outcomes through greater patient support and coordination of care across the system (the Arkansas Health Care Payment Improvement Initiative, or AHCPPII).
- **Health care workforce strategic planning:** To ensure that our health workforce is trained to efficiently use health technology and that patient-centered medical care is available when and where it is needed.
- **Expanded health care coverage options:** To reduce the number of Arkansans without health insurance through development of a health insurance exchange to assist Arkansans in securing suitable coverage and expansion of other insurance programs.
- **Acceleration of health information technology:** To support coordinated, patient-centered care; improve the accuracy of medical records; and avoid expensive and unnecessary duplication of services.
- **Population health improvement strategies:** To build on existing efforts to improve the health and productivity of Arkansans through risk mitigation, including tobacco cessation and prevention, obesity reduction, and avoiding morbidity and mortality associated with trauma.

The AHCPPII, which commenced a public and private sector transition from fee-for-service reimbursement to new value-based payment strategies, colored later decisions about coverage expansion in Arkansas and the extent to which the state desired to retain greater control of its health insurance marketplace.

Health Insurance Marketplace Decision Process

Armed with a message of not ceding control of the state's insurance market to the federal government, Beebe and Arkansas

Insurance Department (AID) Commissioner Jay Bradford initially endeavored to create a state-based marketplace via legislation in 2011. The 88th Arkansas General Assembly rejected the idea, with many on both sides of the aisle — particularly those who were facing opponents in upcoming primaries — favoring a “wait and see” approach in light of moving federal decision deadlines and pending ACA court cases.

In late 2011, when the U.S. Department of Health and Human Services (HHS) signaled more flexibility for marketplace implementation, Bradford announced that Arkansas was discontinuing planning efforts for a state-based marketplace. Instead, Beebe formally petitioned HHS in December 2011 to implement a federally facilitated marketplace (FFM) partnership model.

Through early 2014, Arkansas’s FFM partnership received approximately \$1.2 million in state planning funds and \$57 million in Level One grants for research, information technology development, and implementation of the FFM partnership. More specifically, the grant funding was used to:

- Design and implement automation functions to connect Arkansas Medicaid and appropriate state-run marketplace functions with the FFM partnership eligibility and enrollment portal;
- Design, develop, and implement operations and information systems to support state-operated FFM consumer assistance functions; and
- Design, develop, and automate state-operated plan management functions of the FFM, including qualified health plan (QHP) certification, rating, monitoring, and evaluation, to effect continuous quality improvement.

The AID Health Connector Division, led by Cynthia Crone, set up an advisory structure to make recommendations to Bradford for marketplace operations. The advisory committees consisted of:

- A plan management committee, which offered policy recommendations regarding plan benefits, plan choice, and certification standards.
- A consumer assistance committee, which guided the policy and planning for consumer outreach and education.

The plan management and consumer assistance committees sent recommendations to a steering committee to affirm or modify, which then offered proposals to Bradford for a decision.

During the 89th Arkansas General Assembly, as part of the Medicaid expansion negotiations, legislators passed a law that would potentially transition the FFM partnership to a state-based marketplace called the Arkansas Health Insurance Marketplace (AHIM). The law established a private, nonprofit board to administer the marketplace and signaled transition of the authority for the marketplace from the federal-state partnership model at AID to the AHIM board no earlier than July 1, 2015.

The AHIM board has eleven members representing insurance brokers or agents, consumer advocates, health insurers, small business employers, and health professionals appointed by the governor, the Senate president pro tempore, and the House speaker. Joining appointed members are ex-officio members, the AID commissioner and the Arkansas Department of Human Services (DHS) director.

With legislative committee oversight, the AHIM board has begun its work toward establishing a state-based marketplace, including applying for federal grants in cooperation with AID and identifying staffing needs. The board will be in charge of the Small Business Health Options Program (SHOP) for the 2016 plan year and anticipates taking over operations of the individual marketplace in 2017.

As of March 15, 2015, nearly 66,000 individuals with incomes above 138 percent of FPL had enrolled in the Arkansas marketplace.³ While this reflects roughly a 50 percent increase in total enrollment versus the previous year, it is well below projected potential enrollment of 150,000 to 200,000. Likely contributors to lower-than-expected enrollment are legislative restrictions placed on outreach and education activities, not only on AID but also on all other state agencies with limited use of funding for this purpose. This included halting an expansive advertising campaign just prior to open enrollment for the 2014 plan year that has never been reinstated.

