

Arkansas Qualified Health Plan Management: Open Marketplace vs. Active Purchaser

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I. Introduction

Arkansas' Federally-Facilitated Partnership Exchange is the venue through which most non-Medicaid eligible, uninsured Arkansans will purchase health insurance coverage in the individual and small group markets beginning in 2014. The Exchange is intended to organize insurance markets, to increase competition amongst health insurance carriers and to use tax credits to make coverage more affordable.

The Affordable Care Act (ACA) provides states with wide latitude in how they organize and run their Exchanges, leaving many decision points for Arkansas. One of these options is positioning the Exchange as an "active purchaser" versus an "open marketplace." There is debate among policy makers and among states (with different states already taking differing approaches) about the relative value of these two approaches. Differences in the status of insurance markets across states means not all states will find the same value in the same approach.

The "active purchaser" model can take many different forms. For example, an Exchange could contract with select insurance carriers or establish Exchange certification criteria beyond the minimum requirements of the ACA. The Exchange might choose to negotiate with issuers on the price of plans.

Being selective in choosing plans is not the only way an Exchange can be an "active purchaser." Other strategies might include taking active steps to draw more plans into the market. The Exchange may also wish to align qualified health plan offerings with other programs, such as Medicaid, or other delivery or payment system reforms being pursued in the state.

A contrasting approach to the active purchaser model is the open marketplace. This describes an Exchange adopting a more passive approach to plan selection that allows any plan meeting the ACA's minimum legal criteria to be available for purchase by the state's consumers via the Exchange's marketplace.

This issue brief is designed to help the members of the Plan Management Advisory Committee determine an approach that works best for Arkansas. It includes background information that identifies Affordable Care Act minimum requirements for health plan certification. It summarizes approaches being taken by other states. It considers the variety of ways health plan selection could be "active."

Finally, this paper frames a series of policy questions for the Advisory Committee to determine. The goal for June is for the Advisory Committee to generally recommend whether the interest of Exchange consumers will be better supported by a more active or more open approach to plan selection. To that end, a "decision matrix" is provided at the close of this paper to facilitate Advisory Committee input on these issues. The July issue brief will then dig deeper into strategies for successfully implementing an active or open approach to plan management.

II. Statutory Requirements and Regulations

The ACA itself establishes minimum requirements a health plan must meet to participate in the Exchange. This includes offering the Essential Health Benefit package, meeting cost sharing and actuarial value requirements, and satisfying certain certification criteria. These criteria are established in Section 1311(c) of the ACA, which requires the Secretary of the United States Department of Health and Human Services to develop regulatory standards in the following five areas:

- Marketing
- Network adequacy
- Accreditation for performance measures
- Quality improvement and reporting
- Uniform enrollment procedures

Additional areas from the ACA where Exchanges must ensure plan compliance with regulatory standards established by the Secretary include:

- Information on the availability of in-network and out-of-network providers as identified in Section 1311(c)(1)(B) and (C), including provider directories and availability of essential community providers
- Consideration of plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases under Section 1311(e)(2)
- Public disclosure of plan data identified in Section 1311(e)(3)(A), including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by the Secretary
- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers as described in Section 1311(e)(3)(C)
- Information for participants in group health plans as described in Section 1311(e)(3)(D)
- Information on plan quality improvement activities as specified in Section 1311(g)

The federal government's initial guidance to States on Exchanges¹ provides States with the broad power to exercise "discretion to determine whether health plans offered through the Exchange

¹ <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-Exchanges.html>

are ‘in the interests of qualified individuals and qualified employers’ as Section 1311(e)(1) requires.”

III. Current State Activity

States have already begun to develop approaches regarding how active or open they will be in their plan selection activities. Six states are either authorized or required to use an active purchaser strategy. Three states have authorizing language that is silent on the issue. Two states are specifically prevented from using the active purchaser model².

States that have moved in the direction of an active purchaser mode include:

- **California:** Authorizing legislation *requires* the state’s Exchange to use a competitive process to select carriers.
- **Connecticut:** Authorizing legislation allows the Exchange to use selective criteria to determine plan participation, as long as there are an adequate number of choices.
- **District of Columbia:** Authorizing legislation allows the Exchange to use selective criteria to determine plan participation, as long as there are an adequate number of choices.
- **Oregon:** Authorizing legislation allows the state to enter into contract terms with plans, but requires the same terms apply to all insurers.
- **Rhode Island:** authorizing executive order allows the Exchange to choose plans beyond minimum standards.
- **Vermont:** allows the Commissioner of Vermont Health Access to organize contract terms with insurers upon a determination of a plan’s quality, affordability, and other standards.”

