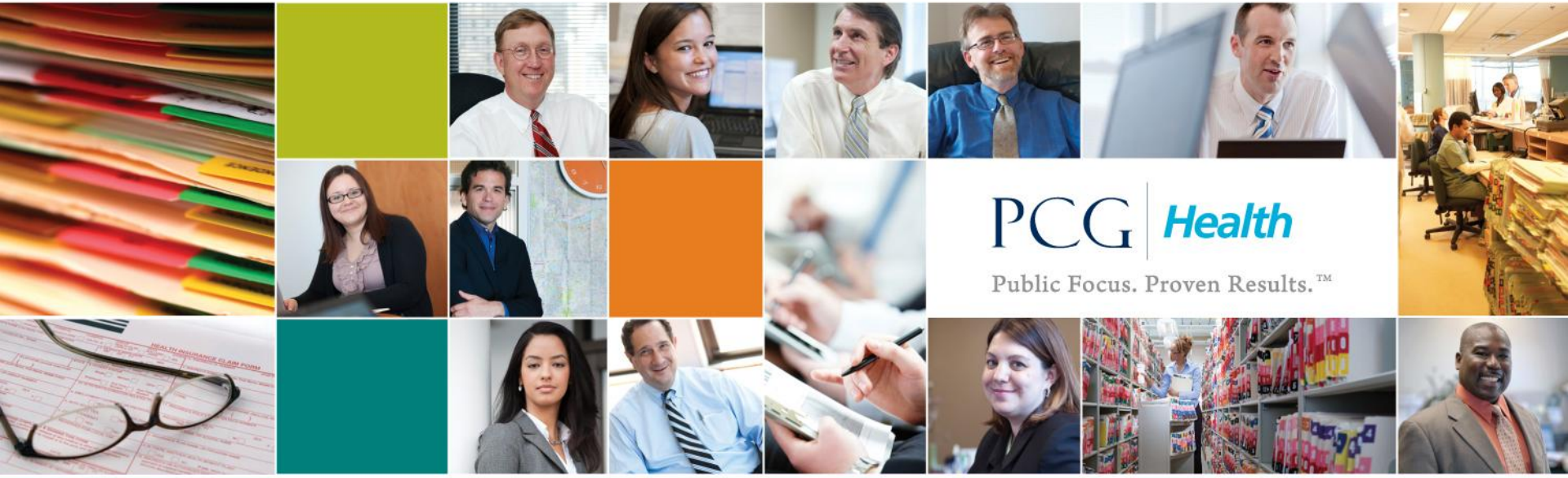
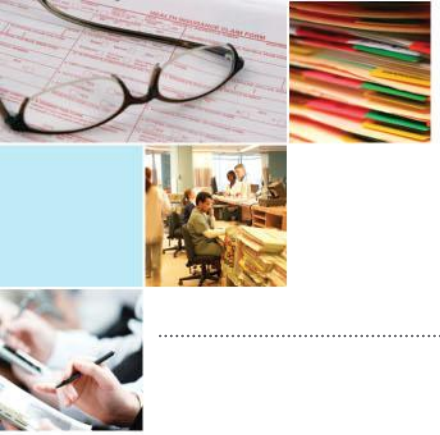
Open Marketplace vs. Active Purchaser

Arkansas QHP Advisory Committee

June 8, 2012





Agenda

- Overview of Presentation
- Active Purchaser vs. Open Marketplace Defined
- Statutory Environment
- Current State Activity
- Possible Approaches to Active Purchasing
- Decision Matrix
- Discussion of Possible Approaches

Overview

- Active Purchaser vs Open Marketplace briefing continues pace of QHP policy development in Arkansas.
- Brief takes place across two months.
- For June, focus is to lay out possible areas of intervention and understand why an Exchange would want to set requirements on plans in these areas.
- For July, those possible “actions” in which the State expresses interest could be developed into a specific proposal and analyzed for cost and administrative impact
- Broad QHP timeline remains focused on policy this summer and operational development this fall.

Defining "Active Purchaser"

- Increasing State intervention in the design of terms guiding how carriers and their plans can participate in the Exchange.
- Focus may be “selective” to raise the bar and ask more of carriers as a condition of their participation.
- Conversely, focus could be “inclusive” to actively attempt to draw more carriers into the Arkansas insurance market.

