Arkansas Health Insurance Marketplace in Transition

ACHI
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Arkansas will again be a trailblazer state as it begins its transition from a federally facilitated marketplace (FFM) partnership to a state-based marketplace (SBM) in July 2015. The legislatively established Arkansas Health Insurance Marketplace (AHIM) board and staff will assume full responsibility for operation of the small business health options program (SHOP) when open enrollment begins in November 2015. The Arkansas Health Insurance Marketplace (AHIM) will also provide consumer assistance, outreach and education as well as marketing for the individual marketplace—functions previously provided by the federally facilitated marketplace partnership. Because the state relies on marketplace qualified health plans (QHPs) to provide coverage for low-income Arkansans through the Health Care Independence Program, delineation of eligibility and enrollment responsibilities will be critical as the state moves ahead with the transition. This fact sheet describes the state's current partnership responsibilities, required state-based marketplace (SBM) functions, and current and anticipated eligibility and enrollment processes following the transition of core functions to the state.

INTRODUCTION

The Patient Protection Affordable Care Act (PPACA) required the establishment of health insurance marketplaces in every state as of January 1, 2014, to facilitate the availability and purchase of healthcare coverage.[1] While the options exist for states to set up their own marketplace exchanges or assume some exchange responsibility through a partnership with the federal government, 27 states have decided not to do either.[2,3] As a result, a federally facilitated marketplace (FFM) exists in those states, and the core functions are operated by the federal government.[1,4]

Table 1: Health Insurance Marketplace Core Functions[1,2]

FUNCTIONS	RESPONSIBILITIES
Eligibility	**Provide an accessible application *online, by mail, phone, or in person***
	Determine individual eligibility for federal subsidies, *including premium assistance, tax credits, and reductions in cost sharing*
	Verify individuals have access to affordable employer insurance coverage
	Screen eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
	Determine continued eligibility over time
	Have an appeals process for denied eligibility for individuals and employers denied eligibility
Enrollment	Help enroll individuals determined as eligible into a plan
Plan Management	Recommend health plans for certification to the marketplace
	Certify, recertify, and decertify health plans
	Collect and review health plans' rate and benefit information
	Regulate health plan marketing
	Assign quality rankings to plans
	Conduct health plan oversight and monitoring
Consumer Assistance	Maintain a website and call center
	Conduct outreach and education
	Operate a "Navigator" program to help people and small employers
	Run an "in-person assistance" program, while the federal government runs a "Navigator" program
Financial Management	Perform functions to oversee finances
	Collect premiums directly, serve as an electronic "pass-through"
	Take no part in premium collection at all and have consumers transmit premiums directly to health plans

Note: **Bold, highlighted** items performed by the Arkansas FFM-partnership marketplace.

Only 14 states and D.C. have chosen to establish and operate a state-based marketplace (SBM) in which the state is responsible for all core functions.[1,2,3] However, Oregon voted on April 26, 2014, to abandon its state-run marketplace website for plan-year 2015 and convert to the federal portal, Healthcare.gov.[5] Nevada also is using the federal portal in 2015. Both states retain their SBM status.

In remaining states, including Arkansas, the state has assumed some marketplace functionality—e.g., plan management and consumer assistance—but has relied on the federal government for other marketplace functions, particularly the portal for eligibility and enrollment.[4] The U.S. Department of Health and Human Services (HHS) has indicated that states can use the FFM-partnership model as a "stepping stone" to an SBM, which is the case with Arkansas.[1]

In its FFM partnership, the Arkansas Insurance Department (AID) completes qualified health plan (QHP) certification, monitoring, and rating processes as plan management functions.[6] As part of the consumer assistance functions in the Arkansas FFM partnership, AID operated an "in-person assistance" program and provided outreach and education as permitted by state law. AID also operated a state-specific resource center to supplement the federal call center to locally assist with all issues. Except for regulatory functions that will remain with AID, the Arkansas Health Insurance Marketplace (AHIM) must prepare to assume the current AID functions as well as the other core functions in Table 1. As currently planned, AHIM will operate the Small Business Health Options Program (SHOP) for plan-year 2016[6] and the individual marketplace in 2017. The 2017 transition will require close coordination with Arkansas Medicaid to ensure Health Care Independence Program benefits eligibility and enrollment processes are successful.