States specifically prevented from using active purchaser model include:

- **Colorado:** authorizing legislation specifically prohibits the Exchange from being an active purchaser.
- **Hawaii:** authorizing legislation requires all qualified health plans to be offered on the Exchange.

States silent on active purchaser model:

- **Nevada**
- **Washington**
- **West Virginia**

² <http://www.statereform.org/blog/Six-States-Give-Green-Light-to-Active-Purchasing-in-the-Exchange>

III. Possible Approaches to Active Purchasing

In the open marketplace model, the Exchange adds no standards to the minimum federal criteria used to determine which plans may be offered to consumers in the Exchange. These requirements include standards for accreditation, essential health benefits, marketing, network adequacy, quality improvement, standardization of enrollment forms, and transparency. Under this approach, the Exchange would allow all plans that meet the baseline criteria to sell their products on the Exchange if they apply to do so.

An active purchaser model would mean exceeding the minimum federal requirements that plans must meet in order to be offered on the Exchange in order to promote the interest of consumers. A 2011 Robert Wood Johnson foundation report identified seven possible categories of approaches to active purchasing. They are:

- Additional Certification Criteria
- Selective Contracting and Price Negotiation
- Streamlining Plan and Benefit Designs
- Piloting New Delivery System and Reimbursement Strategies
- Aligning with Other State Purchasers (i.e. Medicaid)
- Use of Web-based Decision Tools to Drive Value-Oriented Decisions
- Recruiting new entrants to the marketplace

In this paper, PCG will provide background information to describe each approach and provide a decision matrix for Advisory Committee members to provide input.

1) Additional Certification Criteria

As previously mentioned, the ACA established minimum standards plans must meet in order to participate on an Exchange. The ACA allows for states to build on these minimum standards to meet state-specific goals.

These include plan quality, access to providers, and delivery system reform. Other ideas are requiring plans to participate in specific efforts, such as IT reform and having strategies for continuity of care for individuals who move from public programs due to changes in income.

In order to establish additional certification criteria, the Exchange would have to determine which additional criteria it wanted to create and then issue guidance to plans explaining the criteria and how it must be met.

While adding criteria provides the benefit of creating higher standards, ensuring coverage options for those in rural areas, and/or helping to promote certain programs, it could also work to dissuade insurers from offering plans on the Exchange if the additional criteria are deemed overly onerous to meet.

Arkansas must also weigh the potential administrative cost of adding certification criteria as well as the administrative burden and timeliness challenges this will place on the organization charged with approving QHPs. As the Advisory Committee identifies potential plan selection criteria, PCG will further consider cost impact in our July analysis.

The following list provides areas in which Arkansas may want to consider additional certification criteria. Following the list, each area is discussed in more detail.

Possible areas for additional certification criteria:

- Enhanced quality standards
- Requirements for plan offerings in underserved parts of the state (state wide coverage requirement)
- 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

Enhanced quality standards

A key part of the Exchanges, as detailed in the Act, is providing consumers and employers with access to a wide range of customer assistance tools – including information about prices, quality, and physician and hospital networks.

In Arkansas, the Exchange is being established as a Federally-Facilitated Partnership through which Arkansas can choose to operate functions it has traditionally performed including managing insurance plans and assisting consumers through outreach and education. As part of insurance plan management, Arkansas will not only conduct plan management functions, such as insurance plan selection, rating, monitoring and oversight, it will be responsible for working with public and private payers to set plan and care standards and evaluate outcomes that align with the State's quality improvement efforts and will help inform both providers and consumers, designing economic incentives for both. Thus, the Exchange will be a key driver of value—that is, encouraging the delivery of care by providers and plans that result in improving outcomes and quality while controlling or reducing costs.

A key question facing the Arkansas Exchange is what metrics can be used to help determine value for consumers and the State Medicaid program. There are many quality measures being used at the federal and state levels—as well as by individual health plans. In fact, Medicare is engaged in a value-based purchasing program that incorporates both financial rewards and penalties for provider performance in reducing readmissions and healthcare-associated infections as well as for improving the patient experience. Likewise, the federally-designated Accountable Care Organizations (ACOs) must meet 33 quality measures related to the patient and caregiver

experience, care coordination and patient safety, preventive care, and the care of at-risk populations.

