



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.

SECTION II – INTRODUCTION

This section provides overviews of:

- Health benefit exchanges (HBEs) in general
- The current individual and small group health insurance markets in North Carolina
- Current rating practices
- The purpose and scope of this study
- Limitations of this study

Overview of Health Benefit Exchanges

A health benefit exchange (HBE) is a market for health insurance products. The Affordable Care Act (ACA) requires that exchanges be operational in each state no later than January 1, 2014. Each state has the right to create its own exchange. If a state chooses not to create an exchange, HHS will set up a Federal exchange within that state. The state may set up the exchange as a state entity or as an independent quasi-government entity. The exchange must follow the requirements stated in ACA, but many other decisions are left to the state.

Functions of the exchange include:

- Providing a marketplace for individual and small-group purchasers
- Offering a variety of certified health plans
- Describing plan alternatives, and providing education and assistance to help consumers understand their choices
- Informing buyers of subsidies for which they are eligible

To support its success, the HBE may also consider ways to:

- Encourage participation by insurers and consumers
- Manage risk, particularly adverse selection risk
- Control costs
- Improve the delivery of healthcare
- Help employees efficiently make purchasing decisions, given their employer's level of contribution

Overview of the Current Individual and Small Group Markets in North Carolina

As shown below in Tables 2.1 and 2.2, according to data collected by the North Carolina Department of Insurance (NCDOI), the number of carriers providing comprehensive major medical insurance in 2009 was approximately 19 in the individual market (including Inclusive Health, the North Carolina State High Risk Pool) and approximately 24 in the small group market. The total number of covered lives is 414,947 in the individual market and 423,755 in the small group market. Blue Cross Blue Shield of North Carolina covers about 81% of lives in the individual market, and about 67% of lives in the small group market. The small group market is defined as employers having 50 or fewer employees who are eligible for coverage.

**Table 2.1
Individual Comprehensive Health Insurance Market**

Carrier Name	# of Lives Covered by Non-Employer Based Coverage in 2009	Market Share Based on Covered Lives in 2009	Cumulative Market Share
Blue Cross Blue Shield of NC	336,699	81.1%	81.1%
WellPath Select Inc.	19,927	4.8%	85.9%
Time Ins Co	11,624	2.8%	88.7%
Golden Rule Ins Co	10,967	2.6%	91.4%
Humana Ins Co	5,729	1.4%	92.8%
Celtic Ins Co	4,872	1.2%	93.9%
MEGA Life and Health Ins Co	4,284	1.0%	95.0%
Aetna Life Insurance Company	4,067	1.0%	96.0%
Mid-West National Life Ins Co of Tennessee	3,635	0.9%	96.8%
American Republic Ins Co	2,925	0.7%	97.5%
World Ins Co	2,561	0.6%	98.2%
Inclusive Health (NC Health Insurance Risk Pool)	2,506	0.6%	98.8%
John Alden Life Ins Co	2,026	0.5%	99.2%
Reserve National Ins Co	1,817	0.4%	99.7%
American National Life Ins Co of Texas	972	0.2%	99.9%
Standard Life & Accident Ins Co	157	0.0%	100.0%
Connecticut General Life Ins Co	130	0.0%	100.0%
American National Ins Co	40	0.0%	100.0%
Guarantee Trust Life	9	0.0%	100.0%
FirstCarolinaCare	0	0.0%	100.0%
National Foundation Life Insurance Company	NR	N/A	N/A
United American Insurance Company	NR	N/A	N/A
Total	414,947	100.0%	

Source: Data collected by the NC DOI.

Table 2.2
Small Employer Comprehensive Health Insurance Market

Carrier Name	# of Small Group Lives in 2009	Market Share Based on Small Group Lives in 2009	Cumulative Market Share
Blue Cross Blue Shield of North Carolina	282,730	66.7%	66.7%
United Health Insurance Company	55,423	13.1%	79.8%
WellPath Select, Inc.	27,393	6.5%	86.3%
Coventry Health and Life Insurance Company	21,658	5.1%	91.4%
UnitedHealthCare of North Carolina, Inc.	12,239	2.9%	94.3%
Principal Life Insurance Company	5,546	1.3%	95.6%
John Alden Life Ins Company	3,406	0.8%	96.4%
FirstCarolinaCare Insurance Company, Inc.	2,638	0.6%	97.0%
Federated Mutual Insurance Company	2,452	0.6%	97.6%
Aetna Health of the Carolinas, Inc.	2,219	0.5%	98.1%
Trustmark Life Insurance Company	1,406	0.3%	98.4%
Guardian Life Insurance Company of America	1,257	0.3%	98.7%
MEGA Life and Health Insurance Company	1,014	0.2%	99.0%
Aetna Life Insurance Company	867	0.2%	99.2%
Standard Security Life Insurance Company of NY	779	0.2%	99.4%
CIGNA HealthCare of North Carolina, Inc.	623	0.1%	99.5%
Humana Insurance Company	588	0.1%	99.6%
Madison National Life Insurance Company, Inc.	403	0.1%	99.7%
Union Security Insurance Company	347	0.1%	99.8%
Independence American Insurance Company	308	0.1%	99.9%
Time Insurance Company	281	0.1%	100.0%
North Carolina Mutual Life Insurance Company	125	0.0%	100.0%
Connecticut General Life Insurance Company	41	0.0%	100.0%
Transamerica Life Insurance Company	12	0.0%	100.0%
Total	423,755	100.0%	

Source: Data collected by the NC DOI.

Current Rating Practices

The North Carolina individual market is currently not guaranteed issue and does not use adjusted community rating (defined in the paragraph below). Individual applicants are underwritten by carriers and may be denied coverage, may be offered coverage at “standard” or “preferred” rates, or may be issued insurance with a premium load on top of the standard rates. There is currently “no carrier of last resort” in the individual market, except the state high risk pool, Inclusive Health.

The North Carolina small group market is currently guaranteed issue (i.e., qualifying groups must be offered coverage), at adjusted community rates. Under the adjusted community rating approach, the premium rates can be adjusted to reflect an employer group's benefit plan, geographic area, industry, mix of employees by age, gender, and family size, and may be adjusted by up to an additional +/- 25% at the carrier's discretion to reflect additional group-specific morbidity differences.

Starting January 1, 2014, the individual and small group markets will both be guaranteed issue and will use adjusted community rating. Premium rates will be allowed to reflect an enrollee's benefit plan, geographic area, age, family size, and tobacco usage. Gender rating will no longer be allowed. Additional premium rate adjustments based on the health status of individuals or small group enrollees will not be allowed. A carrier's premium rates for the individual market will be based on a combined risk pool that includes all of the carrier's individual policyholders, including plans sold in the HBE or out of the HBE. The same will be true for small group, with premium rates being based on the combined risk pool that includes all of a carrier's small group insureds. The State also has the option to require that carriers combine their individual and small group risk pools for purposes of setting premium rates.

A possible exception to the risk pooling requirements described above is with grandfathered plans. Carriers might have the option to pool grandfathered plans with all other plans, or allow the grandfathered plans to be rated separately. The ACA does not seem to prohibit this choice. Whether grandfathered plans are pooled with non-grandfathered plans may be an important decision, particularly for carriers currently having significant numbers of individual policyholders. This issue is discussed more in the response to SOW item #10.

Purpose and Scope of this Study

This study was engaged by the North Carolina Department of Insurance (NCDI). The study was funded by a grant from the federal Department of Health and Human Services. 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 study addresses many of the issues fundamental to design of an HBE, including discussion, modeling, and sensitivity testing surrounding:

- Number of eligible lives.
- Numbers of enrollees.
- Characteristics of the enrollees.
- Effects of current market conditions and health plan practices on the numbers of enrollees.