Medicaid Expansion

In January 2013, the 89th Arkansas General Assembly convened with coverage expansion and a projected \$250 million Medicaid budget deficit as the principal issues. Advocates for expansion, including providers, consumer advocates, faith-based leaders, and business leaders, were met with tea party grassroots opposition reinforced by national objections to the ACA. External independent assessments of expanding coverage projecting improved health for Arkansans and a positive economic impact could not override opposition.

A key debate within the state's Senate Public Health Committee focused on what appeared to be an idiosyncrasy in the law. Without expansion, individuals with income from 100 to 400 percent of the FPL would be eligible to receive tax credits toward the purchase of private insurance, but no financial assistance would be available to those earning below 100 percent of the FPL. With expansion, individuals earning up to 138 percent of the FPL would be eligible for Medicaid and individuals earning between 100 and 138 percent of the FPL would be denied tax credits and thus the ability to buy private health insurance.

Out of that debate and discussions between Beebe and executive and legislative leadership surfaced Arkansas's premium assistance model utilizing federal funding to purchase private insurance coverage for individuals eligible for the ACA's

Medicaid expansion. The goal was not just to provide coverage in a politically palatable way, but also to reform Arkansas's Medicaid program and strengthen competition in the health insurance marketplace. A meeting with then-HHS Secretary Kathleen Sebelius in February 2013 determined that her agency was open to exploring Arkansas's premium assistance option as a new avenue for expansion coverage.

To achieve the necessary supermajority support for the "private option" – more formally known as the Health Care Independence Program (HCIP) – additional Medicaid and market changes were incorporated into enabling legislation. Provisions were added to the bill that would transition current Medicaid beneficiaries into the HCIP, e.g., children covered through the State Children's Health Insurance Program. A separate bill established the Office of the Medicaid Inspector General, while another bill established the AHIM board to take over marketplace functions. Special language in agency appropriations resulted in restrictions on outreach and enrollment for several state agencies, and those involved in enrollment were required to obtain licensure through AID to do so. There were also accompanying reductions in uncompensated care payments to community health centers and the state's academic medical center. Sweetening the pot were tax cuts in anticipation of the influx of federal funding from expanded coverage.

The Health Care Independence Act of 2013⁴ materialized late in the legislative session and passed with slim margins in both chambers. Once the bill was signed into law by Beebe on April 23, 2013, work immediately turned to waiver development and program implementation. Following months of negotiations, federal waiver approval for the HCIP occurred just days before marketplace open enrollment began on October 1, 2013.

The HCIP faced another appropriation hurdle and supermajority vote for continuation during the 89th General Assembly's fiscal session in early 2014. By that time, Republicans had increased their majorities in both chambers of the legislature. The appropriation passed once again by slim margins after a fifth vote by the Arkansas House of Representatives and the addition of tight deadlines for implementation of cost-sharing for individuals below the poverty line to 50 percent of FPL and of a health savings program.

In late 2014, the Republican surge reached the governor's office, and a term-limited Beebe was succeeded by Asa Hutchinson. During his campaign and the early days of his tenure, Hutchinson had hedged his opinion regarding the HCIP. However, without federal funds from the HCIP, campaign-promised tax cuts were untenable. In a late January 2015 speech, Hutchinson requested that legislators allow continuation of the HCIP in its current form through 2016, the end date of the waiver under which it was implemented and the sunset provision date in the Health Care Independence Act. The governor further requested

formation of a legislative task force – later memorialized in the Health Care Reform Act of 2015 with broad bipartisan support – to recommend a path for coverage of HCIP eligibles and more comprehensive reform for the Arkansas Medicaid program. Once the legislative task force was created, Hutchinson created an Advisory Council on Medicaid Reform to work with his office and the legislative task force to identify more efficient and effective reforms for the Medicaid program.

As of the end of March 2015, approximately 230,000 individuals with incomes at or below 138 percent of the FPL had gained coverage in Arkansas through the HCIP. Private plans covered roughly 90 percent of that population, while the remaining 10 percent were determined by an enrollment questionnaire to have exceptional health care needs that would be better met through coverage in the traditional Medicaid program. HCIP enrollment to date approaches the projected number of individuals eligible for the program despite legislative restrictions on outreach and education about HCIP.