States, like Florida, and individual health plans across the country are finding that simply reporting or sharing comparative provider-specific quality measures, such as readmissions, with no financial incentives attached, leads to changes in behavior and improvements in care.

Given the significant changes in the health insurance marketplace driven by Exchanges, Arkansas may want to consider a number of different outcome-based measures, which can be phased in over time—perhaps beginning with sharing and public reporting of plan and/or provider-specific key metrics and then incorporating financial incentives to incent additional changes in behavior.

In our response to Arkansas' Qualified Health Plan Specialist request for proposal, PCG partnered with Treo Solutions to provide the quality metrics requirements of the scope of work. Treo has provided the content for the quality section of this paper, and a representative of Treo will be present at the Plan Management Advisory Committee meeting on Friday, June 8, 2012.

Treo has done extensive research into valid, credible metrics that enable solid and easy-to-understand review of plan and provider performance, and can be influenced by changes in provider behavior. They take into account patient conditions, processes of care, and outcomes of care. These metrics, organized by domain, provide in the aggregate, a holistic overview of the quality of care; can be used to provide a quality perspective of the value for dollars spent; enable the ability to find specific opportunities for improvement; and rely on current claims data. The following highlights domains of measures for consideration by Arkansas as it develops its Exchange in partnership with federal agencies.

Patient Experience: Recent studies have shown that patient experience has an impact on clinical outcomes. As a result, payers are looking closely at patient experience as a value-based purchasing (VBP) metric. For example, the Centers for Medicare and Medicaid Services is now using patient experience as measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for Medicare VBP. This marks the movement towards new and growing financial incentives to strengthen patient experiences with care. In order to account for this emerging focus and to meet the Exchange's mandate to publish perception of care measures, Arkansas may wish to consider including the following four core measures, which are drawn from the *How's Your Health* survey developed by John Wasson, MD Professor of Community and Family Medicine, and Medicine at Dartmouth Medical School:

- Patient confidence
- Continuity of care
- Office efficiency
- Access to care

Primary and Secondary Prevention: Drawn from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, Primary and Secondary Prevention measures can be considered. They can include metrics such as:

- Provider's pediatric well-visits for children 30 days to 15 months, and 3 years to 6 years
- Provider's mammogram screening to applicable patient populations
- Provider's colorectal cancer screening to eligible patient population

In addition, other screening measures, such as screening for cervical cancer or diabetes, can be added.

Tertiary Prevention: A tertiary prevention set of measures that evaluate the effectiveness of a provider in addressing "sick" care can be considered, such as:

- Percent difference between the expected number of hospital admissions that are potentially preventable and the actual rate of the provider's population
- Percent difference between the expected number of hospital emergency room visits that are potentially preventable and the rate of the provider's population

Population Health Status: One measure for determining providers' ability to deliver quality care is their ability to manage the health status of their patient panel from one time period to another. A risk-adjusted assessment of the percent difference between the expected rate of disease progression and the actual rate of the disease progression in the provider's patient panel may offer another useful set of metrics. Two metrics of disease progression to be considered are:

- change in the number of chronic conditions
- change in the severity within the chronic conditions

Continuity of Care is associated with a number of positive outcomes, such as lower rates of hospitalization and readmissions, more efficient medical care, and higher patient satisfaction.

Specifically, measures can include:

- Percent difference between the expected Continuity of Care score for providers serving similar populations and the actual score for the provider's panel (as published by Bice, T. W., & Boxerman, S. B. (1977). A Quantitative Measure of Continuity of Care. *Medical Care*, 15(4), 347-349)
- Percent of the provider's panel visiting a primary care provider (PCP)
- Percent of the provider's panel who are non-users of health service

Chronic Care Follow Up: For members of the population who have chronic conditions, three measures can be considered:

- Percent difference between the number of expected hospital readmissions that are potentially preventable and the provider's actual number of potentially preventable readmissions
- Percent of the provider's panel that visited a physician office within 30 days post-discharge
- Percent of the provider's panel with chronic disease that have three or more physician visits

Efficiency measures can help to determine the appropriate use of outpatient services for a physician's panel as well as the physician's rate of prescribing generic medications. The analysis of outpatient services examines potentially preventable ancillary services, such as an MRI, ordered by primary care physicians or specialists that may not provide useful information for diagnosis and treatment (e.g., MRI for back pain). Specifically, measures can include:

- Percent difference between a physician's historic and current performance on potentially preventable services
- Percent difference between a physician's historic and current rate of prescribing generic drugs

These measures, which are currently being incorporated by health plans across the country, serve as a starting point as Arkansas develops its health insurance Exchange and defines its goals and objectives for driving value in the new insurance marketplace.