Defining "Open Marketplace"

- Under this approach, the State takes a more passive role in defining the terms carriers must meet to be certified to offer their plans in the Exchange

- In its purest form, the State allows any plan meeting the ACA's minimum legal criteria to be offered to consumers in the Exchange

- It is generally presumed that a passive State approach creates a more open market for plan participation (hence the name). However, it is possible that some "active" choices made by States could also make the market more "open."

Statutory Environment: Affordable Care Act

- Federal minimum requirements for a health plan to participate in the Exchange can be found in Section 1311 of the ACA and concern five areas:
  - Marketing
  - Network Adequacy-Section
  - Accreditation for performance measures
  - Quality Improvement & Reporting
  - Uniform Reporting Standards

Statutory Environment: Affordable Care Act

- Additional Areas from the ACA Section 1311 that ensure plan compliance with regulatory standards:
  - 1311(c)(1)(B), (C) – Information on the availability of providers, including provider directories and availability of essential community providers
  - 1311(e)(2) – Plan patterns, practices, and justifications for premium increases
  - 1311 (e)(3)(A) – Claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, and cost sharing for out-of-network providers
  - 1311 (e)(3)(C) – Information for consumers requests their for disclosure regarding their amount of cost sharing
  - 1311 (e)(3)(D) – Information for participants in group health plans
  - 1311 (g) – Information on plan quality improvement activities

Current State Activity

- Several states have already begun to develop strategies for how they will approach plan selection activities
  - 6 states are authorized or required to use an active purchaser strategy
    - California, Connecticut, District of Columbia, Oregon, Rhode Island, Vermont
  - 3 states have authorizing language that is silent on the issue
    - Nevada, Washington, West Virginia
  - 2 states are specifically prevented from using the active purchaser model
    - Colorado, Hawaii

Approaches to Active Purchasing

- To promote the interests of the consumer, states pursuing a federal partnership Exchange may broadly engage carriers in setting standards for plan participation, including:
  - Additional Certification Criteria
  - Selective Contracting and Price Negotiation
  - Streamlining Plan and Benefit Designs
  - Piloting New Delivery and Reimbursement Strategies
  - Aligning with Other State Purchasers (i.e. Medicaid)
  - Use of Web-Based Tools to Drive Value-Oriented Decisions
  - Recruiting New Entrants to the Marketplace

Additional Certification Criteria

- Adding certification criteria is a potential strategy to help a state pursue health policy goals that plans can influence.
- Potential downside is that more criteria may increase plan management costs and administrative complexity.
- Possible areas for additional certification criteria
  - Enhanced Quality Standards
    - **Overview by Rick Keller of Treo Solutions**
  - Requirements for plan offerings in underserved parts of the state
  - Enhancements to minimum network adequacy standards
  - Mandatory participation in SHOP Exchange if participating in Individual Exchange
  - Adoption of Arkansas Bundled payment methodology for Exchange plans
  - Criteria to trigger changes in the state health care delivery system

Additional Certification Criteria

- Requirements for plan offerings in underserved parts of the State
  - ACA minimum requirement only for county-wide network planning
  - Carriers may choose to bypass offering plans in rural areas because of perception of too much effort for too little business
  - Conversely, carriers may be motivated to expand to rural areas without being required to do so because premium subsidies create opportunities for significant rural membership uptake
  - Requirement for state-wide offerings will ensure that all Arkansans have the same options for purchasing a plan and increase options available to underserved areas of the state
  - But requirement could inhibit carrier participation in the Exchange
  - May also hinder carriers' ability to tailor a product to a specific area
  - Potential solution: Lowering requirements for out-of-network fees

Additional Certification Criteria

- Enhancement standards for Network Adequacy
  - ACA minimum standards require QHPs to:
    - Include essential community providers;
    - Maintain a network sufficient in number and types of providers to assure access to all services without “unreasonable delay;” and
    - Meet the network adequacy provisions in the Patient Health Safety Act
  - Impact of requiring plans to be offered statewide
  - Cost considerations
  - Ideas for carrots rather than sticks in attracting statewide participation

