HEALTH BENEFIT EXCHANGE AND INSURANCE OVERSIGHT

Wednesday, September 15, 2010
North Carolina Institute of Medicine, Morrisville
1:00-4:00
Minutes

Members present: Louis Belo (co-chair), Allen Feezor (co-chair), David Atkinson, Tracy Baker, Barbara Morales Burke, Abby Carter Emanuelson, Steve Cline, Sue Perry Cole, Teri Guitierrez, Mark Hall, Mark Holmes, Representative Verla Insko, Sharon Jones, Ken Lewis, Adam Linker, Cole Locklear, Mike Matznick, Sen. Floyd McKissick, Carla Obiol, Garland Scott, Joe Vincoli

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

Staff: Pam Silberman, Lauren Short

Other interested persons: Kari Barsness, Conor Brockett, Jeff Cherry, Barbra Foley, Phil Harewood, Ann Lore, Ben Popkin, Lendy Pridgen, Rebecca Whitaker, Amy Whited

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

The co-chair explained that the goal of the meeting was to address and discuss guidelines for an exchange in North Carolina to follow. He posed the question to the workgroup: given the needs of the state, what facts or research are needed to make those changes?

REVIEW OF THE ROLE OF HEALTH INFORMATION EXCHANGES AND UPDATE ON GRANT APPLICATION

Jean Holliday
Regulatory Project Manager
Life & Health Division
North Carolina Department of Insurance

Jean Holliday presented the grants that the state recently applied for and will apply for in the near future. These included the Exchange Planning grant set forth under Section 1311 of the ACA, which offers planning and establishment grants to states for their health benefits exchange. States will be eligible for grants of up to $1M for the first year.

Another grant opportunity currently being worked on is the Consumer Assistance Program grant, whose funds will be used to help people with their insurance problems and appeals. Consumer assistance programs will provide information to help people understand different insurance options and about the premium and cost sharing subsidies. The federal government appropriated $30M in total for these grants, which will be allocated to applicant states.

Ms. Holliday also gave a more detailed overview of the role of Health Benefits Exchanges. Click here to see a copy of Ms. Holliday's presentation: Overview of the Role of Health Benefits Exchanges.

DISCUSSION OF GUIDING PRINCIPLES FOR HBE
PRELIMINARY DATA ON THE UNINSURED AND SMALL GROUP MARKET
Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine

Jean Holliday

Dr. Silberman's presentation covered two main topics. First she presented potential guiding principles that could help frame the committee's discussion and decision making. In addition, Dr. Silberman presented data on the demographics of the uninsured and on the small group market. Ms. Holliday also presented information on the market share of insurers in the small group and non-group market. Click here to see a copy of their combined presentations: Potential workgroup principles, data on the uninsured and small group market.

Dr. Silberman began her presentation by offering five possible guiding principles for HBE construction. These principles included:

- Increasing choice of carriers
- Increasing transparency and simplifying shopping, comparison and purchase
- Ensuring the HBE provide value and is sustainable over the long term
- Creating seamlessness for individuals transitioning between public and HBE coverage
- Encouraging take-up, minimizing adverse selection, and reducing per capita costs for people covered through HBE.

She explained that some of the principles represent competing interests ie., simplification and choice. The principles were not ranked in order of priority, but should be considered as a whole as they assist the group create balance on trade-offs.

In response to these principles, the workgroup's primary comments concerned "choice" in Health Benefit Exchanges. Dr. Silberman pointed out that "choice" could imply extensive, unlimited choice of plans and/or carriers, or it could mean "reasonable" choice, which implies a more limited choice of plans and/or carriers. For example, too many different choices may make it more difficult for consumers to select plans, and may make it more difficult for providers who would need to be credentialed for different carriers. However, too little choice may mean that consumers have less coverage options. This is a decision point for the state, ie, whether to limit the number of plans or carriers offered in the HBE. Some workgroup members noted that this may be a moot point, if there are a limited number of insurers who control most of the market. If this is the case, how should the North Carolina increase or encourage choice of carriers?

Workgroup members also talked about the importance of ensuring network adequacy for the plans that are offered through the HBE. Qualified health plans are required to contract with essential community

providers (ie, safety net providers), as long as those providers are willing to accept generally applicable reimbursement rates. Workgroup members also raised other points, including the importance of patient-centeredness, ensuring access to care, and ensuring that the HBEs add value to the consumers.