Requirements for plan offerings in underserved parts of the state (statewide coverage requirement)

Arkansas may want to consider requiring Exchange plans to offer statewide coverage in their networks. The ACA only requires plan networks to be county-wide, not statewide. Many states, including Arkansas, have a gap in coverage options between urban and rural areas. These gaps can be due to several reasons. The population of providers is lower in rural areas, on a raw and sometimes a per capita basis.

In addition, plans may not make the effort to recruit providers into their networks in rural areas since doing so may be perceived to be too much effort to gain too little business. However, since the Exchange will be the only place where plans can capture the subsidized market, issuers may be more open to expanded networks for their Exchange products.

Requiring plans to have statewide networks would assure that all citizens of the state have the same options when it comes to purchasing a plan from the Exchange. It would also increase options available to those who live in more rural and traditionally underserved areas of the state. However, it does run the risk of dissuading plans from offering products on the Exchange.

For example, if a company currently does business in Arkansas but lacks a statewide product, it may not offer an Exchange plan if it must be statewide, though the company may be willing to do so if it may offer a Little Rock (or other area) specific plan. Another potential drawback to statewide requirements is plans will not be able to tailor a project to one specific area, be it rural or urban. One potential solution to this situation would be to require out-of-network penalties to be eased for Exchange plans when a covered individual accesses an out-of-network provider anywhere in the state.

Enhancements to minimum network adequacy standards

In the final regulations (“Exchange Establishment Standards and Other Related Standards under the Affordable Care Act.”) published in the Federal Register, March 27, 2012, HHS set out the minimum requirements for network adequacy that a plan related must meet to be certified as a QHP.

In “Subpart C – Qualified Health Plan Minimum Certification Standards, section 156.230 Network Adequacy standards,” the rules state that a QHP issuer must ensure that the provider network of each of its QHPs meets these standards: 1) include essential community providers; 2) maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and 3) is consistent with the network adequacy provisions of section 2702(c) of the Patient Health Safety Act.

In addition, the final rules require a QHP issuer to make its provider directory for a QHP available to the Exchange for publication online and to potential enrollees upon request. The provider directory must identify providers that are not accepting new patients.

Exchange officials in Arkansas will have to determine if these requirements are sufficient, or if additional criteria should be established. The rules do not specifically enhance coverage options for those in rural areas or whose coverage options may be limited for other reasons. Increased competition from the Exchange may solve these issues, but if they haven’t been solved so far, there is no guarantee Exchange completion will solve them either.

Network requirements could be used to ensure that hard-to-reach consumers can receive care from Exchange plans. Options include required and on-going recruitment of new providers (perhaps with a focus on primary care) and perhaps use of specialty mobile health units in provider networks to ensure that care reaches all regions of Arkansas.

It is possible that harder to reach individuals will have higher health costs, which may dissuade plans from wanting to reach them or may possibly drive up the costs of insurance for Exchange plans, leading to adverse selection and driving individuals in areas with more choices from the Exchange to purchase plans outside the Exchange.



As with other options, increasing provider network requirements inside the Exchange will have to be carefully weighed for its potential affect on issuers wanting to do business in the Exchange, and also the end cost to the consumer.

Mandatory participation in SHOP Exchange if participating in Individual Exchange

Estimates for Exchange participation across the nation anticipate significantly higher participation levels in the individual Exchange than the small group (or SHOP) Exchange. The individual mandate will drive those without insurance to the individual Exchange, and perhaps more importantly, premium subsidies are available in the individual Exchange for those at varying income levels. For these reasons, individual Exchange participation is expected to be much higher than SHOP participation.