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- Benefit plan design.
 - Expected benefit costs.
 - On-going HBE administrative expenses.
 - Ways to fund the HBE administrative expenses.
 - Producer roles and compensation.
 - Allocation of program funding among participants, health plans, the State, and possibly other parties (e.g., healthcare providers).
 - Effects on the non-HBE insurance market.
 - HBE design and operational issues, such as:
 - Governance structure
 - Mandatory participation of carriers
 - Adverse selection
 - Whether to include small groups of size 51 to 100 employees
 - Whether to merge the individual and small group markets

These issues are discussed in-depth in Section III of this report, which presents responses to every SOW item that was listed in the RFP. The table of contents at the front of this report lists all of the SOW items and a short description of each one.

Limitations of this Study

The purpose of the report is to provide actuarial projections and guidance related to the issue of establishing an HBE in North Carolina. It is our expectation that the State will use this report to understand the approximate magnitudes of HBE enrollees, premium rates, administrative expenses, and other statistics. The report may not be suitable for other purposes, such as for setting premium rates or administration fees.

The projections described in this report are not predictions. Rather, they are projections of consequences that will occur if the underlying assumptions are realized precisely. Actual experience will deviate from these projections due to a variety of influences. If an HBE is implemented, experience data should be collected, studied, and if appropriate, any projections should be modified to reflect that experience.

In performing this study, Milliman has relied on data and information from many sources, including data provided by North Carolina health plans and the North Carolina Department of Insurance. We have not audited the data sources for accuracy, although we have reviewed them for reasonableness. If data or information provided to us were inaccurate or incomplete, then our projections and conclusions may also be inaccurate.

This report was prepared by Milliman for the State. Although Milliman understands that this report may be distributed to third parties, Milliman does not intend to benefit any such third parties. If this report is distributed to third parties, it should be distributed only in its entirety.

The information presented in this report may not be appropriate for states other than North Carolina. It would also be inappropriate to extrapolate the results presented in this report to any given carrier.

The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon this report without a thorough understanding of those assumptions and methods.

Milliman's consultants are not attorneys and are not qualified to give legal advice. We recommend that users of this report consult with their own legal counsel regarding interpretation of legislation and administrative rules, possible implications of specific HBE features, or other legal issues related to implementation of an HBE.

The views expressed in this paper are being made by the authors of this paper and do not represent the opinion of Milliman, Inc. Other Milliman consultants may hold different views.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this paper are members of the American Academy of Actuaries, and meet the qualification standards for performing this analysis.

SECTION III – RESPONSES TO RFP STATEMENT OF WORK ITEMS

In this section, we have responded separately to each of the 20 items listed in the RFP's Scope of Work (SOW) section. Each item is listed in **bold text**, followed by Milliman's response in non-bold text.

The only exception to this presentation is for SOW item numbers 1, 2, and 3, which we have grouped together, since they are all related and all involve detailed projections of various reform and Exchange scenarios.

RFP STATEMENT OF WORK ITEM #1

Provide impact analyses (to include the measures defined in #2 and #3 below) of the following scenarios and time periods with respect to the impact of the Act in North Carolina. For purposes of this analysis, assume that the State does not impose any mandated benefits above those defined as an Essential Benefit through the Act: a. Baseline estimates for 2009 and projections for each year 2013 – 2016 assuming status quo (no Act provisions).

(Under Statement of Work items 1, 2, and 3, the RFP listed many specific splits the State wanted. We have not repeated them all here.)

RFP STATEMENT OF WORK ITEM #2

Employer Impact: For each scenario in #1 above, analysis should include the following measures for employer groups: a. Number and percent of employers offering health insurance to their employees for each of the following employer group sizes:

RFP STATEMENT OF WORK ITEM #3

Population Impact: For each scenario in #1 above, analysis should include estimates of the following measures for each demographic group defined in #3 below:

RESPONSE

This section discusses the following topics:

- "Status quo" projections of the insurance market

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- “Baseline reform scenario” projections of the insurance market (i.e., “best estimate” of market with introduction of HBEs)
 - Variations on the baseline reform scenario:
 - Merging the individual and small group market risk pools
 - Including groups with 51 to 100 employees in the HBE starting in 2014
 - Methods and assumptions used for the projections

Status Quo

The status quo projections shows the current North Carolina markets, projected forward assuming that none of the ACA provisions will be enacted. It is important to recognize that these projections do not represent a realistic scenario for North Carolina, since some of the ACA provisions have already been enacted and others ultimately will be enacted, unless the law is changed. Nevertheless, the scenario provides a helpful basis for comparison to the other projections presented in this section.

We modeled the major markets (e.g., individual, small group, large group), to estimate the membership, medical costs, benefit plan costs, and insurance premiums from 2008 through 2016. A summary of the status quo projections is provided in Table 3.1 below. More detailed exhibits are provided in Appendix D.

**Table 3.1
Status Quo Projections**

	2009	2010	2011	2012	2013	2014	2015	2016
Population Counts								
Medicaid/CHIP	1,256,332	1,334,043	1,360,724	1,387,939	1,415,697	1,444,011	1,472,892	1,502,349
Other Government Program (1)	750,055	739,364	731,839	734,260	729,108	719,376	708,609	702,653
Large Group	3,346,529	3,368,306	3,415,361	3,447,223	3,481,619	3,522,157	3,562,920	3,603,955
Small Group: 1-50 Employees	604,823	608,180	614,423	616,637	626,543	633,660	636,641	636,047
Small Group: 51-100 Employees	285,400	285,084	289,330	293,170	296,905	302,541	309,354	314,233
Individual	416,546	416,681	421,313	429,226	433,196	437,157	438,936	443,277
Uninsured	1,344,912	1,354,970	1,373,669	1,382,972	1,394,838	1,409,567	1,426,948	1,442,142
Undocumented Uninsured	192,066	194,246	199,755	204,712	208,625	211,326	215,332	220,459
	8,196,663	8,300,875	8,406,413	8,496,138	8,586,532	8,679,795	8,771,631	8,865,116
Gross Health Care Costs per Person per Year (2)								
Medicaid/CHIP	\$3,344	\$3,502	\$3,690	\$3,907	\$4,175	\$4,426	\$4,682	\$4,990
Other Government Program (1)	9,810	10,194	10,521	11,050	11,502	11,924	12,321	12,698
Large Group	3,905	4,311	4,708	5,141	5,623	6,206	6,835	7,528
Small Group: 1-50 Employees	4,155	4,590	5,003	5,434	6,173	6,619	7,351	8,102
Small Group: 51-100 Employees	4,358	4,762	5,137	5,685	6,141	6,725	7,553	8,282
Individual	3,670	3,950	4,271	4,749	5,107	5,597	6,011	6,645
Uninsured	1,389	1,542	1,701	1,865	2,040	2,248	2,470	2,711
Undocumented Uninsured	1,081	1,173	1,300	1,447	1,601	1,743	1,899	2,136
	\$3,903	\$4,197	\$4,492	\$4,848	\$5,236	\$5,650	\$6,107	\$6,614

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

(2) For insured people, gross costs are before application of member cost sharing (e.g., copays and deductibles).

Our projections were made using a combination of information from public sources, data collected by the NCDI, and Milliman’s proprietary databases and tools, including a microsimulation model that Milliman developed specifically for making health care reform-related projections. Additional information on the data sources, tools, and assumptions used to make the projections are presented in Appendix A.

Non-Exchange Reform Impacts

Before considering the impact of introducing exchanges to the individual and small group markets, we modeled the impact of the following other changes included in the ACA:

- Expand coverage of dependents to age 26 regardless of student status
- Remove lifetime and overall annual maximums in benefit plans
- Cover preventive care services at 100% in benefit plans
- Cover all children without considering pre-existing conditions
- Assume that new taxes on medical device and pharmaceutical manufacturers are passed through as additions to medical costs in all markets
- Assume insurer tax is added to premiums in all insured markets

These changes increase the expected benefit costs and premiums in each market. For the individual market, the impact of all but the insurer premium tax increases expected premium rates by 6.8%. The insurer tax is assumed to be added to premiums as additional retention and adds approximately 1.2% more. Therefore, the estimated impact of reform changes before the introduction of Exchanges is an increase in premium rates of approximately 8.1% by 2014. For the small group market, the corresponding increase in total premium rates is approximately 1.5% in benefit costs, plus 1.2% for the new premium tax, for a total increase in premium rates of approximately 2.7%.

