



North Carolina Health Benefit Exchange Study

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Prepared for:
The North Carolina Department of Insurance

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SECTION I – EXECUTIVE SUMMARY

This report was prepared by Milliman, Inc. at the request of the North Carolina Department of Insurance (NCDI). The purpose of the report is to provide actuarial projections and guidance related to the issue of establishing a health benefit exchange (HBE) in North Carolina. The scope of the study was defined in RFP number 12-001065 issued by the NCDI and was further clarified through discussions with the NCDI staff.

The majority of this report is dedicated to responding to the 20 Statement of Work (SOW) items that were listed in the RFP. The table of contents lists those SOW items, and Section III of this report responds to each of them in sequence.

This Executive Summary presents the following:

- Key decisions the State will need to make
- Overview of projections presented in this report
- Overview of each of the “key decisions” and relevant considerations

Throughout this report we have attempted to provide objective, unbiased information. We have generally tried to avoid providing specific recommendations since the consequences of any given recommendation may have positive or negative consequences for various North Carolina stakeholders. By recommending one approach versus another, we would need to make value decisions that should really only be made by North Carolinians who are qualified to weigh the impacts on their fellow residents, and who will themselves live with the consequences. Therefore, we have tried to provide only balanced discussion of each decision the State needs to make and the possible implications of possible choices.

There is tremendous uncertainty surrounding many of the projections presented in this report. That uncertainty stems from many sources, including imperfect data, evolving legislation and regulations, changing economic decisions, interdependencies of variables, and the impossibility of perfectly predicting the reactions of employers and consumers to decisions that most have not faced in the past. The dynamics of the entire health insurance system and its impending changes are extraordinarily complex and are unprecedented in the history of the U.S. health care system. It is unlikely that the State will be able to perfectly anticipate every challenge that will emerge. Therefore, it is critical that the State continue to solicit input from all stakeholders, including producers, carriers, consumers and providers, throughout the entire process of HBE development and implementation. Careful collection, consideration, and appropriate application of that input will help ensure the HBE’s success, and may ultimately protect the financial security of many North Carolinians who currently do not have insurance coverage.

Key Decisions the State Will Need to Make

This report is intended to help the State make key decisions related to the design and operation of the HBE. Later in this Executive Summary is a brief discussion of each of the following key decisions and topics (pertinent SOW items are listed in parentheses):

1. What can the State do to influence the level of HBE participation?
2. Should carrier participation in the HBE be mandatory? (SOW #17)
3. Should the individual and small group markets be merged? (SOW #4)
4. Should the HBE allow groups with 51 to 100 employees to participate starting in 2014 or in 2016? (SOW #5)
5. How can the State help control adverse selection against the HBE? (SOW #6)
6. Should the HBE define standardized benefit packages as the only plans that may be offered in the HBE? (SOW #18)
7. Should the State continue to require coverage of North Carolina mandated benefits that are in excess of “essential benefits” defined in the ACA? (SOW #14)
8. Should the State establish multiple regional exchanges? (SOW #16)
9. Should the State establish a Basic Health Plan? (SOW #20)
10. Should the HBE be an active purchaser of insurance, or simply an open market? (SOW #17)
11. For employer plans, will the HBE provide value-added services such as facilitating employee selection of benefit plans from all available carriers and benefit plan options?
12. How much will it cost to administer the HBE and what are possible funding methods? (SOW #8 and 9)

Overview of Projections Presented in this Report

This report contains a variety of very detailed projections of eligibility for insurance, enrollment in insurance, premium rates, subsidies, and other statistics, split by:

- Type of coverage (e.g., individual, small group, large group, uninsured)
- Income level
- Employment status
- Employer size
- Age
- Gender
- Race/ethnicity

These projections are presented in Section III of this report, primarily under our responses to SOW item numbers 1, 2, and 3. Most of the projections were made using a microsimulation model developed by Milliman, Inc.