Due to the anticipated larger market, some issuers may choose to offer plans in the individual market only and not offer a SHOP plan. If too many plans only participate in the individual market Exchange, it could significantly reduce options in the SHOP Exchange. It is anticipated that participation by issuers only in the SHOP Exchange will not be widespread.

A lack of plans in the SHOP Exchange could be detrimental to its success. Without the heavy level of subsidies that will be available in the individual Exchange, the SHOP Exchange will have to rely on the benefits it provides businesses (such as premium aggregation) and the selection of plans in order to gain participants.

One way to assure that the SHOP Exchange has enough plans to drive completion amongst the plans and also make it an attractive place to shop for small business health insurance products is to increase the amount of plans available for sale within it. Perhaps the easiest way to accomplish this is to require all issuers that sell insurance in the individual Exchange to also sell products in the SHOP Exchange.

It may not make sense to require issuers to offer the same number of plans in both Exchanges. Due to the different metallic levels and other complexities of the individual Exchange, it is only natural that a higher number of plans will be available in the individual Exchange. However, it is not unrealistic to require any issuer that wants to offer a plan in the individual market to include an offering in the small group Exchange.

Once again, this does carry the downside of possibly driving issuers from the Exchange altogether if a company does not want to design a small group plan. However, since most companies that do business in the individual market also do business in the small group, this may not be that much of a risk.

Adoption of Arkansas bundled payment methodology for Exchange plans

A new initiative underway in Arkansas is a “bundled payment” methodology that involves both public and private payers. As stated on the Department of Human Services’ (DHS) website³:

“In an effort to make health care more affordable and to improve the quality of care, the DHS is working with health insurers, doctors, hospitals and other health providers to transform the payment structure of the health care system statewide. Department leaders began this effort with the support of Gov. Mike Beebe because they recognized that Medicaid programs in every state are facing a growing challenge of providing good care with limited resources. To avoid making the dramatic cuts that other states are making to Medicaid programs, Arkansas leaders decided to truly transform the state's health care system so that it is sustainable in the long-term. But they knew the problems facing Medicaid also were facing private payers. DHS and Medicaid have partnered with private insurers to change the current volume-driven model to one that pays health care providers for episodes of care and incentivizes quality care. The intent is to eliminate duplicate tests, poor coordination between your health care providers and unnecessary procedures. Initially, we will focus on six clinical episodes: Ambulatory Upper Respiratory Infections, Cardiovascular Disease, Developmental Disabilities, Behavioral Health, Musculoskeletal Disease, and Pregnancy/NICU.”

The cost of providing coverage to the Exchange population, particularly for those receiving subsidies via the individual Exchange, will likely track with general health costs and those on Medicaid in particular. The Exchange board may want to require Exchange plans to follow the same payment strategy being undertaken in Medicaid. This could help drive statewide change and lower the cost of care throughout the state. It would also serve to more closely align Exchange participants with Medicaid, which may ease confusion due to the anticipated churning between the two programs.

However, mandating payment methodology on plans could be seen as an overreach of Exchange authority and prevent private plans from utilizing their own methodology or continuing to innovate new ideas. Also, forcing a bundled payment methodology on private insurers in order to do business on the Exchange may have the effect of making them choose to do business outside of the Exchange exclusively, if they do not want to follow new regulations on payment structures.

Criteria to trigger changes in the state health care delivery system

The Exchange may want to require issuers, in order to be certified to sell products on the Exchange, to demonstrate their plans include measures that will help to promote better value and improve the overall health delivery system in the state. These may include measures that

³ <http://humanservices.arkansas.gov/director/Pages/APII.aspx>

improve health and wellness, improve quality, lower health care costs and/or reduce health disparities and outcomes amongst the population.

Possible requirements could include mandates on the payment structure of health plans in the Exchange, administrative complexity adjustments, and other innovations. In contrast to the previously mentioned alignment with Medicaid bundled payment methodology, this could be a more open approach. Instead of mandating that Exchange plans follow a specific reform initiative, they could simply be required to demonstrate they are taking some action to foment change in the health care system.

This option most likely has less potential danger of driving plans from the Exchange, since most plans are already taking action to control cost and create reforms to the system. However, like all of the other options, any additional requirements must be carefully weighed against potentially driving issuers away from the Exchange.