Table 3.2 summarizes some key projection results under this scenario.

	2009	2010	2011	2012	2013
<u>Enrollees</u>					
Medicaid/CHIP	1,256,332	1,334,043	1,360,724	1,387,939	1,415,697
Other Government Program (1)	750,055	739,351	731,913	734,479	729,275
Large Group	3,346,529	3,368,377	3,512,281	3,575,590	3,635,549
Small Group: 1-50 Employees	604,823	608,155	630,236	636,870	650,462
Small Group: 51-100 Employees	285,400	285,119	297,911	303,927	309,741
Individual	416,546	416,692	421,219	429,084	432,781
Uninsured	1,344,912	1,354,867	1,252,306	1,223,459	1,204,329
Undocumented Uninsured	192,066	194,271	199,823	204,790	208,699
	8,196,663	8,300,875	8,406,413	8,496,138	8,586,532
<u>Gross Health Care Costs per Person per Year (2)</u>					
Medicaid/CHIP	\$3,344	\$3,502	\$3,693	\$3,912	\$4,180
Other Government Program (1)	9,810	10,194	10,512	11,052	11,511
Large Group	3,905	4,311	4,703	5,136	5,630
Small Group: 1-50 Employees	4,155	4,590	4,960	5,411	6,047
Small Group: 51-100 Employees	4,358	4,762	5,194	5,707	6,152
Individual	3,670	3,950	4,464	4,977	5,372
Uninsured	1,389	1,542	1,767	1,955	2,157
Undocumented Uninsured	1,081	1,173	1,392	1,558	1,717
	\$3,903	\$4,197	\$4,554	\$4,936	\$5,346

(1) Includes Veterans Administration, TRICARE, and Medicare disabled.
 (2) For insured people, gross costs are before application of member cost sharing (e.g., copays and deductibles).

HBE Projections – Baseline Reform Scenario

Except where noted otherwise, we have modeled the HBE under what we call a “baseline reform scenario”. The baseline reform scenario is our “best estimate” of what the market will look like once the HBEs are introduced. It reflects the following assumptions:

- 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.

These are assumptions made by Milliman. To our knowledge, the State has not yet made the decisions that will define these characteristics of the North Carolina HBE and non-HBE markets.

HBE Impact – Individual Market

Introduction of the HBE will impact the individual market significantly, even beyond the impact of the non-HBE reform provisions described above. The individual market will experience additional growth in 2014 due to the availability of premium and cost sharing subsidies for policies purchased through the exchange. Table 3.3 below summarizes the projections under the baseline reform scenario.

		2013	2014	2015	2016
Non-HBE	Enrollees	432,781	254,610	249,915	243,417
	Net Benefit Costs PMPY	\$3,861	\$5,257	\$5,734	\$6,266
	Claims and Administrative Cost PMPY	\$4,916	\$6,491	\$7,266	\$7,943
	Subsidy PMPY (1)	\$0	\$0	\$0	\$0
	Medical Loss Ratio	78.5%	81.0%	78.9%	78.9%
HBE	Enrollees	n/a	510,614	584,575	660,311
	Net Benefit Costs PMPY	n/a	\$5,590	\$6,115	\$6,651
	Claims and Administrative Cost PMPY	n/a	\$7,252	\$7,826	\$8,497
	Subsidy PMPY (1)	n/a	\$4,596	\$5,103	\$5,573
	Medical Loss Ratio	n/a	77.1%	78.1%	78.3%
Total	Enrollees	432,781	765,224	834,491	903,728
	Net Benefit Costs PMPY	\$3,861	\$5,479	\$6,001	\$6,547
	Claims and Administrative Cost PMPY	\$4,916	\$6,999	\$7,658	\$8,348
	Subsidy PMPY (1)	\$0	\$3,067	\$3,575	\$4,072
	Medical Loss Ratio	78.5%	78.3%	78.4%	78.4%
(1)	Subsidies are per HBE participant, not just per participant who qualifies for a subsidy. They include premium and cost-sharing subsidies.				

Assumptions that we made to determine where people eligible for the individual Exchange will seek their coverage include:

- All uninsured, undocumented people remain uninsured.
- All documented, uninsured people with household incomes at 138% of FPL and below will enter the Medicaid market. We did not project the impact on Medicaid expenditures of this movement.
- Remaining documented, uninsured people will chose between the individual HBE and non-HBE markets based on their health status (expected health claims), expected subsidies (both for premium and cost sharing subsidies), and relative premium rates and premium rate changes. Some people will choose to continue being uninsured.
- Carriers are assumed to attract members based on their premium rate levels. We assumed all carriers would offer all four plan levels (bronze through platinum) in the HBE.

-
- Existing plans are assumed to be grandfathered. Insurers will continue to maintain these plans but members will make choices to potentially move to new plans if it is economically favorable to do so.
 - Claim costs reflect the health status of the members in each market and benefit designs available. In the status quo scenario, uninsured people at the lowest income levels have the lowest healthcare expenditures. When those people move to the HBE, their costs are assumed to increase to levels more typical of someone with insurance.

Observations about member movement, medical costs and premiums for the individual market and exchange are:

- Approximately half of the exchange membership will come from the previously uninsured population and half from the individual market. However, not all of the currently uninsured are assumed to select some type of coverage. Given the level of the individual mandate penalty relative to the cost of insurance, and the ability of members to move freely into and out of markets due to guarantee issue requirements, some people will consider it financially advantageous to continue being uninsured. The effectiveness of penalty enforcement, the specific enrollment rules, and select open enrollment periods will also impact participation.
- The projected HBE members are a bit older on average than non-HBE members, as was shown in Table 1.3. In general, the implementation of rate restrictions allowing only a 3-to-1 premium ratio will favor older members. This restriction limits the ratio of the highest premium rate to the lowest premium rate to no more than 3-to-1.
- The uninsured entering the exchange are projected to be less healthy than current individual plan enrollees. We also assumed that the previously uninsured will increase their demand for services once coverage is available. In total we estimate that medical costs for previously uninsured people who move into the exchange will be about 30% more than a person of similar age and gender in the current individual market.
- As shown in Table 3.4 below, most of the HBE members receive subsidies, particularly those who were previously uninsured.

INSERT UPDATED TABLE 3.4

- Some of the metal plans required by reform (i.e., bronze, silver, gold, and platinum) provide richer benefits than the average plans in the current market. In the current individual market, the average actuarial value of net benefit costs as a percent of gross medical costs is approximately 70%. The metal plans offered under reform range from

60% for bronze to 90% for platinum. We estimated that the average value of all plans, across all individual HBE enrollees, will be approximately 72%.

- Table 3.5 below summarizes information about the average enrollee projected in each benefit plan tier in the HBE. Typically we would expect the most generous plan to attract members who are the least healthy. However, the presence of subsidies changes the purchasing decision. For example, individuals who are the most healthy may still find the platinum plan attractive from a cost perspective if they qualify for a premium subsidy.

	Enrollment Distribution	Average Age	Average Health	Actuarial Value
Platinum	17.6%	34.4	1.07	90%
Gold	20.1%	35.0	1.09	80%
Silver	30.7%	36.9	1.11	70%
Bronze	31.7%	36.8	1.11	60%
Composite	100.0%	36.0	1.10	72%

There is considerable uncertainty around our estimate of the average actuarial value of plans in which HBE participants are enrolled. We estimated the distribution of enrollees by benefit tier using modeled reactions to plan premiums, given a consumer’s income level, qualification for subsidies, and expectations or their claim costs based on their health status. The actual distribution of enrollees by benefit tier could differ materially from our projections.

HBE Impact – Small Group Market

The small group market will be less affected by the presence of the HBE. Some key results from the projections are summarized below in Table 3.6.