Some highlights from the study's projections are presented below. The projections presented in this report would be best characterized as "best estimates" under various specific scenarios. For example, we have presented projections assuming individual and small group insurance markets remain separate, and assuming the markets are merged. Both sets of projections are best estimates, but have different underlying assumptions. For purposes of making our projections, we have defined a set of key assumptions that we call the "baseline reform scenario." Except where noted otherwise throughout this report, our projections reflect the assumptions underlying that baseline reform scenario. The baseline reform scenario assumptions should not be interpreted as our recommendation or expectation of how the HBE should be designed. The assumptions are meant to be one possible set of parameters and are not meant to represent any preference for the HBE format they reflect. Those assumptions include:

- The individual and small group markets are kept separate.
- The small group exchange only includes employer groups with 50 or fewer employees.
- Carrier participation in the Exchange is not mandatory.
- All insurers that qualify will be allowed to participate in the HBE.
- Insurers will be allowed to sell insurance both inside and outside of the Exchange.
- There is no Basic Health Plan.

All projections in this report include only the non-aged population, excluding people age 65 or higher. Most people age 65 or higher will get their insurance through Medicare or private Medicare Advantage insurance plans.

Some highlights of the projections under the baseline reform scenario are:

Projected Population by Type of Insurance

Table 1.1 below summarizes projected population counts by type of insurance coverage under the baseline reform scenario. Some observations on the results are:

- The uninsured population as a percentage of the total population decreases from 19% in 2010 to 17% in 2011, largely due to the required expansion of eligibility for dependent children up to age 26.
- In 2014, the uninsured population as a percentage of the total population decreases from 16% to 7%. The change is due to (1) Medicaid/CHIP enrollment increasing by approximately 32% in 2014, due to expansion of Medicaid coverage to people having

incomes of up to 138% of FPL, and (2) previously uninsured people becoming covered by individual insurance plans in the HBE. People purchasing in the HBE will tend to do so because they will receive premium and cost sharing subsidies only if they purchase through the HBE.

- HBE enrollment grows from approximately 578,000 in 2014 to approximately 731,000 in 2016. In 2016, approximately 90% of the enrollees are individuals, and the other 10% are participants in small employer group plans. Some smaller employers will have an incentive to move into the HBE to take advantage of tax credits which cease being available on non-HBE plans starting in 2014.
- Small employer group enrollment (groups having 50 or fewer employees) declines in 2014, primarily due to the elimination of experience rating, and to a lesser extent due to the impact of Medicaid expansion. Under current North Carolina small group insurance law, carriers can rate an employer group up or down 25% base on the group's own experience or health status of their participants. Starting in 2014, those premium rate adjustments will not be allowed. Therefore, groups that were getting a 25% discount from manual rates in 2013 will receive significant premium rate increases in 2014, and many will drop their employee medical plans. Many of the affected people will then purchase individual insurance in or out of the HBE.
- Ongoing increases in health care costs continue to erode affordability of care, and causes some people to drop coverage.

Table 1.1
Projected North Carolina Population by Type of Insurance Coverage
Non-aged Population Only (ages less than 65)
Baseline Reform Scenario

Market	2009	2010	2011	2012	2013	2014	2015	2016
Medicaid/CHIP	1,256,332	1,334,043	1,360,724	1,387,939	1,415,697	1,873,242	1,929,291	1,985,787
Other Government Program (1)	750,055	739,351	731,913	734,479	729,275	731,936	719,525	711,849
Employer Sponsored Insurance - Large Group								
HBE	0	0	0	0	0	0	0	0
Non-HBE	3,346,529	3,368,377	3,512,281	3,575,590	3,635,549	3,746,444	3,779,705	3,813,157
Subtotal	3,346,529	3,368,377	3,512,281	3,575,590	3,635,549	3,746,444	3,779,705	3,813,157
Employer Sponsored Insurance - Small Group (under 50)								
HBE	0	0	0	0	0	67,667	67,728	70,627
Non-HBE	604,823	608,155	630,236	636,870	650,462	545,427	505,808	458,348
Subtotal	604,823	608,155	630,236	636,870	650,462	613,094	573,536	528,975
Employer Sponsored Insurance - Small Group (over 50)								
HBE	0	0	0	0	0	0	0	0
Non-HBE	285,400	285,119	297,911	303,927	309,741	313,627	290,718	274,719
Subtotal	285,400	285,119	297,911	303,927	309,741	313,627	290,718	274,719
Individual Market								
HBE	0	0	0	0	0	510,614	584,575	660,311
Non-HBE	416,546	416,692	421,219	429,084	432,781	254,610	249,915	243,417
Subtotal	416,546	416,692	421,219	429,084	432,781	765,224	834,491	903,728
Uninsured	1,344,912	1,354,867	1,252,306	1,223,459	1,204,329	421,150	425,658	423,547
Undocumented Uninsured	192,066	194,271	199,823	204,790	208,699	215,079	218,708	223,355
TOTAL	8,196,663	8,300,875	8,406,413	8,496,138	8,586,532	8,679,795	8,771,631	8,865,116
Total HBE Insureds	0	0	0	0	0	578,281	652,303	730,938

(1) Includes Veterans Administration, TRICARE, and Medicare disabled.