Additional Certification Criteria

- Mandatory participation in SHOP (small group) Exchange if participating in Individual Exchange
  - Higher premium subsidies and the ACA individual mandate may drive most consumers to the Individual Exchange and not the SHOP Exchange
  - In light of the larger Individual Exchange market, carriers may choose to exclude SHOP plans to reduce cost
  - Requiring issuers entering the Individual Exchange to also make offerings in the SHOP exchange can create more options and coverage for SHOP users
  - Downside risk of driving carriers from the Exchange program altogether or increasing the costs of individual plans

Additional Certification Criteria

- Adoption of Arkansas bundles payment methodology for Exchange plans
  - "Bundled payment" system pays providers for episodes of care, creating incentives to eliminate unnecessary tests and procedures while improving care coordination
  - If required of plans inside the Exchange, this payment methodology may lower overall healthcare costs and promote Medicaid/Exchange integration.
  - However, the administrative complexity of adopting the change by carriers not already set up to use the method may create disincentives to new carriers entering the Arkansas insurance market.

Additional Certification Criteria

- Criteria to effectuate change in the state health care delivery system consistent with current Arkansas health policy goals
  - Payment Reform
  - Delivery System Reform
  - Challenge plans to come to the table with innovative ideas of their own that they can use to compete for customers based on quality.

Selective Contracting and Price Negotiation

- State Exchanges with multiple willing participants have the power limit the number of plans and to negotiate price and terms of the coverage offered
- Two-step process for selective contracting
  - Initial certification process to verify that a plan is qualified to participate in the Exchange
  - All certified plans would be permitted to bid on Exchange business and the Exchange can select plans based on these bids
- Arkansas price negotiations may be difficult because of the concentration of the market and small number of plans
- Active purchasing habits may drive plans from the market, and the Exchange may then not have enough partners to warrant a selective contracting approach

Streamlining Plan and Benefit Offerings

- Avoid overwhelming consumers with choices in the Exchange that, in reality, offer the same coverage
- Limiting the amount of plans sold at each metallic level and setting up standards of cost sharing, especially by the same carrier
- Put rules in place to set percentage differences between copays and deductibles between each plan
- Limiting the number of plans offered can be difficult in the highly concentrated Arkansas market

Piloting New Delivery System and Reimbursement Strategies

- Exchanges have the potential to drive long-term systematic change to the health care system
- Arkansas can require plans to experiment with reimbursements methodologies or value-based purchasing models
- Mandating that every plan on the Exchange provide some new element can encourage innovation in the practices of the health care system
- This may pose a risk of negatively affecting insurers who are forced to include risky or unprofitable models in their practices, and can cause some to elect not to participate in the Exchange program

Aligning with Other State Purchasers

- Collaborations could focus on individuals whose incomes fluctuate, and as a result will move in an out of eligibility for the two programs
- One possibility to ease this transition is to require Exchange insurers to offer Medicaid Managed care products as “bridge plans.” These could be limited to those leaving the Exchange for Medicaid.
- Any introduction of Medicaid managed care would require significant administrative and policy support from the state Medicaid agency

Use Web-Based Tools to Drive Value-Oriented Decisions

- Web-based decision tools are useful in leveraging consumer actions and choices
- Effective web-based tools help customers take into account more than just price and availability
- These tools will assist the Exchange in highlighting programs that perform exceptionally well in other areas:
  - Cost-sharing arrangements
  - Quality rankings
  - Key ratios
  - Customer service surveys

Recruiting New Entrants to the Marketplace

- Should Arkansas actively try to recruit new plans to the market?
- What strategies can Arkansas use to do so?
- Medicaid expansion brings 251,000 new health care customers forward. Can Arkansas use this to leverage more plans coming to the market?
- Would Arkansas consider setting Medicaid managed care certification criteria that requires Exchange participation of plans to gain share of Medicaid market?

Decision Matrix

- The Decision Matrix is intended to frame the decision points related to Open Marketplace versus Active Purchaser Exchange programs.

Item	Why Pursue?	Why Not Pursue?	Recommendation
Quality Criteria			
Statewide Offerings			
Enhanced Network Adequacy Standards			
SHOP Participation			
Adopt AR Payment Improvement Method			
TBD Delivery System Reforms			
Selective Contracting and Price Negotiations			
Streamlining Plan and Benefit Designs			
Piloting New Delivery System and Reimbursement Strategies			
Aligning with Medicaid			
Web Based Tools to Drive Value-Oriented Decisions			
Recruiting new entrants to the market			

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