INSERT UPDATED TABLE 3.6

Some observations on the small group projections are:

- Small group participation in the exchange is projected to be relatively low, at approximately ___% of the total small group market. Some small groups have less

incentive to participate in an exchange than do individuals. Small group employers will be eligible for tax credits if they continue providing coverage. These tax credits are available regardless of whether the coverage is purchased in or out of the HBE.

- We assumed that small group employers who currently choose to not purchase insurance will also tend to not purchase insurance when the HBE is introduced. In our projections, their employees are represented by people in other markets, such as individual, uninsured, Medicaid, or dependents elsewhere in the group market.
- The current market already requires guaranteed issue for small groups, but the new rating restrictions on age and health status will result in premium rate changes for specific groups. The changes will not encourage additional employers to enter the market.
- The average actuarial value of benefit plans in the current small group market is ____%. We estimated that the average actuarial value of plans purchased by small group HBE enrollees will be approximately ____%. As previously described for the individual HBE market, there is considerable uncertainty around this estimate.
- If employee contributions, including dependent coverage, exceed 9.5% of household income for families at less than 400% of FPL, the employees and dependents will be eligible for the individual exchange and for premium subsidies. This opportunity could result in lower participation in small group coverage over time.
- We anticipate that the small group exchange will have premium rates consistent with the non-exchange market. Therefore, unless the exchange can offer some administrative advantages to employers or producers, such as facilitating employee choices among benefit plan tiers, enrollment may be limited.

Variations from the Baseline Reform Scenario

We also modeled some variations from the baseline reform scenario. Two key variations are described below.

Variation #1 – Merging the Individual and Small Group Risk Pools

The issue of whether North Carolina should merge the individual and small group risk pools is explored more fully in our response to SOW item #4.

Tables 1.6, which was presented in Section I, summarized the projected impact of merging the pools. The projected individual HBE enrollees are expected to have poorer health status than the small group members. Therefore, combining the individual and small group risk pools is

likely to result in an increase in small group premium rates and a decrease in individual premium rates.

A best case scenario is that the premium rate would be unaffected in all markets, but the expanded risk pool provides improved predictability of claim costs and provides some administrative economies. A worst case scenario might be, for example, that the small group market ends of providing large subsidies to the individual market, causing small employers to consider dropping their benefit plans.

Variation #2 – Permitting Employers up to 100 Employees to Participate in the HBE

The issue of whether North Carolina should allow employers from 51 to 100 employees to participate in the HBE starting in 2014 is explored more fully in our response to SOW item #5.

Table 1.7, which was presented in Section I, shows the average health status of the 1-50 and 51-100 groups are very similar. Therefore, the overall impact on average premium rates of combining all small groups in the exchange would likely be minimal. However, groups with 51-100 employees probably have even less incentive to seek coverage through the HBE than smaller groups unless a significant premium or administrative advantage exists. In addition, the larger groups in the 51-100 range may be more likely to try self-funding.

Coverage by Type of Employer

Table 3.7 provides additional information on estimated numbers of insureds and employers by employer size and year.

Group Size (# of employees)	2009			2010			2011			2012		
	1 to 50	51-99	100+									
Number of Individuals Enrolled (in millions)	0.605	0.285	3.347	0.608	0.285	3.368	0.630	0.298	3.512	0.637	0.304	3.576
Percentage Enrolling in:												
Self-Funded Coverage	0.0%	0.0%	75.2%	0.0%	0.0%	75.1%	0.0%	0.0%	74.8%	0.0%	0.0%	74.6%
Fully Insured Exchange	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Fully Insured Non-Exchange	100.0%	100.0%	24.8%	100.0%	100.0%	24.9%	100.0%	100.0%	25.2%	100.0%	100.0%	25.4%
Group Size (# of employees)	2013			2014			2015			2016		
	1 to 50	51-99	100+									
Number of Individuals Enrolled (in millions)	0.650	0.310	3.636	0.613	0.314	3.746	0.574	0.291	3.780	0.529	0.275	3.813
Percentage Enrolling in:												
Self-Funded Coverage	0.0%	0.0%	74.4%	0.0%	0.0%	74.1%	0.0%	0.0%	73.9%	0.0%	0.0%	73.5%
Fully Insured Exchange	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	9.2%	0.0%	0.0%	8.7%	0.0%	0.0%
Fully Insured Non-Exchange	100.0%	100.0%	25.6%	96.4%	100.0%	25.9%	90.8%	100.0%	26.1%	91.3%	100.0%	26.5%

Data Sources and Assumptions

Appendix A provides information on some of the key data sources, tools, and assumptions we used to make the projections. Some other modeling assumptions included:

- We assumed that carriers will come into compliance with the ACA's minimum medical loss ratios (MLR) requirements. The ACA imposes minimum MLR requirements whereby MLRs must be at least 80% for individual and small group products (groups of less than 100 employees), both in and out of the HBE. Implementation of the minimum MLR requirements will force some carriers to modify their benefits or administrative expenses to achieve the 80% minimum. This assumption is particularly important in the individual market where most of the carriers, with the exception of Blue Cross Blue Shield of North Carolina (BCBSNC), currently have average loss ratios well below the 80% minimum. BCBSNC tends to have higher average loss ratios. We assumed that carriers will meet the minimum requirements by reducing their administrative expense loads.
- We have not projected in the impact of risk adjustment among carriers. Presumably the risk transfer payments would be designed to be neutral within a market. The results or impact on any specific carrier could be significantly different than our modeling indicates.
- We assume all employers with 100 or more employees continue coverage at current levels. We did not model the large employer decision to offer coverage meeting minimum requirements or pay the penalties and let employees use the exchange.
- We assumed that State employees will continue to participate in the State employee benefit plan, which we modeled as a large employer group. However, current data indicate that a significant number of dependents of State employees may have individual insurance or be uninsured. These dependents are modeled as members of their respective current markets.
- We assumed that full-time and part-time individuals have similar health statuses and that their work statuses will not change.
- We assumed uninsured members with incomes below 138% of FPL will move to the Medicaid market. However, we did not analyze the impact these new members would have on overall Medicaid costs.

RFP STATEMENT OF WORK ITEM #4

Based on the analysis above and other relevant factors provide a descriptive analysis of the impact of merging the individual and the small employer markets for purposes of creating a single rating pool. Include in the analysis the pros and cons of merging the risk pools as well as a recommendation. Provide best and worst case scenarios. If the impact of merging the markets is dramatic, provide scenarios and recommendations of how to phase in revisions to rating methodology between now and 2014.

RESPONSE

Having separate risk pools means that for purposes of setting premium rates, a carrier would set individual premium rates based on the claims experience of their individual policies, and would set small group rates based on the claims experience of their small group policies. This means that a participant with a given set of allowable rating characteristics (i.e., age, family size, geographic area, tobacco usage, and benefit plan), could be quoted very different premium rates in the individual and small group markets.

The ACA allows states to merge the individual and small group markets. It does not specify exactly what that means. For example, it does not say that individual and small group premium rates must be the same for a given person. Even if a carrier combined their individual and small group claims experience for purposes of setting future premium rates, the premium rates might differ for individual and small group due to having different administrative expense loads or different broker commission rates, for example.

State Motives

Whether the State decides to combine the risk pools or keep them separate, the rationale should be clearly identified. Possible reasons for either course are listed below.

- Why 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

- Why combine the pools?
 - It creates a larger, more stable risk pool

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- 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

What Might the HBE Look Like with Separate Risk Pools?

Listed below are characteristics the HBE would have with separate risk pools. We have not attempted to classify them as “pros or cons,” since that determination will vary among stakeholder perspectives. If the individual and small group risk pools are separated, the market might have the following characteristics:

- The sizes of the two risk pools would be smaller than if they were combined, possibly producing less premium rate stability and greater need for risk adjustment.
- In the HBE, individual and small group premium rates might be materially different for the same person.
- Premium rate differences between the two HBE markets might cause individuals to migrate from the higher cost market to the lower cost market. This would also affect non-HBE premium rates for carriers that operate in and out of the HBE, since carriers must combine their HBE and non-HBE experience into a single risk pool.
- Carriers might be more likely to offer different HBE benefit plans for individuals and small groups, if the State allows them to do so.