2) Selective Contracting and Price Negotiation

Those who support more active regulation and power in Exchanges often argue that selective contracting and price negotiation is at the heart of the value Exchanges can add to the health insurance marketplace. In a situation with multiple plans trying to enter the Exchange marketplace, an Exchange would have the power and ability to limit the number of plans on the Exchange and negotiate on contract terms and the price of coverage offered in the Exchange.

The Robert Wood Johnson foundation identified a two step process for selective contracting and price negotiation. First, there would be an initial certification process that verified a plan was qualified to participate on an Exchange, ensuring the plan met ACA and any additional standards of the Arkansas Exchange. Then, all certified plans would be permitted to bid on Exchange business and the Arkansas Exchange would select plans based on these bids. It would be up to Exchange officials if a formal request for proposal process is used, or if a more informal negotiation process was put in place.

Such a process has the potential to help keep costs down for Exchange consumers. However, it is important to note that the ACA does place some limits on what an Exchange can do in terms of price negotiation. Section 1311(e)(1)(B) specifically prohibits an Exchange from precluding a plan via “the imposition of premium price controls.” This is not specifically defined, but it assumed to mean that an Exchange can’t specifically require a certain price be charged for certain benefit packages; however, price negotiation and competition is allowed.

For example, California is expected to be able stimulate price competition amongst insurers. It is believed that in that state health plans will want a place in the Exchange marketplace, and in order to do so will have to compete on price and value to earn a spot. So, while specifically demanding certain prices is not legal, price negotiation, competition, and selection of plans using price as a criteria is seen as being within the legal realm of active purchasing. However, there must be enough competition in the marketplace to make price competition and negotiation work.

A review of the current Arkansas health insurance marketplace raises some flags about the potential efficacy of selective contracting and price negotiation in the state. Given the lack of competition in the market, negotiations may prove difficult. The marketplace is concentrated and there may not be enough plans to negotiate with. Just how concentrated the marketplace is in Arkansas is demonstrated by an October 2011 study performed by the Kaiser Family Foundation⁴ on health insurance market concentration in the 50 states.

The goal of this study was to assist states in making Exchange related decisions, including the question of being an active purchaser versus the open marketplace model. The paper analyzes markets on several criteria, including market share of the largest insurer, the number of insurers with at least five percent of the market, and through the Herfindahl-Hirschman Index (HHI). The HHI is a commonly used tool to measure market concentration in a variety of industries. According to the Kaiser study:

“HHI values range from 0 to 10,000, with a value closer to zero indicating a more competitive market and values closer to 10,000 indicating a less competitive market. As a rule of thumb, an HHI index below 1,000 indicates a highly competitive market, and a value between 1,000 and 1,500 indicates an unconcentrated market. Values between 1,500 and 2,500 suggest moderate concentration, and markets with results above 2,500 are generally considered highly concentrated.”

The study was conducted for both the individual and small group markets. The following chart summarizes where Arkansas stands in relation to national figures.

Individual Market	Arkansas	United States
Number of Insurers with More than 5% Market Share	3	4
Market Share of Largest Insurer (Based on Enrollment)	77%	54%
Herfindahl-Hirschman Index (HHI)	5,954	3,761

Small Group Market	Arkansas	United States
Number of Insurers with More than 5% Market Share	3	4
Market Share of Largest Insurer (Based on Enrollment)	51%	51%
Herfindahl-Hirschman Index (HHI)	3,518	3,595

⁴ <http://www.kff.org/healthreform/upload/8242.pdf>

In Arkansas, the number of companies with at least five percent of the market is low, the market share of the largest company is high, and the HHI index indicates that both the individual and small group markets in Arkansas are highly concentrated.

Looking at the figures in more detail, the state's Individual Market in particular appears to be particularly concentrated, both in terms of the market share of the largest plan and when compared to national figures. While the small group market is more on par with national figures, it is still concentrated, both in terms of the HHI as well as with the number of insurers with meaningful market share.

It may be important to remember that, of the two markets, competition amongst insurers in the individual market may be more crucial than in the small group, since Exchange subsidies are focused on the individual market, and overall enrollment may be more robust in the individual than small group market. Thus, the concentration of the individual market is likely of more importance than that of the small group.

Since the individual market is particularly concentrated it may be difficult for the state to negotiate with plans on price or other criteria and then move forward to deny entry to other plans if they are not able to meet the higher standards. Active purchasing of this nature may have the unintended consequence of driving plans from the Exchange marketplace and limiting consumer choice, particularly if only the plan with the largest market share is willing and able to negotiate with the Exchange. The Exchange simply may not have enough partners to warrant a selective contracting approach.

