Health Benefits Exchange and Insurance Oversight
Wednesday, October 13, 2010
North Carolina Institute of Medicine, Morrisville
9am-12pm
Minutes

*Workgroup Members :*Louis Belo (co-chair), Allen Feezor (co-chair), David Atkinson, Tracy Baker, , Teri Gutierrez, Mark Hall, Mark Holmes, Bob Jackson, Linwood Jones, Sharon Jones, Michael Keough, Ken Lewis, Adam Linker, Rich Lord, Cole Locklear, Sen. Floyd McKissick, Barbara Morales-Burke, Mike Matznick, Carla Obiol, George Reed, Garland Scott, Anthony Vellucci, Joe Vincoli

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

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Marie Britt, Conor Brockett, Melanie Bush, Abby Carter Emanuelson, Steve Cline, John Dervin, Lee Dixon, Jennie Dorsett, Bo Heath, Markita Keaton, Walter Klaumeier, Ann Lore, Kathryn Millican, Ernest Nickerson, Andrea Phillips, Tiesha Pope, Ben Popkin, Lendy Pridgen, Chris Skowronek, Ashlee Smart, Chuck Stone, 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 briefly welcomed everyone. Workgroup members and guests then introduced themselves.

Update on Federal HBE Grant
Jean Holliday
Regulatory Project Manager
Life and Health Division
North Carolina Department of Insurance

Ms. Holliday stated that the state has received the federal grant to plan to establish the health benefits exchange. The grant was a collaborative effort between the NC Department of Insurance, the NC Department of Health and Human Services and the NC Institute of Medicine. Funding for the grant will be used to help pay for consultants and other resources needed to establish an exchange.

Ms. Holliday also noted that at the last meeting, she had presented information about the concentration and numbers of covered lives in the non-group market. However, she now realizes these data included people who had purchased Medicare-related coverage (ie, Medicare supplements or Medicare Advantage). She is going to work with the insurers to get better numbers of the number of covered lives in the non-group, non-Medicare health insurance market. She hopes to bring these data to the workgroup at the November meeting.

Updated Data on the Uninsured
Federally Mandated vs. State Options for Health Benefits Exchange
Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman gave a presentation on recent data about the uninsured in North Carolina, particularly those that are currently uninsured that will be eligible for Medicaid and HBE after Health Reform is fully implemented. The second part of her presentation summarized the federal provisions of HBE and the state's option to design and operate certain aspects of HBE. Her presentation can be found here: **Uninsured and HBE Provisions**.

Selected questions and comments:

- Q: Is it likely that small groups of 25-50 make up the majority of the 70,000 persons employed by firms with 25-99 employees?
  A: Yes. We think that there are a greater number of employees working in smaller firms, so that it is likely that a majority of the employees in the 25-99 group are probably in firms with 25-50 employees.
- Q: Who are the acceptable accrediting bodies for HBEs?
  A: The bill does not specify accrediting agencies. We assume that the Secretary may specify different acceptable accreditation agencies. The ACA does mention HEDIS say who the HBE must be accredited by. It does mention HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems). Because the National Committee for Quality Assurance (NCQA) created the HEDIS quality measurement system, and NCQA accredits health plans, we assume that NCQA will be one of the acceptable accrediting agencies. But, there may be others that are also allowable. We assume, but do not know yet, that health plans can choose to seek accreditation from different accrediting bodies.
- Q: How can a member change plans in the exchange?
  A: The ACA requires the Secretary to determine initial open enrollment, annual open enrollment periods, and special enrollment periods (similar to the way insurance enrolls people now) (Sec. 1311(c)(6)).
- Is there a strong feeling about which option (federally-operated or state-operated HBE) to choose from a consumer standpoint?
  A: Consumers are interested in what the exchange will look like. Initial interest is in a state-operated exchange because there the state has more say over how it will operate (e.g. you know the people who run and create the oversight); however, it would depend on how it is structured.

- Q: What does the ACA say about the Health Benefit Exchange having to be self-sufficient?
  A: The ACA states that "no grant shall be awarded …after January 1, 2015." (Sec. 1311(a)(4)(B)). The ACA also states that "In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or other otherwise generate funding, to support its operations." (Sec. 1311(d)(5)). Thus, one possible source of revenues would include fees on insurers for participating in the exchange. Sustainability might mean something other than state appropriation, so creating a state operated exchange does not necessarily mean a drain on state funds.
- Q: If there are changes needed down the road related to Medicaid enrollment and interface between Medicaid and the exchange, which system (ie, state or federal operated) would provide a better opportunity or lower cost to the state?
  A: If the state controlled the exchange, then we could share eligibility rules set between NC FAST and the exchange so there would be no need to duplicate the rules. If we have a federally-operated exchange, then we would have to find a way to share Medicaid and NC Health Choice eligibility rules with them.
- Comment: Insurance, agents and doctors should not be a part of governance and/or control of appointing governance due to conflict of interest; however, we don't want to lose their expertise.
- Comment: 1) We need to structure the expansion of coverage in a way that will move it away from being seen as welfare or state-sponsored; 2) It is important to stress *who* is on the board rather than *who* is appointing the board because people want experts to make hard decisions; 3) Administrative duties of the exchange will have to include handling of funds (public and private); therefore, trusteeship and fiduciary duties come into play.
- Comment: One solution to the possible conflict of interest of having insurers on the board is to have advising groups to the board made up of industry leaders, consumer interest groups and/or legislative groups.
- Comment: There seems to be an assumption that the industry is in conflict with the exchange. This exchange is essentially the industry except with oversight. We are still delivering products to NC citizens. Aren't having insurers on the board the same as having Medicaid on the board?
- Comment: Body has to be in concert with federal policy, state perceptions and broader industry regulatory framework. We do not want undue political influence, but we still want the entity to be publically accountable for the functions it is set up to do. One way of avoiding conflicts is to have performance and review measures.