What Might the HBE Look Like with a Single Combined Risk Pool?

If the individual and small group risk pools are combined, the market might have the following characteristics:

- Each carrier would probably have a larger combined pool of HBE enrollees upon which to base their premium rates, giving them more rate stability. However, this might not be true for all carriers. For example, for carriers with significant current enrollment in individual and small group products, combining the markets might raise their small group premium rates and lower their individual premium rates, causing enrollment shifts among the carriers.
- In the HBE, individual and small group premium rates would be more likely to be similar. Some difference may still exist, for example, due to different administrative expense loads or commissions in individual and small group premium rates.
- A larger risk pool may be more appealing to carriers. They may be more likely to participate in the HBE if the pools are merged.

-
- The HBE and carriers may have moderately lower administrative costs per enrollee if the pools are combined.
 - A combined pool might be less confusing to consumers. However, most consumers will probably be unaware of the pooling process.
 - Carriers might be more likely to offer that the same benefit plans to both individuals and small groups.
 - The HBE would probably still need separate portals for employers and individuals to access the HBE. For example, an employer might set up their employee benefit plan through the HBE and commit to paying 90% of the cost of a given silver plan. Participants in that employer plan would then need to individually spend the employer contribution on a benefit plan of their own choice.
 - Combining individual and small group risk pools in the HBE implies that they would need to be combined outside the exchange. This might necessitate immediate premium rate changes if it also applies to existing policyholders. For example, if the health status of the current individual enrollees is worse than that of the current small group enrollees (after adjusting for age/sex mix differences and other allowable rating characteristics), then carriers having the greatest proportion of individual business (as a percentage of their total individual and small group business) will have the greatest increase in their small group rates when the individual and small group markets are combined.

Possible Further Integration of Individual and Small Group Markets

The State could also take this opportunity to integrate the two markets, beyond just combining the risk pools that determine premium rates. For example, they could require that HBE products and premium rates be the same for individual and small group. This might produce a market that is easier for consumers and employers to navigate and understand. However it might have characteristics considered undesirable by some stakeholders, such as:

- Actual benefit costs and administrative expenses are certain to differ between the individual and small group markets, so combining them will result in one subsidizing the other.
- Having a combined market might limit flexibility in dealing with the different needs of individuals and small groups.

Merging the markets might encourage more carriers to offer insurance to both individuals and small groups, rather than just one or the other.

Actions of Other States

Massachusetts merged their individual and small rating pools. They did, however, split the rating pool and between subsidized and non-subsidized (Commonwealth Care and Commonwealth Choice, respectively). Massachusetts has yet to implement risk adjustment to equalize the costs among carriers.

California has begun to set up separate risk pools for individual and small groups. It appears that there will be one governing body that administers both.

Washington will also have separate risk pools for small group and individual markets. There will be one administrative body for both.

Impact of Merger on the HBE Projections

We have performed enrollment and cost projections under two scenarios:

- Separate individual and small group risk pools
- Combined individual and small group risk pools

Table 1.6 (in Section I) summarizes the impacts on enrollment and average health status of merging the individual and small group risk pools. By “health status,” we mean the estimated gross costs expected from each member, beyond that which is due simply to their age. 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.

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.

Recommendations

We recommend that North Carolina seek carrier input on this issue, as they are in the best position to estimate what will happen with their own premium rates if the pools are merged. To aid in carriers’ decision making, the State could make available the market average projections provided in this report, or other such information.

Some additional issues that the State may wish to consider are:

- Whether grandfathered plans are included in the risk pool may be important to some carriers. For example, in the current insurance market, Blue Cross Blue Shield of North Carolina (BCBSNC) insures over 80% of all covered lives in the individual market, and approximately two-thirds of lives in the small group market. BCBSNC might have the most to gain or lose from merging the markets.

-
- If carriers choose to pool the experience of their grandfathered and non-grandfathered plans, then there may be less need to combine the individual and small group pools to achieve a target number of pooled lives.
 - If the State elects to have multiple regional exchanges within North Carolina, then it might make sense to pool the individual and small group markets to keep the sizes of the regional rating pools as large as possible.

North Carolina might want to consider phasing in a merger of the individual and small group markets, giving carriers more time to react to the changing market. Ways to do that include:

- For purposes of developing premium rates, blending the individual and small group experience, with the blending weights increasing over time. The blending weights and number of years the phase-in applies could also be a function of the difference between the individual and small group costs, with a longer phase-in being allowed for bigger differences.
- Phasing in the change by geographic area. For example, the merger could be implemented in 2014 for the Raleigh-Durham area, and then for the rest of the state in 2015.
- Delaying the merger until 2016, or later.

RFP STATEMENT OF WORK ITEM #5

Based on the analysis above and other relevant factors, provide a descriptive analysis of the impact of defining a small employer to include those with up to 100 employees on January 1, 2014 and the impact of delaying that change until January 1, 2016. Include in the analysis the pros and cons of each approach as well as a recommendation.

RESPONSE

Federal Requirements

The HBE must be open to small employers on 1-1-2014. States can open the 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.

Other States

Massachusetts and Utah have small business exchanges in operation currently, and both states' exchanges are open to businesses with 50 or fewer employees. California has created legislation that outlines plans for a small business exchange that will be open to businesses with 50 or fewer employees.

Arguments in Favor of Allowing Employers with 51 to 100 Employees to Participate

Opening the exchange in 2014 to groups of up to 100 may have positive results, such as:

- More people will purchase through the exchange. Economies of scale should result in lower HBE administration costs per member.
- The "small group" risk pool will be larger, pooling employers from 1 to 100 employees both in and out of the HBE. A larger risk pool will give carriers greater predictability in their benefit costs. A smaller risk pool might make carriers more hesitant to participate in the HBE.
- 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.
- The HBE must be open to all employer groups of size 51 to 100 in 2016. It might be easier to bring in the 51 to 100 groups in 2014, rather than possibly having the disruption of a wave of new enrollees in 2016.

-
- If the State waits until 2016 to allow the 51 to 100 groups to join, that might delay 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 Allowing Employers with 51 to 100 Employees to Participate

Reasons that North Carolina might not want to open the HBE to employers of size 51 to 100 prior to 2016 are:

- North Carolina currently has insurance laws and regulations that apply to “small groups,” defined as those having 1 to 50 employees. Opening the exchange to groups of up to 100 could lead to inconsistent definitions of small groups inside and outside the exchange, or may require that the small group rules and regulations be changed. In any case, this challenge will need to be faced prior to 2016.
- 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.
- Groups of 51 to 100 who are relatively healthy are likely to consider self-insuring. However, if their populations become unhealthy, they could enter the exchange. While this problem is also present with groups of 1 to 50, opening the exchange to groups of up to 100 people might result in the exchange enrolling a proportionally greater number of less healthy people.

Projections

Table 1.7 (in Section I) showed 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.

Recommendations

We recommend that the State not make this decision too lightly. As listed in the bullets above, the implications may be dramatic for the existing insurance market, particularly for smaller carriers. The State’s decision should be consistent with the State’s long term goals and vision

of how they want the insurance market to operate in North Carolina, and what path they want to follow in achieving those goals.

RFP STATEMENT OF WORK ITEM #6

Study the issues of anti-selection in the health insurance markets under the rules established for Exchanges in the Act. Provide recommendations on how to reduce or eliminate anti-selection against participation in the Exchanges (i.e., disproportionate number of people who are in poorer health and have high health expenses enroll in coverage through the Exchanges, while healthier, lower-cost people disproportionately enroll in plans offered in the individual and small group markets outside the Exchanges) when various Exchange structures are established. Provide the pros and cons of each approach including the impact on insurer participation, consumer choice, and the ability of the Exchanges to influence the quality and delivery of health care in North Carolina.