Projected Migration of People among Markets

Table 1.2 summarizes our projection of the market shifts that will occur between 2013 and 2014. The shifts reflect a variety of changes that will occur in 2014. Those having the greatest impact on coverage shifts are:

- Expansion of Medicaid coverage to include all non-aged people up to 138% of FPL.
- Individual insurance market rating and underwriting reforms that will require individual insurance to be guaranteed issue at defined premium rates that can not vary with an applicant's health status (except as reflected by their age).
- Small group insurance reform that eliminates carriers' ability to rate groups up or down by 25% around a manual rate, which is commonly done to reflect a group's own claims experience or the health status of its participants.
- Availability of premium and cost sharing subsidies for plans sold in the HBE.
- Penalties for not purchasing qualified benefit plans.

The net effects of these changes are to increase insurance coverage, and convince approximately 578,000 people to enroll in the HBE.

Table 1.2
Projected Migration of Population Among Markets from 2013 to 2014
Non-aged Population Only (ages less than 65)
Baseline Reform Scenario

	Market in 2013	Market Changes in 2014							
	Total Population	i. Medicaid/CHIP	ii. Other Government Program (VA, Tricare, etc.)	iii. Employer Sponsored Insurance in the Exchange	iv. Employer Sponsored Insurance not in the Exchange	v. Individual Market in the Exchange	vi. Individual Market not in the Exchange	vii. Uninsured	viii. Undocumented Uninsured
i. Medicaid/CHIP	1,418,253	1,415,697	0	13	2,061	153	15	314	0
ii. Other Government Program (VA, Tricare, etc.)	734,765	193	731,542	90	2,582	39	320	0	0
iii. Employer Sponsored Insurance in the Exchange	0	0	0	0	0	0	0	0	0
iv. Employer Sponsored Insurance not in the Exchange	4,726,104	13,321	394	67,376	4,581,236	1,535	60,120	2,121	0
v. Individual Market in the Exchange	0	0	0	0	0	0	0	0	0
vi. Individual Market not in the Exchange	444,031	16,307	0	8	1,889	231,647	194,120	59	0
vii. Uninsured	1,141,563	427,725	0	181	17,728	277,240	34	418,655	0
viii. Undocumented Uninsured	215,079	0	0	0	0	0	0	0	215,079
	8,679,795	1,873,242	731,936	67,667	4,605,497	510,614	254,610	421,150	215,079

Projected Individual Market Enrollees by Age

Table 1.3 shows the projected distribution of individual market members by age. The counts are shown in 2016, after the HBE market has matured somewhat. The percentage distributions of members by age are generally similar between the HBE and non-HBE markets.

Table 1.3
Projected Individual Market Enrollees by Age in 2014
Baseline Reform Scenario

Age Band	# of Enrollees			% Distribution by Age		
	HBE	Non-HBE	Total	HBE	Non-HBE	Total
Under age 19	119,292	62,616	181,909	23%	25%	24%
19 through 24	48,596	27,176	75,772	10%	11%	10%
25 through 29	31,281	32,212	63,493	6%	13%	8%
30 through 39	84,429	38,343	122,772	17%	15%	16%
40 through 49	103,022	38,181	141,203	20%	15%	18%
50 through 59	88,676	39,214	127,890	17%	15%	17%
60 through 64	35,318	16,868	52,186	7%	7%	7%
Total	510,614	254,610	765,224	100%	100%	100%
Average Age	34.6	32.7	34.0			

Projected Individual Market Enrollee Gross Health Care Costs by Age

Table 1.4 shows the projected gross health care costs PMPY (per member per year) in 2014, for people enrolled in individual plans in or out of the HBE. By “gross costs,” we mean total health care costs before application of member cost sharing (e.g., deductibles and copays) or cost sharing subsidies. The costs for a person age 60-64 are approximately seven time higher than the costs for a person age less than 19. The ACA requires that the highest premium age band cannot be more than three times the lowest cost age band. This 3:1 ratio will clearly provide built-in premium subsidies for older people, which will be funded by premiums paid by younger people.

