

Health Reform: Health Benefit Exchange and Insurance Oversight
Friday, April 1, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Louis Belo (co-chair), Allen Feezor (co-chair), David Atkinson, Tracy Baker, Steve Cline, Teri Gutierrez, Verla Insko, Bob Jackson, Linwood Jones, Sharon Jones, Michael Keough, Adam Linker, Cole Locklear, Barbara Morales-Burke, Carla Obiol

Steering Committee Members: Julia Lerche, Jean Holliday

NCIOM Staff: Thalia Fuller, Lauren Short, Pam Silberman, Rachel Williams

Other Interested Persons: Tony Bentley, Conor Brockett, Melanie Bush, Barbara Collier, John Dervin, Lee Dixon, Chris Evans, Chris Girod, Jennifer Grady, R. Russell Greene, Kevin Hutchinson, Jackie Ireland, Amy Jo Johnson, Fred Joyner, Markita Keaton, Andy Landis, Stacey Muller, Ernest Nickerson, Steve Owen, Laura Parkinson, Lendy Pridgen, Melissa Reed, Stephanie Ross, Ashlee Smart, Jim Toole, Kevin Wardle, Mike Wells, Rebecca Whitaker

Welcome and Introductions

Louis Belo

Chief Deputy Commissioner

North Carolina Department of Insurance

Co-chair

Allen Feezor

Special Health Policy Advisor

North Carolina Department of Health and Human Services

Co-chair

Mr. Belo welcomed everyone to the meeting.

Update on Milliman Report

Chris Girod, FSA, MAAA

Principal and Consulting Actuary

Milliman, Inc.

The North Carolina Department of Insurance (DOI) hired Milliman, Inc., to conduct a study to help plan a health benefit exchange (HBE) in North Carolina. Mr. Girod led the workgroup through a draft of the Executive Summary. The report provides objective information so that the workgroup can make informed recommendations on state options.

Projections in the report are best estimates based on certain assumptions. Milliman assumed insurers would offer the same plans in and out of the exchange, all qualified carriers would be able to offer plans in the exchange, participation in the exchange would not be mandatory, individual and small group markets would be kept separate, the state would wait until 2016 to include employers with 51-100 employees in the exchange, all individuals are under the age of 65, and that the state would not opt for a basic health plan. Projections were calculated using a microsimulation, which uses a probability model to determine what each individual in the state will do given certain circumstances.

The state will have to make key decisions regarding certain provision options. The report highlights these decisions and offers pros and cons. Decisions the state will need to make include: influencing the level of exchange participation; requiring carrier participation in the exchange; merging individual and small group markets; allowing small group employers with 51-100 employees to join the HBE in 2014; controlling adverse selection; standardizing benefit packages; continuing coverage of mandated benefits; having multiple regional exchanges; establishing a basic health plan; establishing the HBE as active purchaser or open market; providing value-added services; and determining HBE administrative expenses so the exchange will be self-sustaining.

A draft of the Executive Summary can be found here: [NC HBE Study Executive Summary—Draft](#).

A draft of the Full Report can be found here: [Full Report—Draft](#).

Selected questions and comments:

- Q: Have the major carriers seen many people elect coverage for dependents up to age 26?
A: Blue Cross Blue Shield has seen some, but we do not feel like it has been responsible for a 2% drop in the number of uninsured as listed in this report.
- Q: Do you believe the tax credits will be a driver for small group employers to go into the exchange? A: Tax credits won't be a huge driver because there are only a few small groups that will qualify for it. The Congressional Budget Office (CBO) estimates that only 12% of businesses would qualify for the tax credit. It will be a driver for the small groups that qualify.
- Currently, small groups are rated using adjusted community rating (including age, sex, industry and geography of the enrollees). In addition, small groups can have their

premiums adjusted based on experience. Beginning in 2014, there will be no adjustment for the claims experience of the company and other rating adjustments will be curtailed or eliminated (i.e., gender, age). As a result, some small groups will end up paying up to 25% more for coverage. Other small groups will spend up to 25% less. The small groups that have an increase in costs are less likely to offer coverage to their employees after 2014.