Discussion of HBE Design Options

The workgroup discussed the pros and cons of having a state vs. a federally operated HBE. After the discussion, there was a general consensus that the advantages of establishing a state-operated HBE outweigh the advantages of a federally operated HBE.

Pros of a state-operated HBE:

- State maintains regulatory authority over a large share of the commercial market
- The state has greater ability to mitigate risk selection that can result from different rating and underwriting rules for insurance sold in and outside the HBE. For example, the state can choose

to limit initial enrollment to small groups of 50 or fewer employees (which may be important if some of the larger groups with 51-100 employees self-insure, so that only the unhealthy risks choose to purchase insurance inside the HBE)
- Greater ability to coordinate eligibility and enrollment between the HBE, Medicaid and NC Health Choice
- Ability to promote state health reform strategies and priorities through the HBE (including payment reform, support for patient centered medical homes, etc.)
- More control over the number and types of plans offered through the HBE
- If the federal government operates the HBE, carriers may be subject to two sets of rules and reporting requirements for policies sold in the HBE (federal oversight) and those sold outside the HBE (state oversight)
- We do not know what a federal HBE will look like, and have greater control over the initial decisions
- Greater state flexibility, creativity and oversight of costs if the state operates the HBE
- Greater ability to modify the operations if we discover some aspects not working well for North Carolinians
- State policy makers have a voice in the process, and would be potentially more committed to make sure the agency is meeting the needs of North Carolinians

Pros of a federally operated HBE:
- The state would not be burdened with developing a new program
- The federal government would need to ensure that the HBE was self-sustaining by 2015
- Tension between keeping administrative fees low and satisfying demands for high quality customer service
- While the group thought it may be easier to address risk selection if the state were regulating insurers both inside and outside the HBE; the group recognized that the federal government would also have to address this potential problem if it were operating the HBE
- May be economies of scale if the federal government were operating multiple HBEs, and this could reduce administrative costs (although the group did question whether it would be more or less affordable at the state or federal levels)

The workgroup also discussed the pros and cons of different organizational structures: state agency, quasi-state agency, or non-profit organization. The workgroups discussion is summarized below.

State agency operated HBE:

Pros of a state agency operated HBE:
- Direct link to other state administrative agencies, which may make it easier to coordinate between agencies
- More accountability to the public

Cons of a state agency operated HBE
- Decision-making and operations could become politicized. In addition, changing political leadership could change operations of the HBE.

- Difficult to be nimble in hiring, contracting if the agency were required to follow all the state procurement and state personnel requirements

Quasi-state operated HBE:

Pros of a quasi-state operated HBE:

- Could be exempt from the state personnel and procurement laws
- More independence from existing state agencies (less chance of politicization)
- Concerns between state and non-profit can be addressed with a quasi-state agency.
- We are developing a similar model for the operation of the health information exchange (HIE)>

Cons of quasi-state HBE:

- May be more difficult to coordinate health purchasing strategies and initiatives with other state agencies
- Need clear lines of control and accountability
- Time and resources needed to create a new agency.

Non-profit HBE

Pros of a non-profit HBE:

- Flexibility in decision making and less opportunity to become politicized

Cons of a non-profit HBE:

- Isolation from state policy makers and key agency staff
- Decreased public accountability. Need to ensure clear lines of control and accountability.
- Time and resources needed to create a new agency.

General questions/comments

- Do we have an existing state agency that could operate a HBE without a conflict?
- New insurance products should be separated from a state Medicaid agency to remove the stigma of a welfare program
- Are any of the HBE's responsibilities considered public, and can you delegate "public" functions to a private non-profit?
- If we are creating an HBE to operate indefinitely, what model is bet able to address potential problems as they arise?
- This is a business enterprise. We need to structure the HBE so it can make decisions nimbly.
- How can we ensure accountability and transparency if the HBE is quasi-public or nonprofit?

The workgroup also discussed the potential governance structure of a health benefits exchange. If a state agency operated the HBE, then there may or may not be a separate governance body. However, if it were a quasi-state or non-profit, then there would be a separate governance body.

The workgroup began the discussion of what types of people should be on a governance body. Should the body include key stakeholder "slots"—for example, insurers, health care professionals, consumers, small business, agents, etc. Or should the governance structure look for people with specific types of expertise? Some workgroup members were concerned that there may be a real or perceived conflict of

interest if insurers/agents/health professionals were on the board. Others argued in favor of having these interests represented on the board because of the expertise they bring about insurance.

Workgroup members asked the NCIOM staff to prepare a document that describes the HBE's major functions, to determine the potential "conflicts of interest" if insurers, agents, health professionals, etc. were on the board. Some of the functions could create a conflict—for example, if the HBE were to select carriers or plans to offer in the HBE (rather than serve solely an information and enrollment function). Workgroup members noted that the function of HBE may change over time. Understanding the potential roles of a HBE is important in order to determine an appropriate governance structure. NCIOM staff reported that they would try to prepare a document for the next meeting

Public Comment Period

No additional public comments were offered.

Meeting Adjourned