

HEALTH BENEFITS EXCHANGE AND INSURANCE OVERSIGHT
Monday, August 9, 2010
North Carolina Institute of Medicine, Morrisville
1:00-4:00
Minutes

Workgroup Members: Louis Belo (co-chair), Allen Feezor (co-chair), David Atkinson, Tracy Baker, Sue Perry Cole, Teri Gutierrez, Mark Holmes, Verla Insko, Bob Jackson, Linwood Jones, Sharon Jones, Michael Keough, Ken Lewis, Adam Linker, Mike Matznick, Floyd McKissick, Barbara Morales Burke, Carla Obiol, Garland Scott, Anthony Velluci, Joe Vincoli

Steering Committee members: Jean Holliday, Julia Lerche, Rose Williams

NCIOM Staff: Pam Silberman, Catherine Liao

Other Interested Members: Kari Barness, Conor Brockett, Steve Cline, Abby Carter Emanuelson, Jeff Cherry, John Dervin, Lee Dixon, Kathryn Millican, Tiesha Pope, Ben Popkin, Lendy Pridgen, Chris Skowronek, Ashlee Smart, Rebecca Whitaker

Welcome and Introductions

Louis Belo

Chief Deputy Commissioner

North Carolina Department of Insurance

Co-Chair

Allen Feezor

North Carolina Department of Health and Human Services

Co-Chair

Mr. Belo welcomed everyone and thanked them for the important work they were about to undertake. Mr. Belo noted that health reform is a major initiative for the state. Want to make sure we do the best that we can to implement the law to benefit the citizens of the state. Mr. Feezor made introductory comments, and then other workgroup members and guests introduced themselves.

Overview of Health Reform, Structure of the Workgroups, and the Charge of this Workgroup

Pam Silberman, JD, DrPH,

President and CEO

North Carolina Institute of Medicine

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups. Click here to view the presentation: [Health Reform overview](#).

Overview of Workgroup's Specific Provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

Pam Silberman

Dr. Silberman gave a more detailed presentation of the health reform provisions related to the Health Benefits Exchange (HBE) and Insurance Oversight. [Click here](#) to view the presentation: Workgroup overview. [Click here](#) to view the ACA legislative language of the sections that will be covered through the workgroup: ACA provisions addressing insurance oversight and health benefits exchange.

Selected questions/comments:

- Q: How many people does the state estimate will become eligible for Medicaid as a result of the new ACA provisions?
A: Mark Holmes did an analysis of the number of uninsured who are likely to enroll in the Medicaid program starting in 2014. His estimate is that there will be about 167,000 uninsured people who are already eligible for Medicaid who will enroll, and another 259,000 people who would become newly eligible for Medicaid and enroll. [Click here](#) to read his analysis in the May/June issue of the North Carolina Medical Journal. Dr. Holmes numbers are different than the Division of Medical Assistance's (DMA) estimates. DMA estimates that between 500,000-800,000 people may enroll in Medicaid. Dr. Holmes only looked at the numbers of uninsured who are likely to enroll in Medicaid. DMA is also counting people who may have another source of coverage (ie, private coverage) who will also enroll in Medicaid.
Comment: Only about 70% of the people who are eligible for Medicaid enroll.
Comment: Once the Health Benefit Exchange (HBE) is operational, people who apply for private insurance through the HBE, but who are eligible for Medicaid, will be enrolled automatically into Medicaid.
- Q: Will private insurers be able to sell a product to undocumented people?
A: Undocumented people cannot purchase coverage through the HBE, and are still not eligible for Medicaid. The Affordable Care Act does not change current laws in this regard.
- Q: How does the money flow for the subsidies? For example, if someone is eligible for a subsidy through the HBE, and buys a silver plan, normally they would need to pay 30% of the health care costs out of pocket. But, with the subsidy, they may only have to pay 6% (for example, for a person whose income is 150% FPG). Essentially, that means that the individual has the equivalent of a 94%/6% plan (where the insurance pays 94% of the actuarial costs of health care benefits, and the individual pays 6% out of pocket). Who will pay for the additional costs of coverage?
A: We think that the money will flow from the federal government to the insurers, but need further clarification on this.
- Q: What expenses are counted in determining a person's out of pocket costs (ie, what costs will apply to the out of pocket cost limit)? Does it include premiums?
A: No, the out of pocket costs that are counted includes copayments, coinsurance, and deductibles, not premium payments.
- Q: Given the penalty levels, won't it be financially advantageous for employers to drop coverage and pay the penalty rather than offer coverage?