As a result, the percentage of uninsured Arkansans declined from 22.5 percent to 11.4 percent,⁵ the highest percentage reduction in the number of uninsured relative to every other state.⁶ This reduction stands in sharp contrast with Arkansas's neighboring states, none of which have decided to expand Medicaid in any form. As was suggested in many discussions leading up to passage of the HCIP's enabling legislation, the HCIP has provided some financial shoring for the state's hospital system. Preliminary numbers from the Arkansas Hospital Association show that the number of hospitalized patients lacking insurance fell by 46 percent.⁷

Part 2 – Implementation Tasks

2.1 Marketplace Priorities

With little competition in the marketplace and domination by one large carrier, one of the first and easiest decisions in the governance process was opting for a more passive approach to QHP purchasing rather than an active approach. Prior to the 2013 legislative session, AID Commissioner Bradford, on advice of the plan management and steering committees, made a number of decisions with a passive approach, such as not requiring statewide offerings, not placing a limit on the number of plans a carrier could offer, and not compelling any greater network adequacy threshold than suggested by the federal standard.

In subsequent years, AID has become more active in purchasing, ramping up network adequacy through comprehensive regulation,⁸ and requiring carrier participation in a quality pilot for display to consumers.⁹ Even in an FFM partnership, Arkansas likely has one of the most active marketplaces with respect to purchasing and managing due to plan designs necessary for compliance with Medicaid requirements for the HCIP. These additional

requirements include contracting with at least one federally qualified health center in the service area in which the carrier is participating; ensuring that the actuarial value of the plans offered to individuals between 101 and 150 percent of the FPL are such that HCIP beneficiaries are not exposed to greater cost-sharing than allowed by Medicaid (e.g., copayments no greater than allowed by the federal Medicaid rule); instituting an auto-assignment process for HCIP beneficiaries who fail to complete the enrollment process that enhances market share for historically less competitive carriers; and injecting a questionnaire during the HCIP enrollment process that diverts those who have greater health care needs into traditional Medicaid and lowers the health risk for the private carriers. The auto-assignment process reflected a desire to draw additional competition into the market by targeting a minimum market share for participants. The target minimum market share in a service area varied based on the number of competing carriers as follows:

- Two carriers: 33 percent of HCIP participants in that service area;
- Three carriers: 25 percent of HCIP participants in that service area;
- Four carriers: 20 percent of HCIP participants in that service area; and
- More than four carriers: 10 percent of HCIP participants in that service area.

The most far-reaching marketplace requirement is reflected in the enabling legislation for the HCIP – incorporation of the Arkansas Health Care Payment Improvement Initiative (AHCPII), inclusive of outcome-based payment and support of patient-centered medical homes. The HCIP legislation converted what had previously been voluntary participation in the AHCPII into a requirement. The intent was to reinforce the cost containment and quality improvement strategies employed by Medicaid and voluntary participants in the AHCPII in the private marketplace. In late 2014, AID issued a rule requiring marketplace carriers to participate in the Arkansas patient-centered medical home support, including providing monetary support to providers to transform their practices, attributing patients to practices, and tracking practice transformation milestones and quality measures, with the ultimate goal of offering shared savings to those practices that demonstrate cost containment and quality improvement.

2.2. Leadership – Who Governs?

Although the governance structure, inclusive of advisory committees set up by AID in the early days of the FFM partnership, was at the forefront of decision-making through 2012, executive branch officials took the helm beginning in 2013 with the advent of the HCIP. At the behest of Thompson, then-Arkansas surgeon general and currently director of the Arkansas Center for Health

Improvement, monthly meetings with state agency leaders involved in the HCIP turned into weekly meetings, which led to almost daily face-to-face meetings or conference calls, many of which included participating carriers. The marketplace and Medicaid blend was led by Crone, the AID Health Connector Division director, and DHS Medicaid Director Andy Allison. Regular convening of those leaders along with key staff mitigated turf battles between agencies and allowed for troubleshooting of operational issues, particularly during the development of the HCIP and throughout open enrollment for plan year 2014. This was important given that the HCIP enabling law provided regulatory authority for both agencies, even though both agencies report directly to the governor.