Selected questions/comments:

- Q: Can we streamline the credentialing process? Can we have a centralized credentialing process so that providers only need to be credentialed once, and that will meet the requirements for different carriers?
- Comment: Choice of health plans should be increased, at least initially. The ACA requires that the HBE offer at least one co-op plan and two multi-state plans. However, it is unclear whether these plans will be competitive over the longer term.
- Comment: Exchanges are intended to sharpen competition by making price and value more transparent to consumers and limiting the possibility for risk segmentation. It will be up to the state to make that happen.

BACKGROUND INFORMATION TO INFORM DISCUSSION OF HBE
Pam Silberman
Jean Holliday

Dr. Silberman discussed data related to the current uninsured, and reasons for being uninsured. Jean Holliday presented current data on small business enrollment in group coverage in North Carolina and those insurance companies that cover them.

Selected questions/comments:

- Q: Should the exchange be limited initially to small businesses with less than 50 employees (<50) or should North Carolina allow small businesses with <100 employees to purchase through the HBE? (The ACA allows states the option of initially limiting the size of the small employer purchasing coverage through the pool to <50). Expanding the pool to small businesses with <100 employees could expand the size of the insured population (as small businesses with 50-99 employees are more likely to offer coverage than small businesses with <50 employees. We need information from actuaries about what will happen to the pool if it is expanded to employers with <100 employees.
- Comment: Currently there are 24 insurance companies that market to non-group insurance (non-employer sponsored). It is likely that some of these carriers will leave the market before the exchange begins. Their retreat from the market will also be due to the new rules related to the Medical Loss Ratio, guaranteed issue and prohibitions on pre-existing condition exclusions that are part of the ACA.

Brief Overview of Health Information Exchanges

Dr. Silberman posed some initial questions to the workgroup which it will begin to address at the next meaning. She asked the workgroup for comments/questions regarding these points, particularly encouraging the group to reflect on whether they should be augmented or clarified.

Questions for Workgroup:

- What data do you need to provide more meaningful advice?

- Should NC create its own exchange or leave it to the federal government (pros and cons of both options)?
- If NC should create an exchange, should there be one or two exchanges (for individual and small group)? Pros and cons of each?
- Who should operate the exchanges? State government, quasi-governmental? Non-profit? Pros and cons of the different options?
- Should the HBE for small groups be initially open to groups of 50-100? Pros and cons of the different approaches?

Selected questions/comments:

- Q: Is there a particular vender market for the HBE?
  A: Yes, vendors have demonstrated interest in providing some of the HBE required services. The ACA gives the HBE the authority to contract with the state Medicaid agency or private vendors to provide certain services.
- Q:If the state creates its own exchange, are there benefits in operation, ease of administration, future flexibility and a greater degree of autonomy offered to the state than if the federal government created it?
  A: Some. The state can limit the choice of carriers, but federal government will dictate a significant amount to the state. In the next meeting, Dr. Silberman said she would prepare a list of provisions that are required regardless of whether the federal government or state operate the HBE, and those provisions where the state would have discretion or flexibility if it chose to operate the HBE.
- Q: If North Carolina defaulted to the state, how would that be financed? If the federal government takes over, would the federal or state employees operate the exchange?
  A: The ACA requires that the HBE be self-sustaining beginning in 2015 (ie, based on premium taxes or other sources of revenues). Thus, there is no required contribution from the state, regardless of whether the federal government or state operates the HBE. However, if the state does not operate the HBE, the federal government will contract with a non-profit organization to run the HBE in North Carolina.
- Comment: The state is already performing some of the regulatory functions (through the Department of Insurance) so it will not have to reinvent this role. We need to make sure that the HBE does not duplicate the regulatory functions which the NC DOI is already performing.
- Q: What are the liabilities if North Carolina runs the program?
- Q: What are current data needs regarding NC having one or two exchanges?
- A: Actuaries can offer a sense of who wins and who loses for having one versus two exchanges.
- Q: Will the exchanges be rated separately? Workgroup would like to see how rates are affected if the state combined the individual and small group market (versus having separate risk pools); and also what happens to the rates if the state expands the small group coverage to employers with <100 employees (vs. initially limiting the pool to employers with <50 employees).
- Comment: Perhaps the state should ask small businesses what they want? Would the small business be selecting the tier and/or carrier and/or plan for its employees?

PUBLIC COMMENT PERIOD

There were no other public comments.