Age Band	Gross Costs PMPY	Ratio to Lowest Cost
Under age 19	\$2,383	1.00
19 through 24	\$3,557	1.49
25 through 29	\$4,035	1.69
30 through 39	\$5,441	2.28
40 through 49	\$6,762	2.84
50 through 59	\$12,189	5.11
60 through 64	\$16,858	7.07

Health Status Factors

Table 1.5 shows the projected health status of enrollees in the individual and small group markets in 2014. By “health status,” we mean the estimated gross costs expected from each member, beyond that which is due simply to their age. As such, these health status differences would probably result in differences in premium rates for each market, if those differences were not constrained by the ACA or by State law. Within each market (individual vs small group), the ACA requires that the experience of HBE and non-HBE markets be pooled for purposes of setting premium rates. Without that requirement, according to Table 1.5, individual market premium rates would likely be higher in the HBE than out of the HBE, since the health status of the HBE enrollees is 1.11, which is higher than the 0.99 of the non-HBE enrollees. Similarly, since the total individual market (HBE + non-HBE) has a health status factor of 1.07, which is

higher than the 1.01 of the total small group market, merging the individual and small group risk pools (discussed later in this Executive Summary) would likely increase premium rates for small groups and decrease premium rates for individuals.

Table 1.5
Projected Average Health Status Factor in 2014
Small Group and Individual Markets Only
Baseline Reform Scenario

Small Group (under 50)	
HBE	0.99
Non-HBE	1.02
Subtotal	1.01
Individual Market	
HBE	1.11
Non-HBE	0.99
Subtotal	1.07
TOTAL	1.04
Total HBE	1.09

Key Decision – Influencing the Level of HBE Participation

If the State wants to maximize HBE enrollment, then they might consider doing the following:

- Requiring carrier participation in the HBE
- Allowing groups with 51 to 100 employees participate in the HBE starting in 2014. The State has the option to do this in 2014 and 2015, and is then required to do it in 2016 and beyond.
- Making enrollment as easy as possible
- Providing value-added services to consumers and employers
- Advertising
- Promoting consumer and navigator education
- Not setting up a Basic Health Plan, since those enrollees would then not be a part of the HBE and its risk pool.

Key Decision – Requiring Carrier Participation in the HBE

The decision of whether to require all carriers to participate in the Exchange, will determine whether the Exchange will be “mainstream” (i.e., the dominant “aggregator” in the private health insurance market) or possibly serving primarily only low-income people. It is the most

significant decision a state can make to determine the breadth of their Exchange for non-subsidized consumers. It will be less important for consumers who qualify for subsidies, since the subsidies only apply to plans sold through the HBE.

If carrier participation in the HBE is required, then:

- HBE participation will be higher for non-subsidized consumers.
- The number of carriers in the HBE might be higher than if participation was not mandatory.
- Carriers would be less likely to take a “wait and see” approach staying out of the HBE during the initial years.
- Some carriers might choose to exit the North Carolina individual or small group markets rather than participate in the HBE.
- Some small carriers might elect to go out of business if they determine that the investment required or the risk associated with participating in the HBE is prohibitive.
- Some small employer trusts might go out of business, creating additional disruption in the insurance market.
- If the number of carriers participating in the HBE is higher, then consumers will have more choice and competition will be more robust

Key Decision – Merging Individual and Small Group Markets

Table 1.6 summarizes the impacts on enrollment and average health status of merging the individual and small group risk pools. As previously discussed, due to differences in the health status of the average individual and small group members, merging the markets would likely result in higher premium rates for small group members and lower premium rates for large group members. The impact would be the greatest for small groups, causing some of them to drop coverage.

