Health Reform: Health Insurance Exchange and Insurance Oversight Workgroup
Monday, November 15, 2010
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:
Workgroup Members: Louis Belo (co-chair), Allen Feezor (co-chair), Craigan Gray, Teri Gutierrez, Mark Hall, Rep. Verla Insko, Bob Jackson, Linwood Jones, Michael Keough, Ken Lewis, Sen. Floyd McKissick, Barbara Morales-Burke, Mike Matznick, Carla Obiol, Susan Perry Cole, George Reed, Joe Vincoli

Steering Committee Members: Julia Lerche, Jean Holliday

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Conor Brockett, Abby Carter Emanuelson, William Cox, John Dervin, Jennie Dorsett, John Friesen, Ted Hamby, John Harris, Bo Heath, Phil Haywood, Fred Joyner, Markita Keaton, Andy Landis, Ann Lore, Kathryn Millican, Kathleen Moran, John Munich, Susan Nestler, Ernest Nickerson, Robert Pascal, Lee Pearson, Amy Poe, Ben Popkin, Lendy Pridgen, Melissa Reed, Robert Seehausen, Ashlee Smart, Brian Starks, Chuck Stone, Jonas Swartz, Rebecca Whitaker, John Yeatts

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. Feezor welcomed the group and invited everyone to introduce themselves.

Discussion of Roles and Responsibilities of HBE Governance Structure
Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman reviewed a chart that tentatively lays out the responsibilities of the federal government, the North Carolina General Assembly, the Health Benefits Exchange (HBE) board, the HBE Staff, and other state agencies have in establishing a HBE. This grid may assist the workgroup in determining what types of individuals and/or skill sets should be represented on the board. The chart can be found here: Responsibilities in Establishing a HBE.

Selected questions and comments:

- Q: When will we go over these responsibilities in more detail and what is the time frame for the final decision? A: We will probably try to prescribe some of the responsibilities by the time the legislature meets in late January. Some of the provisions are policy provisions (such as whether the state or federal government should operate the HBE), and some require an actuarial analysis (such as whether the state should combine the individual and small group pools). We are planning to contract with actuarial consultants to help us answer some of the key questions needed to develop the plan. The consultant's report is not due until mid-February, but we will have interim reports before then.

Start-up Responsibilities: Inclusive Health Case Study
(On behalf of Michael Keough, Executive Director, Inclusive Health)
John Friesen
Vice President, Underwriting and Analytical Services
BCBS of North Carolina
Inclusive Health Board Chair

Ben Popkin, JD, MPH
NC Department of Insurance
(Provided information on quasi-state agencies)

Mr. Friesen, on behalf of Mr. Keough, gave an overview of the structure and implementation of The North Carolina Insurance Risk Pool, or Inclusive Health. Inclusive Health is a 501(c)(26) agency, a state-sponsored organization to provide health coverage to high-risk individuals, established by S.L. 2007-532. While technically a non-profit agency, Inclusive Health is unofficially a quasi-state agency. A review of this organization will help the workgroup decide if the new HBE should be a quasi-state organization as opposed to a state or totally separate private non-profit organization.

The Inclusive Health Board includes three insurers, one agent, two providers, one small business representative, one large business representative, two consumers, a health economist, and the Commissioner of Insurance (ex officio). Board members are appointed by the Commissioner,

the Governor, the President Pro Tempore, and the Speaker of the House. The full presentation can be found here: Inclusive Health Overview.

A handout with Inclusive Health's Conflict of Interest statement can be found here: Inclusive Health COI Statement.

Selected questions and comments:

- Inclusive Health's small organizational size, and active board involvement allows the organization to be nimble and quickly address any issues that arise.
    - There is flexibility within Inclusive Health that state agencies do not have. Board members are actively involved in the oversight of Inclusive Health and helped to staff the organization before the Executive Director was hired.
    - Board members bring needed expertise to the organization.
    - The power among board members is important. No single group dominates.
- North Carolina's Constitution limits the number of administrative departments the state can have to 25 (Article III, Section 11). North Carolina has reached its maximum number of administrative departments. Therefore, if you wish to operate the HBE as a state agency, it would need to be placed within an existing department or agency.
- Q: Is there any clarity on what "quasi-public" means? A: There is not. We understand that the North Carolina General Assembly does not have the legal authority to create a totally private corporation (ie, a totally independent non-profit corporation). However, the General Assembly does have the authority to create separate "quasi-state" non-profit organizations that have specific ties to state government. This can be done through the appointment powers—as with Inclusive Health. All of the Board appointments are made by state officials.
- Q: Mr. Friesen, do you believe Inclusive Health's voluntary transparency is a good idea for the HBE? A: Yes. It seems like a burden at first, but after a while it becomes a non-issue. The public does attend meetings from time to time to give input or for assistance.
- Q: Mr. Friesen, at the last meeting we had a discussion about the potential conflicts of interest if insurance carriers and/or agents served on the HBE board. The group mentioned having carriers on an advisory committee instead of having them on the board. What is your opinion? A: I believe it is important to have the expertise of the carriers on the board. To avoid conflicts of interest they would have to recuse themselves from voting on topics that could be a conflict of interest.
- Q: What liability do you have as an Inclusive Health board member? A: As long as the board acts in good faith then there is statutory liability protection.

