

Health Reform: Overall Advisory Committee
Friday, February 11, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Lanier Cansler (co-chair), Wayne Goodwin (co-chair), James Andrew, Tom Bacon, Louis Belo, Kennon Briggs, Bonnie Cramer, Jeff Engel, Allen Feezor, Laura Gerald, Ernie Grant, Greg Griggs, Bobbi Hapgood, Alan Hirsch, Rep. Verla Insko, Tara Larson, Ben Money, Barbara Morales Burke, Aaron Nelson, John Price, Sen. William Purcell, Adam Searing, Bob Seligson, Steve Shore, Craig Souza, Steve Wegner

Steering Committee Members: Louis Belo, John Dervin, Julia Lerche, Rose Williams

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Sharon Schiro, Pam Silberman, Rachel Williams

Other Interested Persons: Allan Barker, J.J. Casper, Wallace Dawson, Laurie Ellis, Stephen Garrett, Renee Goodwin Batts, Susan Cowell, Tina Gordon, Jean Holliday, Fred Joyner, Markita Keaton, Andy Landis, Ann Lore, Kathryn Millican, Sarah Ovaska, Sarah Pfau, Diane Poole, Lendy Pridgen, Doug Sea, Robert Seehausen, Chris Skowronek, Chuck Stone, Matt Vizithum, Christine Weason, Walker Wilson

Welcome

Lanier Cansler, CPA

Secretary

North Carolina Department of Health and Human Services

Wayne Goodwin, JD

Insurance Commissioner

North Carolina Department of Insurance

Mr. Cansler welcomed everyone to the meeting.

Review of NCIOM Interim Report on Health Reform

Pam Silberman, JD, DrPH

President and CEO

North Carolina Institute of Medicine

The workgroup reviewed the content of the interim report and a draft of the proposed NC Health Benefit Exchange Act.

Selected questions and comments on the content of the interim report:

- In Section I(A) of the Introduction, which discusses numbers of uninsured, rising health care costs and insurance premiums, it would be helpful to include something about medical costs and health care utilization patterns in North Carolina.
- The \$30 million cost offset from the implementation of the CLASS (Community Living Assistance Services and Supports) Act listed in Section II(A)(3) should be revised to reflect some of the latest information coming out of Washington on the Act. Changes will probably have to be made to the program to make it workable.
- Under the Reinsurance bullet point in Section II(B)(2), it would be helpful to include the names of some large companies currently receiving funding from ACA provisions.
- Connecticut and Texas should be added to Chart Three: State Health Benefit Exchange Legislation.
- Regarding Section V(C) on Fraud and Abuse, it is important to recognize that sometimes in the process of good intentions there are also some bad outcomes. Disruptiveness in health care delivery can occur if there is not due process before a provider is found guilty of fraud and abuse.
 - There should be a clear definition of what is defined as credible fraud so good providers do not get payments suspended unnecessarily.

The workgroup made a motion to accept the draft of the NC Health Benefit Exchange Act exclusive of Section 4(A). Section 4(A) addresses the composition of the board, which the workgroup has not reached consensus on. The HBE workgroup discussed two general options—one which included consumer and employer representatives and other technical experts, but did not include insurers or agents. The other option was more of a stakeholder board, with representatives from consumers, employers, insurers, agents, health care providers, and technical experts. Below are comments regarding whether insurers should be on the exchange board.

Selected questions and comments on the proposed HBE Act:

- The more discretion the board has to make decisions and the less accountability or oversight by the General Assembly or Commissioner, the more important it is that insurers, along with other stakeholders, be on the board and be able to have a vote. Board members would not vote to represent insurance industry interests but to speak and vote in authoritative way about the insurance market which is what this exchange is about. The more discretion a board has the more important the board composition.
- The legislation tries to make recusal provisions very strong for both options, either with or without payers on the board. If there is *any* financial interest in the vote a person will have to recuse him/herself.

- Consumer groups really feel that insurers should not be on the board. The real difference between the two board options is that the “consumer-driven” board option provides stronger conflict of interest protections than a “stakeholder board” option. Recusal is not strong enough to prevent conflict of interest on the stakeholder board.
- One duty of the board is to facilitate the purchase and sale of qualified health plans. Providers and carriers have a direct financial stake and therefore should not have a vote. However, the board needs their expertise, so they should act in an advisory role to the exchange board.
- The public perception that will result of having payers on the board will be negative due to the public having so many misgivings about health insurers. There should be a place for them, maybe in an advisory role, because they have great expertise.
- For anyone to think insurers on the board will exercise any discretion on federal mandates is wrong. The more the board has the discretion to control additional functionality, the greater impact they have on insurers and on the insurance market. The greater the impact on the industry, the greater the concerns are in being able to have a voice on the board. If there are no insurers on the board, then no one will be looking at what consequences could occur to insurers based on decisions the board makes. The exchange should confine itself to what federal law requires and have oversight and checks and balances to lessen the need to have insurers on the board.
- A board’s representation is not equal to the decisions it will make. Consuming public has to have confidence in the exchange, but businesses are going to be a part of it and they also have to have the same confidence. The board needs expertise and it needs to be done in a way that is transparent so there is accountability.
 - Could one option be having insurers not selling in the exchange sitting on the board?
- The exchange will not be contracting with insurers. It will determine which insurers are eligible and if their products are eligible by adhering to federal standards. There is not a case under those circumstances where there is a vendor relationship between carriers and the exchange. This idea of inherent conflict of interest with having insurers on the board is not an accurate way of thinking. If the exchange sticks to the model that it is delivering what the federal law requires, then the view of self-interest of an insurer on the board is baseless.
- The concerns insurers have with this draft bill is not just the board composition but the fact that it allows the board to go beyond federal ACA requirements.
 - The legislation includes other issues the workgroup reached consensus on, including whether the exchange can create standardized benefit designs, if needed to ensure meaningful choice. Payers are concerned about not being on the board if the board has the ability to develop limitations on what qualified plans can come into the exchange.

Public Comment Period

- Many cancer patients and cancer survivors are counting on health reform making insurance affordable. It does not make sense to have a member of the marketplace making decisions for the exchange and therefore insurance companies should not be on the board. The advisory option is ideal because it allows all the expertise of insurers to be available without conflict or the perception of conflict.