**Table 1.6
Projected Impact of Merging Individual and Small Group Risk Pools**

		# of Covered Lives			Average Health Status Factor		
		2014	2015	2016	2014	2015	2016
Without	Small Group (under 50)						
Merged	HBE	67,667	67,728	70,627	0.99	1.03	0.98
Markets	Non-HBE	545,427	505,808	458,348	1.02	1.02	1.02
	Subtotal	613,094	573,536	528,975	1.01	1.02	1.01
	Individual Market						
	HBE	510,614	584,575	660,311	1.11	1.10	1.10
	Non-HBE	254,610	249,915	243,417	0.99	0.98	0.99
	Subtotal	765,224	834,491	903,728	1.07	1.07	1.07
	TOTAL	1,378,318	1,408,027	1,432,702	1.04	1.05	1.05
	Total HBE	578,281	652,303	730,938	1.09	1.09	1.09
With	TOTAL						
Merged	HBE	572,218	638,976	632,608	1.09	1.09	1.09
Markets	Non-HBE	797,201	752,940	699,053	1.01	1.01	1.01
	Total	1,369,418	1,391,916	1,331,662	1.04	1.05	1.05

This issue is explored in greater detail in our response to SOW item #4. Some of the other key considerations include:

Reasons to Keep the Pools Separate

- That is what we currently do
- Keeping them separate, at least in the short term, might make it easier for carriers and the State to focus on other market changes
- Keeping them separate would avoid subsidies between the individual and small group markets

Reasons to Merge the Pools

- It creates a larger, more stable risk pool
- It might result in premium rates that are considered more equitable between individual and small group
- To consumers, individual and small group products could still be presented as different products, as they are now
- Premium rates could still be adjusted to reflect administration cost differences or commission rate differences between individual and small group products

The State could also consider phasing in a merger over a period of years, which would give carriers more time to react to the changing market.

Key Decision – Allowing Groups with 51 to 100 employees to Join the HBE in 2014

In 2014 and 2015, states have the option to open their HBE to employers with 50 or fewer employees, or to employers with 100 or fewer employees. By 1-1-2016, the HBE must be open to employers with 100 or fewer employees. On 1-1-2017, states are allowed to open the HBE to employers with more than 100 employees.

Table 1.7 shows the average health status factors of the under 50 small groups and the small groups 51 to 100 employees. The health status factors of the two populations are very similar. Therefore, we expect that combining the two populations would be relatively little impact on premium rates or total insurance enrollment, although HBE enrollment would obviously be higher.

	# of Covered Lives			Average Health Status Factor		
	2014	2015	2016	2014	2015	2016
Small Group (under 50)						
HBE	67,667	67,728	70,627	0.99	1.03	0.98
Non-HBE	545,427	505,808	458,348	1.02	1.02	1.02
Subtotal	613,094	573,536	528,975	1.01	1.02	1.01
Small Group (over 50)						
HBE	55,616	52,199	73,000	1.03	1.00	1.01
Non-HBE	256,715	240,992	191,594	1.02	1.02	1.01
Subtotal	312,331	293,191	264,594	1.02	1.02	1.01
TOTAL	925,425	866,727	793,569	1.02	1.02	1.01
Total HBE	123,283	119,927	143,627	1.01	1.01	1.00

This issue is explored in detail in our response to SOW item #5. Some possible arguments for and against allowing the 51-100 employers to join the HBE in 2014 are:

Arguments For

- Economies of scale should result in lower HBE administration costs per member.
- A larger risk pool will give carriers greater predictability in their benefit costs

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- Improved predictability of benefit costs may result in less significant financial adjustments among carriers based on average member risk scores.
 - Having a greater HBE population may give the HBE more ability to influence costs and quality in the non-HBE market.
 - Less disruption in 2016, when this change would be required.
 - Improved collection of data needed for risk adjustment calculation on those members.
 - For groups of 51 to 100 that are currently uninsured, allowing them to enter the HBE in 2014 will give them more insurance options in 2014 and 2015.

Arguments Against

- North Carolina currently has insurance laws and regulations that apply to “small groups,” defined as those having 1 to 50 employees. Having more time to update them may be desirable.
- Bringing more of the total insurance market into the HBE may result in fewer carriers offering coverage outside HBE. It may also reduce the total number of carriers operating anywhere in North Carolina, in or out of the HBE.
- Benefit innovation may be more likely to occur outside the HBE. Shrinking that market might reduce innovation.
- Opening the exchange to groups of up to 100 people might result in the exchange enrolling a proportionally greater number of less healthy people.