In mid-2014, Allison departed the position of Medicaid director and was succeeded by Dawn Stehle, who had previously led the AHCPII within Medicaid. Following Hutchinson's inauguration as governor in January 2014, Thompson was succeeded as surgeon general by Dr. Greg Bledsoe* and Bradford was succeeded as insurance commissioner by former State Representative Allen Kerr. As governance of the marketplace transitions to the AHIM board in July 2015, the AID Health Connector Division will cease to exist. The significance of these major personnel transitions remains to be seen. Perhaps more important than the personnel transitions are the decisions about the regulatory boundaries between the AHIM board, AID, and Medicaid and the extent to which the AHIM board and its staff can navigate the intricacies of the HCIP.

2.3 Staffing

As is the case with many new projects, the AID Health Connector Division increased its initially small staff significantly to include leads for office operations, plan management, consumer assistance, communications, finance, and agent and broker relationships. Leads were assisted by several staff and outside consultants through 2014. Due to the anticipated transition of operations to the AHIM board and the legislative restrictions on funding for outreach and education, many of the division's staff have migrated to the AHIM board's staff, now comprised of nine and led by Executive Director Cheryl Smith.

DHS is comprised of many divisions, including the Division of Medical Services housing Medicaid and the Division of County Operations conducting eligibility determinations. Despite absorbing an enormous amount of work to enable the HCIP, DHS added no additional staff in compliance with a legislative requirement. In addition to the preoperations policy decisions, work absorbed by DHS staff includes building an enrollment framework for the HCIP inclusive of the health care needs questionnaire through insureark.org; facilitating enrollment of individuals eligible for the Supplemental Nutrition Assistance Program, netting

* Dr. Thompson remains as director of the Arkansas Center for Health Improvement.

approximately 60,000 enrollments; developing and implementing the statutorily required health savings program called Health Independence Accounts; and responding to thousands of beneficiary questions and complaints.

2.4 Outreach and Education; 2.5 Navigational Assistance

Policy decisions regarding outreach, education, and navigational assistance in Arkansas have been guided by a consumer assistance advisory committee through AID, which focused on creating guidelines for outreach efforts and consumer services and developing the state's in-person assister (IPA) guide program.¹⁰ Arkansas was the first state to be granted funding approval by the federal government to develop an IPA program. The IPA guides operated alongside the federally funded navigators, certified application counselors (CACs), brokers, and agents. Extensive training standards and licensure requirements were and continue to be applicable to all individuals assisting with marketplace enrollment.¹¹

In 2013, AID created the Arkansas Health Connector website (<http://ahc.arkansas.gov/>) and a call center to serve as resources for consumers and individuals and organizations assisting consumers. For the 2014 plan year, the department selected twenty-six guide organizations that hired over 500 guides with the guarantee that all seventy-five Arkansas counties would have access to enrollment assistance.¹² To enhance outreach and enrollment to underserved populations — e.g., Hispanics, African Americans, individuals experiencing homelessness — homeless shelters, domestic violence shelters, churches, and various cultural organizations served as guide organizations.¹³ Arkansas additionally had twelve community health centers with eighty-nine sites and a rural health services outreach program that assisted with outreach and enrollment.¹⁴ The guides were supported by 356 CACs, forty-five navigators, and 1,774 agents and brokers licensed to sell marketplace products. Arkansas's recruitment, education and training, and licensure processes have been nationally recognized and replicated.

Prior to open enrollment for the 2014 plan year, AID's legislative appropriation for marketing — and thus its statewide "Get In(sured)" campaign — was held up by the state legislature. Consequently, enrollment assisters lacked the benefit of advertising to draw out potential eligibles. Funding for marketing and enrollment assistance through AID and other state agencies halted altogether during the 89th General Assembly's 2014 fiscal session as a condition of continued HCIP funding. Despite this restriction, fifty guides maintained licensure through AID after June 30, 2014, and some were able to acquire funding from other sources. For the 2015 plan year, there were twenty-two federally funded navigators who worked alongside 287 CACs and 1,257 agents and brokers.¹⁵

2.6 Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. As previously noted in section 2.2, the marriage between Medicaid and private insurance worlds through the HCIP necessitated close intergovernmental relations. A constant focus on agency communications, with the Arkansas surgeon general serving as a third-party convener, has been crucial to the state's successes. Countless times, staff from Arkansas Medicaid and AID entered meetings with divergent positions and left with a unified position. Unanimity has been essential because these agencies are sharing responsibilities in areas that were unexpected – e.g., a Medicaid contractor sends HCIP enrollment transactions to the private insurance carriers; AID certifies plans for marketplace participation and ensures that Medicaid requirements are met; and Medicaid delegates HCIP beneficiary appeals to AID. Much of this shared responsibility is memorialized in memoranda of understanding between the two agencies and each of the participating carriers in the marketplace, something required by the federal government as part of the HCIP waiver terms and conditions.