- Will a gradual phase-in of rate changes mitigate some of the losses? We will have to see if research has been done on that.
- Q: If an employee no longer has employer-sponsored insurance and decides to go into the individual market, do you assume most will go outside the exchange instead of inside the exchange? A: We assume more would go into exchange because many will qualify for the subsidy. A majority of individuals in North Carolina make less than 400% federal poverty level (FPL) which is the cut off for the subsidies.
 - We must consider that as employers make calculations to decide if they should offer insurance, they will also be determining if employees would be better off in the exchange.
- Q: Do you see the health statuses of those in the exchange improving to levels outside the exchange in the future? A: Yes, we see that changing. The poorer health status within the exchange in 2014 is based on the assumption that there will be pent up demand. Newly covered individuals will cost more because they have grown unhealthier due to limited access to care. Also, the first year they are in exchange they will have higher utilization of services due to having access they have not had before. Over time the health status factors become more similar.
 - We need to see what that demand surge might mean for the workforce and check on the capacity of our health care system.
- The state needs to think about an individual and small group market merge on a carrier by carrier basis. Input from carriers is very important. Also, the state may want to consider that not all carriers are selling both small group and individual plans. If there is big difference in costs between individual and small group plans, then there would be a big change in costs. The state may want to implement these changes in over time if it chooses the merging option.
- North Carolina has mandated benefits already in place. The ACA requires coverage of essential benefits but there is not a lot of detail on what those will be. The issue with requiring mandated benefits above and beyond what the federal government requires is that the state has to pay for those benefits.
- Q: Have any studies been done on whether having more plans is a detriment to meaningful choice? A: Studies on Medicare Advantage plans do show that there is such a thing as too many plan options. When choices become too complex people don't shop around and they get trapped into a plan that can be disadvantageous to individuals or the group over time.

- One factor is how sophisticated your exchange is (i.e. sophistication of software). The more sophisticated an exchange is, the more plans it can have. We need sophisticated and easy-to-use tools to help consumers navigate plans. If we have that then we can have a more open market.

Discussion

After Mr. Girod's presentation, the workgroup continued to discuss the cost of the exchange and needed legislation. States have the option to set up their own exchanges or have the federal government set up an exchange for them. The federal government is offering multiple grant opportunities to states, with no funding limits, to set up state-run exchanges. North Carolina will most likely pursue setting up its own exchange and therefore will need to apply for these grants as soon as possible in order to get as much funding as possible. Workgroup members pointed out that even if the federal government sets up the exchange in North Carolina there will be costs to the state. Milliman, Inc., was asked to include possible costs to the state under the federal exchange option in the Executive Summary as a comparison to state costs associated with a state-run exchange.

The ACA requires the exchange to be self-sustaining. The workgroup discussed possible revenues including assessments on plans both inside and outside the exchange. If assessments are added only to plans in the exchange then the extra cost could cause a disincentive for individuals and small groups to go into the exchange.

Due to the urgency to apply for federal exchange grants, the workgroup discussed legislative priorities for the current legislative session. The most important piece of legislation is the establishment of an exchange. Once the exchange is established the board can be appointed and the state can apply for federal grants to begin the process of creating the exchange which includes information technology development. The board will offer valuable input for future legislation including many key decision points discussed in the Milliman report. To help in establishing legislative priorities, the workgroup asked DOI to compile a Gantt chart to create a timeline for the development of the exchange.

Public Comment Period

- Will most-favored-nation contract provisions impact the success of carriers providing competitive products inside and outside of the exchange? We have talked about all carriers being a part of the exchange which might provide more robust competition. What kinds of competition are we talking about? What are the factors that are likely to drive competition and what are the impediments?

- For the long term success of the exchange, the inside exchange affecting the outside exchange issue needs to be looked at. Those differences will affect the number of carriers participating in the exchange and therefore the choices consumers will have based on pricing of the product.