3) Streamlining Plan and Benefit Offerings

Another potential use of active purchasing is not limiting the amount of companies on the Exchange, but instead limiting the amount of plans sold at each metallic level and setting standards for cost sharing. The goal of this would be to limit consumer confusion that could be caused by having an extraordinary number of plans at each level.

One nuance of the ACA's actuarial value methodology for establishing metallic plan levels is that, while issuers are required to offer plans with the full essential health benefits package and other standardized criteria, there is not a standardization of cost-sharing. Cost-sharing in the ACA sets the criteria by which plans are placed at the differing metallic level.

The metallic levels of coverage that plans will be categorized by the ACA are not defined by defined deductibles, copayments, or coinsurance. Instead, "actuarial value" (AV) is used. An example is probably the easiest way to understand this concept. A plan with an AV of 60% (a Bronze plan) means that for a standard population, the plan will pay 60% of their health care expenses, while the enrollees in it will pay 40% of the cost through some combination of deductibles, copays, and coinsurance. The higher the actuarial value, the less patient cost-sharing the plan will have on average. The percentage a plan pays for any given enrollee will generally be different from the actuarial value, which is an aggregated average in terms of spending.

Since the cost sharing can take many different forms, one health insurance company could, in theory, offer a multitude of “different” plans at the same metallic level by gaming the cost-sharing of each plan, despite the fact that the coverage being offered was essentially the same. This could be done in an attempt to distract consumers and drive other companies from the marketplace.

The active purchaser model could be used to prevent this potential pitfall from becoming a reality and is already in place in some areas.

The Massachusetts Connector limits carriers to only offering a few plans at each metallic level. This is similar to the approach CMS intends to take with Medicare Part D plans. In upcoming years, CMS will only approve new Part D plans that are “substantially different” from those currently being offered to consumers.

Perhaps most interestingly, recently officials at the Consumer Information and Insurance Oversight (CCIIO) have indicated they are considering action of this nature for the Federally Facilitated Exchange. Though methodology is not finalized, it appears CCIIO may limit the amount of plans sold at a specific metallic level by a particular insurer by making sure there are legitimate differences in the pricing structure of the plan. It is expected a threshold percentage difference in plan make-up (in terms of cost sharing structure) will be established.

Existing government models, as seen with the Massachusetts Connector and the CMS approach to Part D, are designed to limit consumer confusion resulting from having too many plans listed for sale and confusing consumers.

Arkansas may want to utilize the active purchaser option to make sure that consumers are not overwhelmed by apparent choices in the Exchange that, in reality, are not very different. This could be done by limiting the amount of plans a company may offer at a specific metallic level, by setting percentage differences in the varying cost sharing structures (e.g. there must be a 10% change in the difference between copays and deductibles for each plan), or by simply placing companies on notice that the amount of plans they offer at each metallic level are subject to review and removal if abuse is perceived.

This could be a potential pitfall in states like Arkansas, where a high market share concentration among issuers exists. One issuer thus could take steps to offer a multitude of products in an effort to prevent other companies from entering the state and offering plans on the Exchange.

4) Piloting New Delivery System and Reimbursement Strategies

Some policy and health care experts believe Exchanges can be used to drive long-term systematic change to the health care system. Under the active purchasing model, Arkansas Exchange officials would have the opportunity to require plans to experiment with reimbursement methodologies or experiment with value-based purchasing models. In value

based purchasing, there is an attempt to align consumers' out-of-pocket medical with the value of a service to their health rather than the price of the care. Examples for this include providing preventative care for free, while charging higher co-pays for procedures that may be costly and not extremely effective.

Active purchasing of this nature could be as stringent or open as Exchange officials desired. It could be as simple as mandating that every plan on the Exchange include some innovative approaches that are reviewed one-by-one, or creating a statewide initiative that all plans have to include in order to be included on the Exchange's marketplace.

There is significant opportunity for innovation and experimentation within the Exchange if plans are mandated to include certain new element. However a potential issue for Arkansas is concern about driving plans from the state. Complex requirements in this regard may make plans decide to not apply to be on the Exchange in order to avoid creating new workload not perceived to be sustainable in plan pricing.