ELIGIBLITY: DETERMINATION VS. ASSESSMENT STATES

States that have either declined to establish a marketplace or have opted to partner with the federal government to establish a marketplace have also decided whether the federally facilitated marketplace (FFM) will merely assess Medicaid eligibility (with Medicaid making the final determination), or whether the marketplace will make final determinations of Medicaid eligibility. The federal "determination" option, which Arkansas has chosen, allows states to rely on the federal information technology infrastructure in lieu of building local systems to complete eligibility determinations. This option also shifts fiscal responsibility for eligibility determination errors to the federal government.

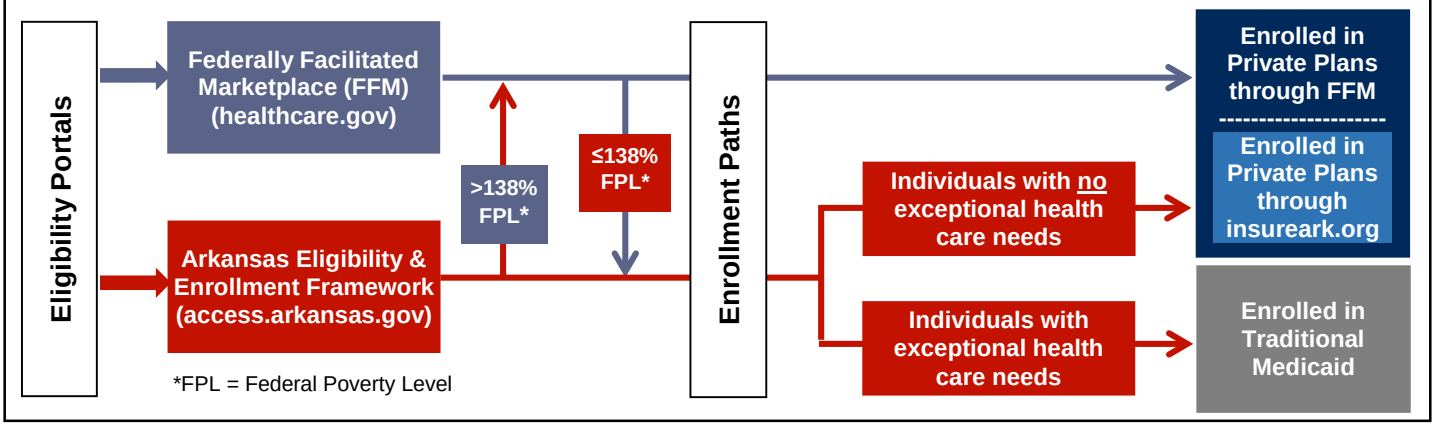
States that have opted for a state-based individual marketplace—including Arkansas in 2017—operate an integrated eligibility system that makes final determinations for both Medicaid and subsidies for marketplace coverage, which 12 states do.[7] State-based marketplaces (SBMs) assume the fiscal responsibility for Medicaid eligibility determination errors. As a result, close coordination between the SBM and the state Medicaid agency regarding eligibility and enrollment functions are critical, just as it is between the FFM and the state Medicaid agency under a partnership marketplace model.

TRANSITIONS IN ELIGIBILITY & ENROLLMENT FUNCTIONS

Currently, the federal portal at www.healthcare.gov makes all eligibility determinations for subsidies to enroll in marketplace plans. The federal portal also makes eligibility determinations for Medicaid and sends them to the state. The state accepts those as final Medicaid eligibility determinations. If an individual is determined by www.healthcare.gov as newly eligible under the PPACA (as opposed to eligible for a Medicaid eligibility category that existed prior to 2014), the state facilitates the enrollment process through the Health Care Independence Program at www.insureark.org.