RESPONSE

The State will need to control adverse selection between the Exchange and the non-Exchange markets, and among carriers within the Exchange. Allowing adverse selection to take hold could quickly reduce the number of carriers and consumers that choose to participate in the Exchange. Adverse selection is an issue that underlies many of the design and operations decisions the State will make in setting up and running the HBE. In this section we discuss the following:

- Federal requirements that will help control adverse selection against the HBE
- Federal requirements that help control adverse selection among carriers within the HBE
- Risk adjustment – protecting carriers from adverse selection
- State opportunities to help control adverse selection against the HBE

Federal Requirements that Help Control Adverse Selection Against the HBE

As described below, the ACA included some provisions that will automatically help protect HBEs against adverse selection.

1. Enrollment

One of the most important ways PPACA controls adverse selection against the Exchange is by encouraging enrollment. It does this in at least two ways. First is through the individual mandate. Requiring all individuals to be covered will bring more people into the market, although they can still buy their coverage outside the Exchange. Second, PPACA makes premium subsidies and cost sharing subsidies available to lower income individuals who enroll in HBE plans.

2. Plan Designs and Pricing

PPACA has plan design and pricing rules that will mitigate adverse selection because they apply to plans both inside and outside the exchange. Some examples include:

- Prohibitions on lifetime and annual benefit limits, and on pre-existing condition exclusions.
- Essential benefits are required to be covered for all individual and small group plans, inside and outside the exchange, unless grandfathered.³
- Limits on out-of-pocket costs.
- Premium rates must be based on adjusted community rating rules, and be independent of health status.
- Qualified health plans must have the same pricing whether sold in or out of the HBE.
- Premium rates must be based on the combined experience of HBE and non-HBE business.

Federal Requirements that Help Control Adverse Selection Among Carriers within the HBE

PPACA also includes three risk management tools that can mitigate the effects of adverse selection among carriers within the HBE. Two are transitional programs and the third is permanent. They are:

1. **Transitional Reinsurance Program, Years 2014-2016.**
The reinsurance program provides carriers with protection against very high cost members. This program is designed to protect individual plans in the Exchange in the early years before the individual mandate is fully phased in, in 2017.
2. **Risk Corridor Program, Years 2014-2016.**
The risk corridor program provides carriers with protection against total claims across all members being higher than expected. A carrier will receive payments if their cost-to-premium ratio is greater than 103%, and make payments if the cost-to-premium ratio is less than 97%.
3. **Risk Adjustment, Years 2014+.**
Under this program, plans with healthier participants have to subsidize plans with less healthy participants. Carriers will set premium rates based on plan design and community rating, and risk adjustment payments will compensate for health status differences not fully reflected in the premium rates.

³ "PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange", Congressional Research Service, June 2010.

Risk Adjustment – Protecting Carriers from Adverse Selection

In a perfect risk adjustment system, there might be no reason for a carrier to care about the health status of the members they enroll. In reality, carriers will probably have some incentive to enroll members who are “better risks.” Better risk members are those for whom the required adjusted community rating process over estimates their expected costs, due to the inherently imperfect predictive ability of the rating system. For example, a rating system might produce a premium rate for an average person aged 40-44. However, within the total population of people aged 40-44 there is a broad distribution of health statuses, and therefore a broad distribution of expected claim costs. The better risks are those people whose expected costs fall below the average for all people aged 40-44. For those people, a premium rate that is based on the average should provide more revenue than is needed to cover the costs of those better risk people.

PPACA requires implementation of risk adjustment to help shift money from carriers who enroll more of these better risk people to carriers that enroll fewer such people. However, that risk adjustment process is unlikely to be perfect and will therefore not completely eliminate the incentive for carriers to enroll as many better risk people as possible. Furthermore, if the risk adjustment system operates retrospectively (i.e., making risk adjustment payment after the insured months they are intended to cover), then some carriers may experience temporary cash flow deficits.

For insurance sold outside the HBE, carriers will also have this same incentive to enroll the better risk people, since their HBE and non-HBE business will be pooled for premium rate setting purposes. Having more better risk enrollees may give them more competitive premium rates.

State Opportunities to Control Adverse Selection Against the HBE

States will also be able to help control adverse selection against the HBE. Ways to do that include:

1. Require all health insurance to be sold only in the HBE. Eliminating the non-HBE market will minimize adverse selection against the HBE. There may still be some adverse selection if, for example, healthy people elect not to purchase any coverage. Additional discussion of this requirement is provided in the response to SOW item #17. Requiring all health insurance to be sold in the HBE might increase carrier participation, or it might cause more carriers to simply exit the North Carolina market. Smaller carriers and carriers that focus on niche markets might be the most likely to exit the market, and possibly go out of business. This requirement would result in fewer choices for

consumers, possibly due to fewer carriers being present, and certainly due to restrictions on qualified benefit plans that can be offered in the HBE. Making the change effective on 1-1-2014 would produce a very large wave of HBE enrollment. It would also cause additional disruption if all non-HBE coverage is required to end on 1-1-2010, forcing many employers to change their benefit plan year anniversary dates.

2. Require that all carriers participate in the HBE, but also allow them to also sell outside the HBE. Some adverse selection against the HBE might still exist if, for example, some benefit plans are offered outside the HBE that are not offered inside the HBE (e.g., plans that might appeal disproportionately to healthier people). Additional discussion of this requirement is provided in the response to SOW item #17. Requiring all carriers to participate in the HBE might cause some carriers to exit the market, resulting in fewer choices for consumers.
3. Encourage carriers to pool grandfathered plans with all other plans for purposes of setting premium rates. This issue is discussed in the response to SOW item #10. If the grandfathered plans are not pooled with the other plans, a carrier with grandfathered policies might see only its least healthy members (i.e., people who were issued with premium rate-ups) enter the HBE to get cheaper coverage. However, this may be a relatively minor issue as the number of people covered by grandfathered plans may shrink rapidly after 2014 due to normal high turnover rates in individual plans.
4. Require that all carriers participating in the HBE offer plans at all benefit tiers (i.e. platinum, gold, silver, bronze, and catastrophic). Without this requirement, a carrier could offer only rich plans in the HBE and only lean plans out of the HBE, thus likely enrolling the carrier's least healthy members in the HBE and their most healthy members out of the HBE. This could give a false impression that the HBE is somehow less efficient or less desirable. Premium rates, however, should be unaffected since they will be based on the pooled experience of HBE and non-HBE benefit plans.
5. Place additional restrictions on benefit plans offered outside the HBE. At one extreme, the State might stipulate that only those plans offered in the HBE may be offered outside the HBE. A more moderate approach would be to restrict the differences between plans offered in and out of the HBE to prevent carriers from offering non-HBE plans that are designed to attract lower risk individuals.
6. Ensure consistency of marketing and pricing rules in and out of the HBE. For example, in terms of pricing, a carrier might be able to attract better risks into their non-HBE plans if they reflect positive selection in their non-HBE premium rates. The State might require that premium rates for qualified plans offered in the HBE be allowed to reflect benefit cost differences only and not be allowed to reflect selection effects among the plans, as is the case with small group health insurance products under current North Carolina law. If, however, this rule does not also apply to nonqualified plans, then carriers might

design and price plans that have a much wider price range than the HBE plans. Prices for lean plans could be well below prices of the leanest qualified HBE plans, drawing the healthiest people to non-HBE products.