2.6(b) Intergovernmental Relations/2.6(c) Federal Relations. Due to Arkansas's FFM Partnership and the HCIP, both of which required multifaceted intergovernmental relations with the federal government, it is most appropriate to respond to section 2(b) and 2(c) together.

Leading up to 2013, Arkansas was heavily reliant on the Center for Consumer Information and Insurance Oversight's (CCIIO) interpretation of federal regulations because of the state's more passive approach to the marketplace. This reliance was particularly critical when it came to establishment of the essential health benefits, including parity requirements for habilitative services and medical plans with pediatric dental offerings. In early 2013, when the HCIP began to take shape, the state took a more proactive approach with both CCIIO and the Center for Medicaid and CHIP Services (CMCS). Less than a month after HCIP legislation passed, AID and Medicaid staff from Arkansas met with CCIIO and CMCS officials in Washington, D.C., and relayed the high-level policy decision that the state intended to pursue. During HCIP negotiations over the following several months, state officials regularly found themselves asking questions of CMCS that required involvement from CCIIO.

Federal officials were receptive to state requests that were within their authority. Among the most notable requests that went unfulfilled, however, was the state's request to customize the notification on HealthCare.gov for Arkansas Medicaid eligibles to notify them that they had been determined eligible for the HCIP. Perhaps recognizing the need for a more direct relationship between CCIIO and CMCS after their experience with Arkansas and looming requests from other states to follow the Arkansas approach, CCIIO was soon thereafter placed under the Centers for Medicare & Medicaid Services administrative umbrella.

2.7 QHP Availability and Program Articulation (Arkansas)

2.7(a) Qualified Health Plans (QHPs). The number of insurance carriers offering plans and QHPs available in the individual marketplace depends on a person's location of residence in Arkansas. Historically, private carriers in Arkansas could select from any of the seventy-five counties to offer coverage. Medicaid, of course, is a statewide program. To support market competition, yet assure statewide coverage, AID established seven geographic service areas based on recommendations in an in-depth actuarial analysis. The analysis concluded that creating seven service areas would decrease issuers' administrative burden and create a better opportunity for competition in the marketplace and therefore reduce or maintain premium rates.¹⁶ The state allowed issuers to choose the service area(s) in which they would offer plans, with a goal of having at least three or more issuers per service area. This goal was not met in plan year 2014, but was achieved in the 2015 plan year.¹⁷

In plan year 2014, four insurance carriers offered a total of seventy-one medical QHPs in the individual marketplace, including a variety of bronze, silver, gold, and catastrophic level plans but no platinum plans.¹⁸ The four medical plan insurance carriers were Arkansas Blue Cross and Blue Shield (BCBS), BCBS Multi-state Plan, Celtic Insurance Company, and QCA Health Plan Inc. Enrollees had a choice of between two and four insurance carriers depending on the service area in which individuals resided. The southeast and the southwest areas — often considered to have higher health risk and fewer providers — had the fewest participating carriers, while the central and west central areas had the most, creating differences in the number of QHPs available per service area.¹⁹ For example, individuals residing in the central region had forty-one plan options, while those in the southeast had only three plan options. In 2014, the southeast and southwest areas were served by Arkansas BCBS and the BCBS Multi-state plan, assuring choice necessary for HCIP waiver requirements.

Broader carrier participation in plan year 2015 led to more balanced plan offerings among service areas. A new medical insurance carrier joined the marketplace, bringing the total to five carriers offering medical QHPs in each of the seven service areas. The five carriers were QualChoice Life & Health and the previous four carriers from 2014. With the addition of another carrier to the market, plans available for purchase increased to seventy-five medical QHP options, once again including a range of bronze, silver, gold, and catastrophic plans with no platinum plans available.²⁰ As a result, individuals in each service area had the identical number of plans — thirty-nine QHPs total — from which to select.