Arkansas also makes Medicaid eligibility determinations through its own state portal at www.access.arkansas.gov by accessing and relying on federal data hubs and other information sources. Those who are not eligible for Medicaid are directed to the federal portal at www.healthcare.gov. If an individual is determined newly eligible for Medicaid through www.access.arkansas.gov, the state facilitates the Health Care Independence Program enrollment process at www.insureark.org. Figure 1 illustrates where the current eligibility and enrollment processes occur.

Figure 1: Current Eligibility and Enrollment Processes

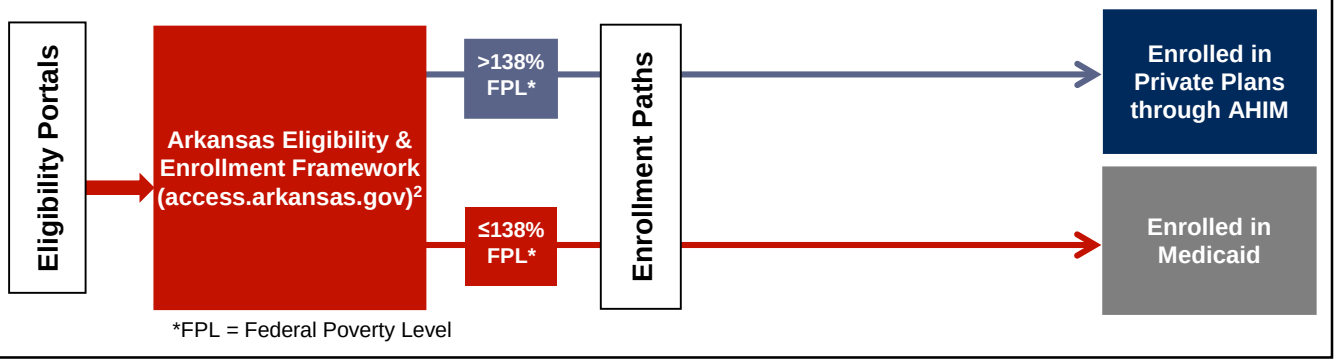


As currently planned, during the open enrollment process beginning in late 2016 for plan-year 2017, all of the federal eligibility and enrollment functions at www.healthcare.gov will shift to the state. The Arkansas Health Insurance Marketplace (AHIM) is planning to augment capacity for the following eligibility and enrollment processes:

- A single entry point for eligibility and enrollment for both marketplace and Medicaid programs
- A single connection per state to the Federal Data Services Hub (FDSH)
- A single business rules engine to perform eligibility determinations

AHIM may leverage existing Medicaid information technology assets for these functions to the greatest extent feasible. Figure 2 illustrates where the eligibility and enrollment processes will occur following transition.

Figure 2: Future Eligibility and Enrollment Processes for 2017[1]



[1] The Health Care Independence Program is slated to end on December 31, 2016.
[2] AHIM is in the process of examining whether www.access.arkansas.gov has the capability of absorbing additional eligibility functionality for individuals with >138% FPL. This graphic displays the potential use of www.access.arkansas.gov for eligibility purposes and does not represent a final AHIM decision.

In addition to the transition of these eligibility and enrollment functions, the Arkansas Health Insurance Marketplace (AHIM) will undertake responsibilities as a state-based marketplace, including operation of a call center to respond to consumer inquiries and financial transfers of premiums from consumers to payers. Details of cost allocation for shared resources such as the call center are yet to be determined. A memorandum of understanding between AHIM and the Arkansas Department of Human Services (DHS) is under development to outline responsibilities following the transition. Importantly, the Arkansas Insurance Department (AID) will continue to perform its regulatory functions with respect to health insurance market issuers, including the issuers offering QHPs, offering plans through the marketplace. The delineation of responsibilities among AHIM, AID, and DHS will be critical to a streamlined transition and efficient management of the marketplace.

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