5) Aligning with Other State Purchasers (e.g. Medicaid)

Medicaid in Arkansas has taken steps to adopt a bundled payment system. Similar to health homes, the bundled payments would start to transform the state's current fee-for-service Medicaid system to one that provides reimbursement for episodes of care in one bundled payment. Exchange officials may want to work with Medicaid leadership to find ways to have Exchange plans include elements that replicate this approach, in order to help drive statewide reform.

To be clear, this would not be a combination of risk pools with private Exchange plans and the public program of Medicaid. Instead, Exchange officials would work with Medicaid to find areas in which collaboration makes sense (such as bundled payments) and then require that plans must include these elements in order to be included on the Exchange's marketplace.

Another way the Exchange may want to align its offerings with Medicaid is to create continuity of care products across the two payer sources. As individual's income fluctuates, they may either lose or gain Medicaid eligibility. The Exchange may want to require qualified health plans to take steps to make sure an individual's medical care is not disrupted during this change in coverage status. One possibility is to require qualified health plans in the Exchange to offer Medicaid managed care products, at least as a transition "bridge" for those who come to Medicaid via the Exchange.

Any introduction of Medicaid managed care would, however, require administrative and policy support from the state Medicaid agency. This would include establishment of a contract process, a capitation rate setting process, a plan enrollment process on the Medicaid side and systems to support encounter claims intake and distribution of membership rosters to plans.

6) Use of Web-based Decision Tools to Drive Value-Oriented Decisions

The use of web-based decision tools is an attempt to use the Exchange's website to help leverage consumer actions and choices. Some expect that consumers will make purchasing decisions on the Exchange based on only two factors: price and provider availability. This may leave out many other important factors, such as exact cost sharing arrangements, the quality of providers in a plans network, and the customer service offered by the plan. The Exchange may want to highlight certain plans that have excellent quality rankings, high Medical Loss Ratios, or rank high on customer service surveys. This option may not require any extra action by plans themselves, so it has a more limited downside than others, which have the possible consequence of driving plans from the Exchange marketplace.

7) Recruiting New Entrants to the Marketplace

The previously discussed options often have a caveat that, given the concentration of the health insurance marketplace in Arkansas, the Exchange may run the risk of driving companies from the Exchange if complex or difficult requirements are placed on plans for Exchange participation.

The ACA does contain mechanisms to increase competition, such as the creation of multi-state insurance plans and health insurance cooperatives. However, these are new entities that may not work or be appealing to purchasers. These new programs could be extremely effective and capture a lot of business, or stumble out of the gates and receive little to no attention. Regardless of the effectiveness of these programs, having more established carriers selling business in the Exchange is likely going to be desirable.

Exchange officials could decide to actively recruit new insurers to the state and to the Exchange, either in concert with any of the above initiatives, or as the sole focus of active purchasing efforts.

The Exchange could take several approaches to gaining new business on the Exchange. First, Arkansas may want to look to states in its geographic area to see if there are companies doing sustainable business in neighboring states but not in Arkansas. It could then reach out to these companies and meet with them in order to encourage them to join the Exchange. Likewise, Exchange officials may want to look to national carriers (such as Aetna, United, and Cigna) and encourage them to offer plans on the Exchange.

The Exchange may want to create marketing material aimed at insurance carriers demonstrating the state's marketplace and steps that need to be taken to be certified to participate on the Exchange in order to encourage companies to do business in Arkansas.



Decision Matrix

To following grid is intended to frame the decision points related to open marketplace vs. active purchaser. The grid also provides the members of the Plan Management Advisory Committee the opportunity to indicate a preference for setting discrete requirements by each possible criterion. A comment column is offered.

This tool has been provided to facilitate discussion at the meeting scheduled for Friday, June 8 from 8am to 11am. While this issue brief provides a framework and an initial list of decision points, the expertise of plan management members will provide unique insights and shed further light on these choices.

The second draft of this paper will incorporate these new insights to provide a deeper look at how criteria for plan selection will shape Arkansas' federally facilitated partnership Exchange.

(See Decision Matrix on following page)



Arkansas Qualified Health Plan Selection Criteria Decision Matrix

Item	Require	Do Not Require	Comment
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			

PCG will present the issues and decision points presented in this paper to the Plan Management Advisory Committee on June 8, with the goal being the formation of an initial list of potential certification criteria warranting more specific vetting in July.