In the 2014 plan year, four carriers offered Stand-Alone Dental Plans (SADPs), providing a total of twenty-four SADPs.²¹ The four SADP carriers were Arkansas BCBS, BEST Life and Health Insurance Company, Delta Dental of Arkansas, and Dentegra

Insurance Company. In the 2015 plan year, only three of the dental carriers (Dentegra is no longer participating) are offering SADPs, totaling twenty plan options for purchase.²²

Overall, the average QHP premiums in Arkansas decreased by 2 percent from plan year 2014 to 2015.²³ Factors influencing the decrease included increasing competition in the market and the lower age demographic injected into the market by the state's HCIP.

2.7(b) Clearinghouse or Active Purchaser Marketplace. As discussed in section 2.1, Arkansas initially took a passive approach to purchasing, but before 2014 open enrollment, the state shifted to more active purchasing and a more extensively managed marketplace due to HCIP needs. For the 2016 plan year, Medicaid will implement a new purchasing strategy for QHPs: Medicaid will purchase only those plans with a premium cost that is no greater than 10 percent higher than the second lowest cost plan available to HCIP eligibles.

2.7(c) Program Articulation, Data Systems, and Reporting. Although the state wholly relied on HealthCare.gov to determine eligibility for tax credits and enroll individuals with income above 138 percent of the FPL, the state developed its own portal to enroll individuals in the HCIP. This was due to the inability of HealthCare.gov to customize and the state's need to incorporate program-specific functions such as the health care needs questionnaire. Like every other state relying on the federal eligibility and enrollment portal, Arkansas experienced significant hiccups with the transfer of information about eligibles. In fact, real-time transfers of eligibility information from the federal portal to Arkansas Medicaid never happened throughout 2014, and the processing of batch files of eligibility information remains the norm.

Arkansas developed its own eligibility and enrollment portals, access.arkansas.gov and insureark.org, respectively, both of which worked relatively well and served as a mitigating factor in streamlining enrollment for HCIP eligibles. The state enrollment portal, insureark.org, could receive eligibility determinations from either the federal or the state portal. A complicating factor, however, was that Arkansas opted to be a "determination" state, which meant that the state accepted as true the eligibility determination of the federal portal. This sometimes resulted in two separate eligibility determinations — one at the federal level and one at the state level — leading to system and consumer confusion.

Since 2014 open enrollment, the lag time between an eligibility determination for HCIP and the ability to enroll has been significantly reduced. For HCIP enrollees for the 2015 plan year, the state detached eligibility from enrollment, meaning that individuals could remain with the same plan* without having to revisit the eligibility or enrollment portals. Eligibility redeterminations for the HCIP population are beginning and will continue on

* Plans were restricted to essential health benefits only in plan year 2015. Thus, beneficiaries were able to remain with the same carrier's essential health benefits-only plan.

anniversary dates of the individual's initial determination on a rolling basis, meaning that some will qualify for a special enrollment period if they no longer qualify for the HCIP.

The AID Health Connector Division has worked with marketplace carriers to develop a reporting system to track enrollment by county. The department reports monthly through the agency's website. Other notable information technology developments from AID are the ability of navigators, guides, certified application counselors, and agents to complete training online, along with the ability of guides to report, and the state to track progress on enrollment through an online guide management system.

Because Arkansas Medicaid transfers enrollment information for the HCIP to carriers, enrollment data are readily available. However, the state has had significant difficulty in obtaining information from the participating carriers regarding utilization, quality, and access to support the HCIP waiver evaluation. The carriers appropriately view the premium assistance model quite differently than a managed care model in which the state contracts directly with managed care organizations to acquire necessary data. With any new financing model, there are questions about the legal parameters of data transfers. The state has been working with participating carriers on this issue and has established a data transfer mechanism that will satisfy the requirement of the state to complete its HCIP waiver evaluation.

2.7(d) States That Did Not Expand Medicaid. Arkansas extended coverage to low-income individuals otherwise newly eligible for Medicaid under the ACA through a premium assistance model, formally known as the Health Care Independence Program.