Key Decision – Controlling Adverse Selection

Adverse selection refers to the risk that the HBE could enroll a mix of members that is less healthy on average than the non-HBE market, resulting in HBE premium rates that are higher than premium rates in the non-HBE market. Although the ACA requires HBE and non-HBE business to be pooled for premium rate setting purposes (separately for individual and small group, or individual and small group can be combined), the HBE may still be in a tenuous position if, for example, carriers find that their HBE business is much less profitable and consider exiting the HBE. Allowing adverse selection to take hold could quickly reduce the number of carriers, employers, and consumers that choose to participate in the Exchange.

The ACA includes some mechanisms to help control adverse selection. The one most commonly discussed is a risk adjustment system, which each HBE is required to have. Risk adjustment will shift money from carriers who enroll more healthy people to carriers that enroll more of the least healthy people, such that no carrier will be penalized or profit from the average health status of their enrollees. North Carolina will need to develop such a risk adjustment system. However, that risk adjustment process is unlikely to be perfect and will therefore not completely eliminate the incentive for carriers to enroll as many low risk people as possible.

The State has the opportunity to define and operate its HBE in such a way as to minimize adverse selection. Ways to do that include:

- Require all health insurance to be sold only in the HBE.
- Require that all carriers participate in the HBE, but also allow them to also sell outside the HBE.
- Require that all carriers participating in the HBE offer plans at all benefit tiers (i.e. platinum, gold, silver, bronze, and catastrophic).
- Place additional restrictions on benefit plans offered outside the HBE.
- Ensure consistency of marketing and pricing rules in and out of the HBE.
- Allow groups of 51-100 employees to join the HBE.
- Take steps to maximize HBE enrollment.
- Implement a timely and sophisticated risk adjustment program.
- Restrict HBE enrollment times.
- Charge penalties for delaying enrollment in the HBE, if the State has the authority to do so.
- For carriers that elect to leave the HBE, prohibit re-entry for a period of time (e.g., five years).
- Prohibit carriers that operate in the HBE from having affiliates that operate only outside the HBE.
- Prohibit use of selection in the pricing of individual and small group plans, as is currently done in North Carolina small group insurance law.

Key Decision – Standardize Benefit Packages

States have the option of restricting carriers to offering only specifically defined benefit plans at each tier level. In deciding whether to require standardization of benefit plans, the issues will be generally similar for the individual and small group markets. Allowing only standardized plans may have the following effects:

- Consumers would probably have an easier time making comparisons among plans.
- Exchange administration may be simplified.
- The process to approve qualified benefit plans may be less burdensome and costly for the HBE, since they would not have to calculate the actuarial value of non-standardized benefit plans.
- There may be significantly less product diversity than if plans were not standardized. That could possibly result in reduced consumer satisfaction and value.
- HBE enrollment might be less if consumers find more attractive plan designs outside the Exchange.
- Carriers will have less ability to differentiate themselves from other carriers.
- Carriers may not have the ability to offer custom benefit packages to a given employer.

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- The HBE may be less responsive to the changing needs of consumers and employers for new types of benefit plans.
 - The HBE may be less responsive to changing health care practices, possibly hindering quality improvement or cost savings.
 - The process for adding new plans may stifle or at least slow the introduction of benefit innovations, such as consumer directed health plans.
 - Standardization might make it impossible for carriers to offer products that take advantage of a unique market situation or provider arrangement.

Key Decision – Continuing to Require Coverage of Current Mandated Benefits

North Carolina currently has a variety of mandated benefits, which are listed in Appendix B. Some of those mandates require coverage of services that may not be “essential benefits,” which are the minimum level of benefits that must be provided by benefit plans offered in the HBE. North Carolina can continue to require coverage of mandated benefits beyond the essential benefits, but the State must pay the cost of those benefits for insurance provided through the HBE, for members who qualify for subsidies. We estimate that the cost to North Carolina of continuing to require the same mandated benefits will be approximately \$32 million in 2014, \$38 million in 2015, and \$45 million in 2016, under the baseline reform scenario. More details behind this projection are provided in our response to SOW item #14.

Key Decision – Multiple Regional Exchanges

The ACA allows states to have multiple regional HBEs within a state. We assume that the State might consider HBEs that are separate only for purposes of risk pooling and premium rate development. We are assuming this because it does not seem cost effective to have regional HBEs that are separate in terms of administration, IT systems, marketing, and other functions.