A: The only comparable experience was from Massachusetts. Massachusetts had a similar mandate but a lower penalty. The Massachusetts experience was that few employers dropped coverage, and more employers began offering coverage. However, we do not know what will happen in North Carolina when the ACA is fully implemented.

- Comment: Large employers are required to offer insurance, not pay for it. But if an employer doesn't pay for the premium (or pays only a small portion), and an employee is required to pay more than 9.5% of their income in premiums, and if that person goes into the HBE and gets a subsidy, then the employer is required to pay a penalty.
Comment: There is a provision that prevents employers from providing higher-paid employees better benefits, but there is no provision that prevents them from offering better benefits to lower-paid employees. Thus, an employer could pay a higher proportion of the premiums for lower paid employees (to avoid having to pay a penalty), and a smaller amount for higher paid employees.
- Q: How will the patient navigators be compensated?
A: The ACA requires the HBE to pay for patient navigator services.
- Q: What requirements do insurers currently have to report quality measures in the small group market?
A: The state used to mandate that HMOs and PPOs report certain quality measures (HEDIS), but the mandatory reporting requirement was removed last year. Now, insurers are not required to report unless the plan is accredited.
- Q: How will the group prioritize all the work it needs to do?
A: The staff will work with the state agencies to find out what information or advice they need first, and will arrange future meetings around those issues.
- Q: What happens if North Carolina chooses not to set up a HBE?
A: If states choose not to set up a HBE, then the federal government will do it?
- Q: How will the state pay for the new Health Information Technology?
A: The state is applying for money to help establish the HBE, but in the first year, it does not plan on using these funds to pay for the creation of the electronic enrollment system.
Comment: We may be able to use some of the Medicaid funding to help pay for part of this, since it will also serve to enroll people into Medicaid. We also need to make sure that the new electronic enrollment system interfaces with the state's new enrollment system (NC FAST).
- The committee also discussed the free choice voucher, co-ops, geographic rating, and health choice compacts.
- Comment: The National Association of Insurance Commissioners (NAIC) will provide information and assistance to states as they move forward and implement the insurance related provisions of the ACA.

Updates from the NC Department of Insurance

Louis Belo

Mr. Belo gave an overview of some of the work of the NC Department of Insurance (DOI) in implementing the health reform legislation. The bill was signed into law on March 23, 2010. On March 24, NC DOI set up an implementation team, as did the NAIC, to guide the state through this process. NAIC has a committee to examine the medical loss ratio issue and another committee to examine consumer protections. NAIC also will be helping the Secretary design the

essential benefit packages, and model laws for states that choose to operate two separate HBEs (one for the non-group market, and another for the small group market), as well as model laws for states that want a combined HBE.

This past legislative session, DOI worked with Inclusive Health to establish the federal high-risk pool. The federal high risk pool operates out of Inclusive Health (which operates the state high risk pool). It began enrolling July 1st and has 75 enrollees. The premiums in the federal high risk pool are at 100% of the standard rate (versus 150% in the state high-risk pool), but to qualify for the federal high risk pool, an individual has to have been uninsured for at least 6 months. Last session, the North Carolina General Assembly also gave DOI the authorizing language to enforce the new insurance laws that were part of the ACA. DOI also received funding to hire new staff to implement the new insurance provisions.

In addition, DOI has or will apply for different grant opportunities, including funding to support premium and rate review, and a consumer ombuds program. DOI is working with the Governor's Office and sister agencies to determine who should submit the grant application for funding to create the HBE. States must make progress on developing the HBE to continue to receive federal funds. January 1, 2013 is when the federal government can come in and decide whether the state is compliant with the creation of the HBE. Before that point, states will have to show that they are making progress in creating a HBE in order to continue receiving federal grants.

[Click here](#) for a copy of Mr. Belo's presentation: Update on DOI Activities.