2.7(e) Government and Markets. Arkansas has used state leverage to reform the private market in a number of ways that have been discussed in various sections of this report. By injecting roughly 205,000 relatively healthy individuals into the marketplace through the HCIP, the state reduced the age demographic of the overall marketplace by nearly a decade, resulting in a 2 percent reduction in individual premiums for 2015 and increasing competition by new carrier participation. The state has leveraged an auto-assignment process for the HCIP to guarantee market share for smaller carriers. Perhaps most importantly, the state has furthered payment and delivery system reform in the private market by mandating participation through legislation. On the horizon are QHP quality measurement requirements and the collection and integration of public and private payer claims data to assess future health care system enhancements.

Part 3 – Supplement on Small Business Marketplaces

3.1. Organization of Small Business Exchanges

Arkansas's Small Business Health Options Program (SHOP) is currently administered by the FFM partnership that started

operations in 2014. Small businesses with fifty or fewer employees can purchase a QHP through a trained agent or broker who assists the employers and employees with enrollment.²⁴ Participating carriers must ensure that the offered QHPs cover all Arkansas counties in any geographic region included in its service area and that all QHPs are the same price as the QHPs offered in the individual marketplace.²⁵

Carrier participation in the Arkansas SHOP has been limited since its implementation, with Arkansas BCBS being the only medical issuer participating. Employer enrollment through SHOP, which was limited in 2014, has increased from plan year 2014 to 2015. However, the employer enrollment remains scant, and the majority of participating employers are small businesses with under twenty-five employees.

In 2015, Arkansas implemented “employee choice” through which employers can provide full-time employees and their dependents access to choose a plan from all QHP options within the plan level selected by the employer through the SHOP marketplace.²⁶ For plan year 2016, the Arkansas SHOP will expand eligibility to small businesses with 100 or fewer employees.²⁷ Arkansas also plans to transition the SHOP marketplace from AID authority to the state-based marketplace under the authority of the AHIM board.²⁸ In early 2015, the AHIM board worked with AID to develop guidelines for participating carriers and has selected a vendor to build the information technology infrastructure to support the SHOP.

Part 4 – Summary Analysis

While public opposition to the ACA remains high across the state, Arkansas’s HCIP rates favorably among Arkansans when there is no evident tie to the ACA.²⁹ Consequently, messaging has been and will continue to be key. The “turning-Obamacare-on-its-head” message of the HCIP as an alternative to Medicaid expansion resonated at a time when Arkansas had a Democratic governor with a wealth of statehouse savvy and who enjoyed broad support across the state despite the changing political tide. Messaging was similarly important when Republican Governor Hutchinson endorsed continuation of the HCIP as scheduled, while at the same time pronouncing its termination and a plan to overhaul the entire Medicaid system.

Establishment of the Arkansas General Assembly’s Medicaid Reform Legislative Task Force and the Governor’s Advisory Council on Medicaid Reform provides venues for dialogue. However, the cohesiveness of either group has yet to be tested and polarized positions within each are clearly delineated. As of the close of the 90th Arkansas General Assembly, positions range from a complete repeal to radical innovation under yet-to-be-detailed federal waiver authorities. Continued maintenance of the existing HCIP requirements will likely prove to be challenging as the AHIM marketplace responsibilities are assumed outside the

executive branch, coordinating control with AID and Medicaid. Finally, uncertainty surrounding the ACA due to upcoming U.S. Supreme Court decisions continue to fuel antiexpansion sentiment.

Arkansas's innovative use of premium assistance has established a new alternative for states through Medicaid beyond the traditional fee-for-service or Medicaid managed care strategies. With approximately one-tenth of the working-age population now covered through the HCIP — combined with the stabilizing impact on health care infrastructure, enhanced competition within the insurance marketplace, and justification for state tax cuts — it is difficult to envision the state retreating from its expansion decision. However, distrust and dislike of the federal government and the current federal administration by a majority of legislators, combined with the 75 percent appropriation requirement for programmatic funding, warrant concern.

As the legislative task force begins deliberations about Medicaid reform in Arkansas this year, its members will have access to limited information about the cost-effectiveness of the HCIP through the federally required waiver evaluation due to timing. One of the most innovative and nationally recognized programs developed by the state could be discarded, and state leaders could revert to more tested models and retrofit them for Arkansas. Alternatively, state leaders could assess promising features and refine as necessary, continuing Arkansas's march toward health care reform.

Endnotes

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