Regional HBEs would offer certain opportunities and present additional challenges, such as:

Opportunities

- Allows for better matching of premium rates and claim costs. Higher cost areas will have higher premium rates, and lower cost areas will have lower premium rates. However, this issue can also be resolved in a single HBE by having premium rate adjustments that reflect different geographic areas.
- Might help avoid adverse selection between the HBE and non-HBE markets. Any differences between rating areas used inside and outside of the Exchange may create opportunities for adverse selection. This problem can be avoided by requiring the HBE and non-HBE markets to use the same degree of geographic specificity in their pricing.

Challenges

- Smaller risk pools. The smaller risk pools will yield greater volatility in average claim costs, possibly producing greater volatility in premium rates. The State could mitigate this problem by allowing a carrier to pool their experience across multiple rating areas for purposes of assessing the average adequacy of premium rates, but setting premium rate relationships among areas using long-term expected cost differences. That is the process that most carriers currently use.
- Additional administration burden for the HBE. There may be additional expenses associated with administering benefit plans and premium rates that vary by area, and with administering risk adjustment settlements.

If the State wants to allow for multiple rating areas, we recommend that they:

1. Require the same rating areas for business sold in and out of the HBE.
2. Solicit input from the carriers to aid in the decision process.

Key Decision – Establishing a Basic Health Plan

PPACA allows states to create a Basic Health Plan (BHP) for residents under 200% of FPL who are not eligible for Medicaid and lack affordable access to comprehensive employer based coverage. If North Carolina implements a BHP, the eligible population must obtain coverage through the BHP and cannot purchase coverage through the Exchange. If North Carolina does not opt to implement the BHP, this population would still be eligible for subsidized coverage under the HBE starting in 2014.

Some pros and cons of offering a BHP are listed below. Note that CMS has not issued regulations governing the BHP option, so these arguments may need to be adjusted as more information becomes available:

Arguments For

- A BHP could likely offer more affordable coverage than would be available in the HBE, since a BHP could use existing Medicaid existing provider agreements, which may result in lower total health care costs.
- The BHP may be able to offer more comprehensive coverage to participants than is available in the HBE. The richest HBE benefit plan will be a “platinum” plan that pays an average of 90% of total health care expenses.

-
- States can end optional adult Medicaid coverage over 138% of FPL (e.g., the Pregnant Women population), while still providing a more affordable form of coverage compared to the HBE.

Arguments Against

- The State would take on the pricing risk of the BHP, so it would need to be confident that the federal subsidies would cover the cost to provide care and administer the program on an ongoing basis. The State would need have confidence that federal fiscal support would continue.
- The BHP removes a portion of the HBE population, which may have an influence on the operation of the HBE.
- The BHP creates an additional state administration burden.
- Access to providers and multiple insurers may be greater for consumers in the HBE.

Key Decision – HBE as an Active Purchaser or Open Market

The State can be more or less aggressive in its control over which carriers participate in the HBE. From a less restrictive Open Market to more restrictive Active Purchaser, the State may authorize the HBE to:¹

- Allow all plans that meet the minimum ACA requirements (Open Market)
- Set additional standards for qualified health plans
- Select those plans based on comparative value (Selective Contracting Agent)
- Negotiate health plan premiums with insurers (Active Purchaser)

The Open Market approach would probably be the least disruptive to the current North Carolina market and would impose the least administrative burden on the State. At the other extreme, the Selective Contracting and Active Purchaser approaches could possibly provide greater value to the people of North Carolina, although they would probably result in fewer HBE plan choices for consumers.