What Research Shows about Consumer Priorities in Choosing Health Plans
(On behalf of Kathleen Moran, Amy Poe, and John Yeatts)
Jonas Swartz

Students in HPM 456
Gillings School of Global Public Health
University of North Carolina at Chapel Hill

Mr. Swartz, on behalf of Kathleen Moran, Amy Poe and John Yeatts, gave a research summary on what consumers want in a health plan, how consumers make decisions on which health plan to buy, what is "too much choice," and how we can improve health plans to cater to the average consumer. Most consumers believe cost, benefits, access, quality, and satisfaction are important to know when choosing a health plan. Consumers do not tend to use a rational decision-making process as the prevailing theory on consumer choices suggests. Instead, consumer preferences evolve during the decision-making process. To make choosing a health plan a more consumer-friendly process, it is suggested to decrease the amount of data presented to the consumer at one time, to make the decision a step-wise decision process, and to standardize plan designs. The presentation can be found here: Consumer Priorities in Choosing Health Care Plans.

Selected questions and comments:

- Q: People are not able to accurately compare variables rated on different scales (i.e. cost in dollars vs. quality star ratings). If you put all the variables on a four-point scale would it still be hard for people to compare? A: Many experts recommend rating variables on a similar scale. It would be easier for people to compare if variables were all on a four-point scale.
- Q: Those with employer-based insurance have fewer plans to choose from than individuals, but did your data include the amount of plans employers can choose from? A: We only compared the number of plans individuals have to choose from, not businesses or other groups.
- I am concerned that when employers choose plans for their employees they make cost too much of a priority. We need to have a way to inform individual consumers so they can either encourage employers to buy a suitable plan or go buy a plan on their own.
    - Ombudsmen will be working on how to educate employers and individuals on what plan will best fit their needs.
    - A lot of work is underway to standardize terminology across plans and to use more lay language.
    - The ACA has set standards that plans must meet to qualify for the exchange.
- Q: Is there any information on what method people use to choose a plan such as the internet, a family member recommendation, a pharmacist recommendation, etc.? Some people that are low income may not have access to good information. A: The ACA requires states to conduct active outreach to certain low-income vulnerable populations. In addition, patient navigators can help provide neutral advise to people about different health plan options.

    - The Senior Health Insurance Information Program (SHIIP) helps Medicare beneficiaries through special outreach that matches a patient with the best plan for their needs. Outreach is done in every county by coordinators, volunteers, staff, partners, the Department of Social Services, TV ads, seminars, etc. SHIIP has also had federal funding to help with an educational multimedia campaign.
- Consumers will want to know whether their provider is in the health plan's provider network because people generally do not want to change their health care professionals.

Discussion of HBE Design Options

The workgroup discussed the HBE legal structure and recommended that the state enact legislation to create a non-profit, quasi-state agency. A quasi-state agency would have more flexibility to react to changes in the marketplace, less regulations and red tape, and more nimbleness for quick decision making. A quasi-state model would also be more sheltered from changes in government politics and state budget cuts.

The workgroup agreed that the quasi-state HBE would need to retain certain aspects of a state agency such as open meeting rules, public records laws (with exceptions for proprietary information), ethics laws, liability protection, authority to use the Administrative Procedure Act (APA) rule-making process, and an appeals process. However, the workgroup members recommended that the General Assembly exempt the HBE from certain state agency requirements such as bidding, contracting, purchasing, and the State Personnel Act.

The workgroup discussed different options for board membership, including both a stakeholder approach and a functional skills approach. The Inclusive Health board is primarily a stakeholder board composition, with representatives of certain key stakeholder groups represented on the board. The main concern expressed by some of the workgroup members was the possible conflict of interest in having insurers and agents on the board. The workgroup discussed alternative ways to obtain the expertise and involvement of insurers, agents and other groups, including having separate advisory committees. The workgroup also discussed other ways to limit the potential conflict of interest including limiting the number of insurers and agents on the board and having insurers announce conflict of interests and withholding votes on issues that could be a conflict of interest. Some other people were concerned with the public's trust in the HBE if insurers and agents were represented on the board. However, other workgroup members argued strongly that insurers and agents bring specific expertise that is necessary for the successful operation of a HBE. No resolution was reached on this topic.

Public Comments

- Not many insurers participated in the Health Purchasing Alliance. I see this lack of participation as a potential problem with the HBE. New York and a couple of other

states have mandated that participating carriers must participate in all areas (i.e. individual plans, group plans, etc.). We should consider whether to include similar requirements in the operation of the HBE.

- Unlike the old Health Purchasing Alliance, there is a strong incentive for carriers to participate in the HBE, as much of the market will be driven through the HBE. Individuals must purchase their insurance through the HBE in order to qualify for the subsidy, and small businesses must purchase coverage through the HBE to qualify for the small business tax credit (beginning in 2014). Thus, insurers will have a strong incentive to offer coverage through the HBE.