Selected questions/comments:

- Comment: This workgroup is likely to get highly technical. If the group gets into actuarial issues, NCDOI will be bringing actuarial staff to help walk us through this process.
- Q: Do we know the timeline we must meet to implement federal health reform?
A: Academy Health has put together a good publication that describes the milestones in creating a health benefit exchange. [Click here](#) to see the timeline for implementing health benefit exchanges.
- Comment: In addition to the DOI internal working group, DHHS also has an internal work group with representatives of all the different divisions, who are examining the different provisions of the ACA to determine how the bill will impact on DHHS.
- Comment: We need to start viewing insurance and Medicaid from a different framework. In the past, Medicaid was perceived as a welfare program. Now, the national health reform legislation makes health care a right, which will be financed both publicly and privately. We need to consider all insurance (including Medicaid and NC Health Choice) as a continuum of options for North Carolinians.
- Comment: We need to create a simple enrollment system. We want a computer system similar to expedia.com (or other comparison websites), where all the available plans will be available for small businesses or individuals to compare. It needs to be simple. We do not want to create a Medicare Part D website, because it's too difficult for consumers to sort through all the different choices (and the benefits are not comparable across insurers). Massachusetts has a nice model of what we want to do. [Click here](#) to view the

Massachusetts health reform website: Health Connector. The US government is also starting to create a comparison website as part of their overall health reform website. Click here to view the [US Department of Health and Human Services health reform website](#).

Comment: We will have to have the discussion of how much choice we want to offer the consumer. There's too much choice in Medicare Part D plans. We don't want to make this too complicated. Need to make sure we consider our user audience.

- Q: How long will the committee meet?

A: It is unclear at this time. We've scheduled the first 5 meetings, but expect that the group will need to continue to meet thereafter. But we expect to have a better understanding of the time commitment after we meet for several months. Also, we may choose to have subcommittees that focus on specific issues and then bring back the work to the full workgroup for feedback.

Brief Overview of Health Information Exchanges

Jean Holliday

Health Care Reform Supervisor

Regulatory Project Manager

Life & Health Division

North Carolina Department of Insurance

Ms. Holliday agreed to skip her presentation so that the workgroup would have more time for discussion. She noted that the workgroup had her presentation, and that a lot of what she wanted to cover was already covered in Dr. Silberman's presentation. [Click here](#) to see a copy of Ms. Holliday's presentation: Immediate Insurance Reforms of the Accountable Care Act and Exchanges.

Workgroup Discussion on Next Steps:

- Q: We would like more information from Massachusetts to understand their experience. For example, is there any information from Massachusetts in terms of what percentage of customers try the online enrollment process but opt to see someone in person instead?
A: We can try to bring down someone from Massachusetts, but it may not be for the next meeting. We may need to get a better idea of the types of data and information we need to make an informed choice before inviting in a speaker from Massachusetts.
- Are there any other similar models from abroad that could guide our work in North Carolina?
- Can we get more information about what the potential differences would be if the federal government ran the HBE rather than the state? Similarly, what are the advantages or disadvantages of entering into a multi-state exchange? Also, what are the potential advantages and disadvantages of offering regional exchanges in North Carolina? What do we know about the advantages or disadvantages of combining the small group and the individual market in the HBE?
- Do we know anything about the demographics of the people who are likely to enroll in the HBE? What about their health status?

- How do we decide as a group how much information we need for the next steps and how much agreement there is already on these different points? Dr. Silberman noted that at the next meeting, we will present basic information on the HBE and get some sense from the workgroup about whether there is already a consensus about the need to develop a statewide HBE (rather than leave it to the federal government). Similarly, if the group already has a consensus that we should develop a statewide (rather than regional exchange), then we won't spend another meeting on how a regional exchange would operate. But Dr. Silberman noted that the work group needs to consider the pros and cons of different options, in addition to whatever recommendation the group wants to make to the overall advisory committee.
- Q: Is there different requirements for American Indians in the ACA?
A: There are some provisions that operate differently for people on reservations, or for nationally recognized American Indians. For example, American Indians will have special enrollment periods into the Health Benefit Exchange (Sec. 1311(c)(6)(D)); American Indians under 300% FPG cannot be charged any cost sharing in plans offered in the non-group market in the HBE (Sec. 1402(d)(1)).
- Comment: As we start to look at these high-level issues, it may be good to have a framework or lens through which we're viewing these different options. For example, the HBE should help increase competition and choice, and reduce competition from underwriting and selection to quality and outcomes and price. We should develop some framework through which we can evaluate the different choices we will have.

Homework for this workgroup: read supporting literature in the notebook and review page 39-49 and 53-55 in the legislation that regards the HBE.