Key Decision – Providing Value-added Services

The State will need to define the scope of services the HBE should provide. The bare minimum of services is discussed in our response to SOW #9, under heading “HBE Administrative Functions.” The State may decide to provide additional services, such as:

Clearing House

¹ Carey, Robert, Health Insurance Exchanges: Key issues for State Implementation, Academy Health, State Coverage Initiatives, September 2010

Premiums will be paid to insurers from multiple sources – cost sharing subsidies from the DHHS, tax credit subsidies from the IRS, and premiums from individuals and employer groups. The State may consider authorizing the HBE to act as a clearing house for all such financial transactions, collecting money and redistributing it to carriers and health care providers (the cost sharing subsidies would go to providers). While this would create an additional administrative burden for the HBE, setting up such a clearing house would have the following benefits:

- Increase convenience for HBE consumers
- Reduce administrative burden for insurers participating in the HBE
- Improve the ability of the HBE to verify that the subsidy for each individual is correct
- Improve the ability of the HBE to conduct risk management programs, such as transitional reinsurance and risk adjustment

Online Comparison Tools

Under ACA, the HBE must maintain a website to provide information on plans for consumers. However, to facilitate participation in the exchange, the HBE could develop much more robust tools to allow consumers to compare health plan choices, estimate their out-of-pocket expenses under those plan choices, find plans that meet specific criteria, or provide other services that would help consumers maximize the value of and their satisfaction with their insurance.

Key Decision – HBE Administrative Expenses

The HBE will have significant administrative expenses, and the ACA requires that it be self-sustaining. The administrative expenses could be funded through premium taxes, carrier assessments per covered life, provider assessments, or via other methods, as discussed near the end of our response to SOW item #8. Some combination of these mechanisms might produce an allocation of costs that is the most broadly accepted among stakeholders.

Table 1.8 summarizes the total projected HBE administration expenses (excluding start-up costs), and expresses them using two possible assessment methods: as costs PMPY, and as percentages of unsubsidized premiums. The cost under each assessment method is shown using three possible assessment bases: (1) HBE members only, (2) all fully-insured members, in and out of the HBE, and (3) all fully-insured and self-insured members in and out of the HBE. Although we have presented what the assessments would be including self-insured lives, due to ERISA regulations, we believe the State may have difficulty collecting assessments on self-funded lives that are not covered under stop-loss insurance.

	2014	2015	2016
Projected HBE Administration Expenses	\$22,023,174	\$22,552,518	\$23,077,933
<u>Expenses PMPY</u>			
HBE Members	578,281	652,303	730,938
HBE Administration Expense PMPY	\$38.08	\$34.57	\$31.57
Total Commercial Fully-Insured Members (1)	2,353,580	2,434,961	2,511,667
HBE Administration Expense PMPY	\$9.36	\$9.26	\$9.19
Total Commercial Fully-Insured and Self-Insured Members (2)	5,124,762	5,187,732	5,245,860
HBE Administration Expense PMPY	\$4.30	\$4.35	\$4.40
<u>Expenses as a Percent of Unsubsidized Premium</u>			
Total HBE Premiums	\$4,144,521,562	\$5,064,298,792	\$6,184,342,202
HBE Administration Expense as a % of Premiums	0.53%	0.45%	0.37%
Total Commercial Fully-Insured Premiums (1)	\$15,977,373,855	\$18,251,211,838	\$20,837,657,727
HBE Administration Expense as a % of Premiums	0.14%	0.12%	0.11%
Total Commercial Fully-Insured and Self-Insured Premiums (2)	\$33,671,444,891	\$37,800,431,984	\$42,454,854,694
HBE Administration Expense as a % of Premiums	0.07%	0.06%	0.05%
(1) Includes individual, small group, and fully-insured large group, both in and out of the HBE.			
(2) Includes individual, small group, and fully-insured and self-funded large group, both in and out of the HBE.			

As described in our response to SOW item #9, the expenses were projected using data from the Massachusetts Connector and from health insurance companies, combined with expectations of the functions that the North Carolina Exchange would provide. For example, the Massachusetts Connector takes an active role in the collection, aggregation, distribution, and reconciliation of premium subsidies, although these activities are not a requirement of HBEs. As discussed near the end of our response to SOW item #9, administrative expenses could be significantly higher if North Carolina requires the HBE to perform those or other functions. Once North Carolina decides exactly what services their HBE will provide, a more detailed projection of administrative expenses should be developed.

The administrative cost projections could possibly be offset by premium tax assessments currently collected to fund the North Carolina State High Risk Pool, Inclusive Health. That program will be eliminated effective January 1, 2014. The assessments collected by Inclusive Health in 2010 totaled \$5.9 million for the six months ending 12-31-2010.²

² Inclusive Health financial statements. <http://www.inclusivehealth.org/stateoption/docs/DecFinancials.pdf>. Downloaded on 3-28-2011.