7. Allowing groups of 51-100 employees to join the HBE. This is required starting in 2016, but states also have the option to allow it in 2014-15. Possible implications are discussed in the response to SOW item #5.
8. Implementing a timely and sophisticated risk adjustment program. To the extent that carriers believe the risk adjustment system protects them from adverse selection, they will be more likely to participate in the HBE.
9. Take other steps to maximize HBE enrollment, such as:
 - a. Advertising
 - b. Promoting consumer and navigator education
 - c. Making enrollment as easy as possible
 - d. Do not set up a Basic Health Plan, since those enrollees would then not be a part of the HBE and its risk pool. More discussion of the Basic Health Plan option is provided in our response to SOW item #20.
10. Restricting HBE enrollment times, or plan switching, to open enrollment windows or at times of special qualifying events (e.g., moving to North Carolina). This would help keep people from delaying insurance coverage until they feel they are likely to need healthcare services.
11. Charging penalties for delaying enrollment in the HBE.
12. For carriers that elect to leave the HBE, prohibiting re-entry for a period of time (e.g., five years). This might prevent carriers who enroll a disproportionately unhealthy mix of insureds from canceling the policies, leaving the market, and then quickly re-entering the market in the hopes of enrolling a healthier mix of people.
13. Prohibiting carriers that operate in the HBE from having affiliates that operate only outside the HBE.
14. Prohibiting carriers from offering only lean plans outside the HBE (e.g., offering only bronze or catastrophic).
15. Monitoring grandfathered plans to make sure that are not encouraging higher cost members to move into the HBE.

RFP STATEMENT OF WORK ITEM #7

Study the issue of adverse selection among benefit tiers within the Exchange, such as between the Silver plan and those with leaner benefits (Bronze and catastrophic). Provide recommendations for how to monitor and adjust plan pricing to offset any anticipated biased selection among benefit tiers.

RESPONSE

PPACA establishes four levels of coverage based on actuarial value (AV), which is the expected value of net benefits (after application of member cost sharing, such as deductibles and copays), as a percentage of total coverage charges. The four levels of coverage based on the actuarial value are:

- Bronze = 60% AV
- Silver = 70% AV
- Gold = 80% AV
- Platinum = 90% AV

Also, a catastrophic plan can be available to people under age 30 who would suffer financial hardship by buying other coverage. In the Exchange, participating plans must offer at least one silver and one gold plan. California has taken this one step further by requiring carriers participating in the Exchange to offer at least one product within each of the five levels of coverage inside and outside the Exchange. Carriers not participating in California's Exchange will be barred from selling the catastrophic plan.

For small groups, an employer may pick a level of coverage and allow all employees to pick a plan within that level. The exchange has the option of allowing employees to choose other levels of coverage, in spite of the plan level the employer has chosen to fund. This option would give more choices to employees, but would introduce additional adverse selection among the benefit tiers.

Mitigating Adverse Selection among Benefit Tiers

Adverse selection among the benefit tiers can be exacerbated, or mitigated, but it cannot be eliminated. The effects can be exacerbated by increasing premium rate differences among the tiers to better reflect differences in benefit costs resulting from the adverse selection. For example, if a carrier knows the average gold plan enrollee is much less healthy than the average silver plan enrollee of the same age, then they might price for this difference and increase the difference between the gold and silver plan premium rates to more than would be needed just because of benefit plan differences. This pricing difference, however, will cause

some of the healthier gold plan enrollees to switch to silver, thereby increasing the average benefit cost per member in the gold plan. The average cost per member in the silver plan might then also increase, causing the most healthy members to switch to bronze or drop coverage altogether.

Possible ways to mitigate adverse selection include:

1. Allowing subsidies among the premium rates by benefit tiers. The HBE could also do this by limiting premium differences among the benefit tiers to be no more than the value of the benefit differences. As a simplistic example, since a gold plan has an actuarial value of 80% and a silver plan has an actuarial value of 70%, the HBE could limit the gold premium to be no more than $80\% / 70\% = 114\%$ of the silver premium. If the HBE limited the difference to be even less, then adverse selection would be even less. This example is simplistic because it does not recognize the fact that carriers' administration cost differences among the tiers might not vary in direct proportion to net benefit costs. For example, a carrier's administration expenses might be \$50 PMPM regardless of whether an enrollee chooses a platinum plan or a bronze plan.
2. Allow the risk adjustment process to compensate carriers for adverse selection. As discussed in the response to SOW item #6, this process is unlikely to compensate perfectly for adverse selection differences among carriers.
3. For employees of small groups, only allow the employees to pick a plan from the one benefit tier the employer has chosen to fund.
4. Combine the richest benefit plans with the most restrictive provider networks, and the leanest plans with the least restrictive networks. This would probably have to be done by carriers, rather than by the State.
5. Giving enrollees in richer plans the option to purchase additional benefits that might appeal to healthier people, such as preventative dental care or gym memberships. This would probably have to be done by carriers, rather than by the State.

Monitoring Adverse Selection

Adverse selection can be monitored using relatively simple methods, or using more sophisticated methods. For example, a simple way is to compare incurred benefit costs PMPM (per member per month) among the benefit plans, after adjusting for differences in the mix of members by geographic area, age, and tobacco usage. The State could do this using actuarial pricing tools and data from the carriers. Adjustments should be made for induced utilization,

which is utilization differences expected among the benefit plans due solely to differences in the richness of the benefits (i.e., when people have leaner benefits, they use less health care).

Additional sophistication could be introduced by adjusting the historical benefit costs for differences in the average risk score of the enrollees in each plan. Risk scores could be calculated using actual medical claims or prescription drug claims, and commercially available risk adjustor software. Many of these calculations would be done during the risk adjustment process. Therefore, the Exchange would be able to monitor adverse selection between tiers by analyzing results of the risk adjustment process.

RFP STATEMENT OF WORK ITEM #8

According to the Act, the Exchange must be self-supporting (i.e. no State or federal assistance) by January 1, 2015. Provide options as to which functions and/or informational services of the Exchange would lend themselves to quality and transparency, benefiting the larger population as a whole, and which could be assessed to the broader health insurance industry as a whole. Specifically include alternatives to funding all of the Exchange administration through premium for coverage obtained through the Exchange.

RESPONSE

An HBE has the opportunity to provide value to both HBE and non-HBE participants by promoting improvements in quality of care and access to care, and increasing the transparency of costs and quality measures. The extent to which the HBE's activities benefit the non-HBE market will be a function of the HBE's market share, and North Carolina's view of where the HBE should fall along the spectrum of possible influence ranging from a minimalist facilitator of insurance purchasing to an aggressive participant in the insurance and health care delivery markets. Where North Carolina falls on that spectrum will define the breadth and depth of the HBE's activities, and the extent to which those activities will influence the non-HBE market.

The HBE has the opportunity to influence the non-HBE market in terms of:

- Lower health care costs and non-benefit expenses (e.g., administrative costs, commissions)
- Improvements in quality of care
- Improved access to care

Specific examples of how the HBE could improve cost, quality and access outside the HBE are listed below. The success of these functions will be driven, at least in part, by increased transparency of information that is easily understood and actionable for individuals, employers, carriers, and health care providers.

Cost

The HBE can help promote cost control by:

- Educating individuals and employers on benefit plans and costs

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- Possibly promoting long-term cost control via increased transparency and scrutiny of premium rates and health care service costs, possibly even allowing price comparisons among specific providers for specific services
 - Providing tools to help best match a consumer's health care needs, financial resources, desired providers, and geographic location with a health insurance company and benefit plan. This type of matching might help a consumer get the best value of his premium dollar. That optimization of consumer value, however, might also result in higher average premium rates across all insureds

Quality

PPACA requires that plans meet certain quality standards in order to be certified as a Qualified Health Plan. Since the HBE must certify all plans in the exchange, it may choose to place higher standards on the plans than are already required from PPACA. Some quality-related areas where such higher standards could be required include disease management, case management, and electronic records systems. For example, the state of Washington's exchange legislation has stated quality goals, in addition to a target medical trend of 4% by the year 2015. Other areas where the HBE could promote quality include:

- Promoting consumer use of measures of:
 - ⇒ Service quality and member satisfaction – improving the member experience of seeking care
 - ⇒ Patient safety – monitoring and enhancing patient safety performance by providers.
 - ⇒ Prevention services – increasing the percent of the population receiving appropriate prevention services
 - ⇒ Chronic care – improving care coordination and oversight of care for people with chronic conditions
 - ⇒ Inpatient quality – monitoring and improving hospital based care
 - ⇒ Outpatient quality – identifying ambulatory care sensitive conditions that indicate unnecessary inpatient admissions or lack of adequate outpatient support
- Promoting use of standardized quality measures. Providers and insurers could have the ability to compare performance and identify opportunities for improvement. Consumers could also have improved ability to make comparisons and interpret their meaning. Examples of sources and measures that can be used include:
 - ⇒ National Committee Quality Assurance (NCQA) HEDIS measures and specialty certification programs for physician groups meeting chronic care management guidelines.
 - ⇒ AHRQ measures of inpatient quality including:
 - i. Prevention Quality Indicators (PQIs), for ambulatory care sensitive conditions, identify hospital admissions that evidence suggests could have been avoided, at least in part, through high quality outpatient care.

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- ii. Inpatient Quality Indicators (IQIs) reflect quality of care inside hospitals and include:
 - a. Inpatient mortality for medical conditions.
 - b. Inpatient mortality for surgical procedures.
 - c. Utilization of procedures for which there are questions of overuse, underuse, or misuse.
 - d. Volume of procedures for which there is evidence that a higher volume of procedures may be associated with lower mortality.
 - iii. Patient Safety Indicators (PSIs) also reflect quality of care inside hospitals, but focus on potentially avoidable complications and iatrogenic events.
 - iv. Pediatric Quality Indicators (PDIs) both reflect quality of care inside hospitals and identify potentially avoidable hospitalizations among children.
- ⇒ Hospital readmission rates and avoidable emergency room use rates through CMS (Centers for Medicare and Medicaid Services) and other nationally endorsed measurement approaches.
- ⇒ Behavioral health and substance abuse measures through sources such as the Department of Health & Human Services endorsed National Registry of Evidence Based Programs and Practices (NREPP).

Access

The HBE can help improve access to providers by:

- Helping consumers find providers that are accepting new patients and will meet their needs
- Promoting network overlap and coordination of care among providers that have traditionally served low income populations and those that have primarily served non-low income populations

The services that the HBE provides and the requirements that it imposes can drive these changes. Specific administrative functions of the HBE that might improve cost, quality, and access outside the HBE include:

- Health plan certification. Application of certification processes for plan offerings outside the HBE would likely create a more consistent consumer experience, ensuring that all plans (both inside and outside the HBE) meet standards such as network adequacy, accreditation using performance measures, enrollment processes, and other functions. Implementing some of these changes, however, would likely require substantial changes to the regulatory environment and might also meet significant resistance from carriers and other stakeholders if they are not sufficiently involved in planning and ongoing operations.

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- Reporting of standardized administrative and quality data from plans both inside and outside the HBE. This would provide useful information to consumers for consideration in the purchasing decision, and may help drive quality improvement. Plan performance and quality metrics presented in the HBE could be useful metrics for all purchasers.

Funding HBE Administration Expenses

The State might want to match the costs of these HBE services to those parties that indirectly benefit from them, such as individuals, employers, and insurance companies participating in the non-HBE insurance market, and health care providers. Possible mechanisms for doing that include:

- Premium tax - The tax could apply to comprehensive major medical insurance sold both inside and outside the HBE
- Carrier assessments based on numbers of covered lives
- Assessments on self-funded employer health plans
- Provider assessments
- Special or one-time assessments on insurance companies, employers, or providers.
- Higher state income taxes for people getting coverage in the HBE - of course, this would discourage HBE participation

Some combination of these mechanisms might produce an allocation of costs that is the most broadly accepted among stakeholders. Table 1.8 in Section I provides some projections of the possible the cost allocations on a per member basis and on a percentage of premium basis, using various populations that could be assessed.

RFP STATEMENT OF WORK ITEM #9

Project the cost to run an Exchange for the first 3 years of operation (beginning January 1, 2014) using the projections for enrollment/participation produced in this report. Base assumptions for the activities, functions and expenses of the Exchange upon the activities, functions, and expenses of the Massachusetts Connector. The analysis should include suggested staffing needs and capabilities, as well as proposed methodologies (e.g. assessments, user fees, etc.) for generating funds sufficient to support operation of the Exchange and its related services, as provided by the Act (e.g. Navigator grants, IT operations, out reach, etc.) along with the costs associated with each method.

RESPONSE

Our response to this SOW item includes discussion of:

- HBE administrative functions
- Assumed HBE structure
- Estimated HBE staffing requirements
- Estimated HBE administrative expense budget for 2014-2016
- Premium subsidy handling
- Early innovator grants
- Navigator outreach grants

Appendix C presents our projected HBE administrative expense budget for the period 2014-2016 under the baseline reform scenario.

The expense projection does not contemplate the start-up expenses that would be necessary to stand-up the HBE. These costs could be substantially higher than one year of operating expenses. For example, the U.S. Department of Health and Human Services (HHS) recently awarded “Early Innovator” grants to seven states to fund development of information systems solutions for HBEs. The grants range from \$6.2 million to \$54.6 million. Although the solutions developed with these grant funds must be shared with other states, North Carolina should anticipate significant investments of its own for implementation of these solutions in addition to other start-up investments.

Discussion of possible methods for funding administrative expenses is provided near the end of our response to SOW item #8.

This section of the report provides a high-level description of the staffing, capabilities, and costs associated with performing the requirements laid out in the CCIO guidance. These estimates are based on assumptions regarding the approaches the State will take in implementing and operationalizing these requirements. If the actual approaches employed by the State vary from

the assumptions we made in developing this response, or if the State's final approach involves functions not contemplated here, then the estimates contained in this analysis (e.g. the staffing requirements or expense estimates) could vary from actual results. We have attempted to make reasonable assumptions based on our professional judgment and experience with other organizations that perform similar functions and based on experience data from the Massachusetts Connector. Notwithstanding this effort, there are functions required of the HBE for which there is no comparable experience on which to rely. In these cases, we have attempted to estimate the workload, qualifications of the staff, intensity of the work, and other factors that drive staffing or expense.

HBE Administrative Functions

The HBE will provide a mechanism for the distribution of health insurance products to individual and small group consumers. It has several major functions as defined in guidance provided by the Center for Consumer Information & Insurance Oversight (CCIO), a part of the Centers for Medicare and Medicaid Services (CMS). These duties are:

- Certification, recertification, and decertification of plans;
- Operation of a toll-free hotline;
- Maintenance of a website for providing information on plans to current and prospective enrollees;
- Assignment of a price and quality rating to plans;
- Presentation of plan benefit options in a standardized format;
- Provision of Information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs;
- Certification of individuals exempt from the individual responsibility requirement;
- Provision of information on certain individuals to the Treasury Department and to employers; and
- Establishment of a Navigator program that provides grants to entities assisting consumers.

In addition, the HBE will be responsible for ensuring that Plans meet regulatory requirements with regard to:

- Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers;
- Consideration of plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases;
- Public disclosure of plan data, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information;

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- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers;
 - Information for participants in group health plans; and
 - Information on plan quality improvement activities.

Finally, the HBE will be responsible for:

- Presentation of enrollee satisfaction survey results;
- Provision for open enrollment periods;
- Consultation with stakeholders, including tribes; and
- Publication of data on the HBE's administrative costs.

Assumed HBE Structure

In developing the staffing assumptions for the HBE, we assumed it would be formed as a separate entity. If, in reality, the State chooses to implement the HBE as a unit of an existing State agency, then certain senior level positions (such as the Director of Information Systems and the Director of Finance) and most infrastructure positions (such as Human Resources and Accounting) would be unnecessary. These functions could be provided on a "purchased services" basis from other agencies. This approach would reduce the HBE's administrative costs by enabling the HBE to access the economies of scale of other agencies. However, such an approach would also shift the associated workload to those other agencies. In addition, a part-time management team, with other primary responsibilities may not give the HBE the level of attention necessary during its first few years of operation.

Estimated HBE Staffing Requirements

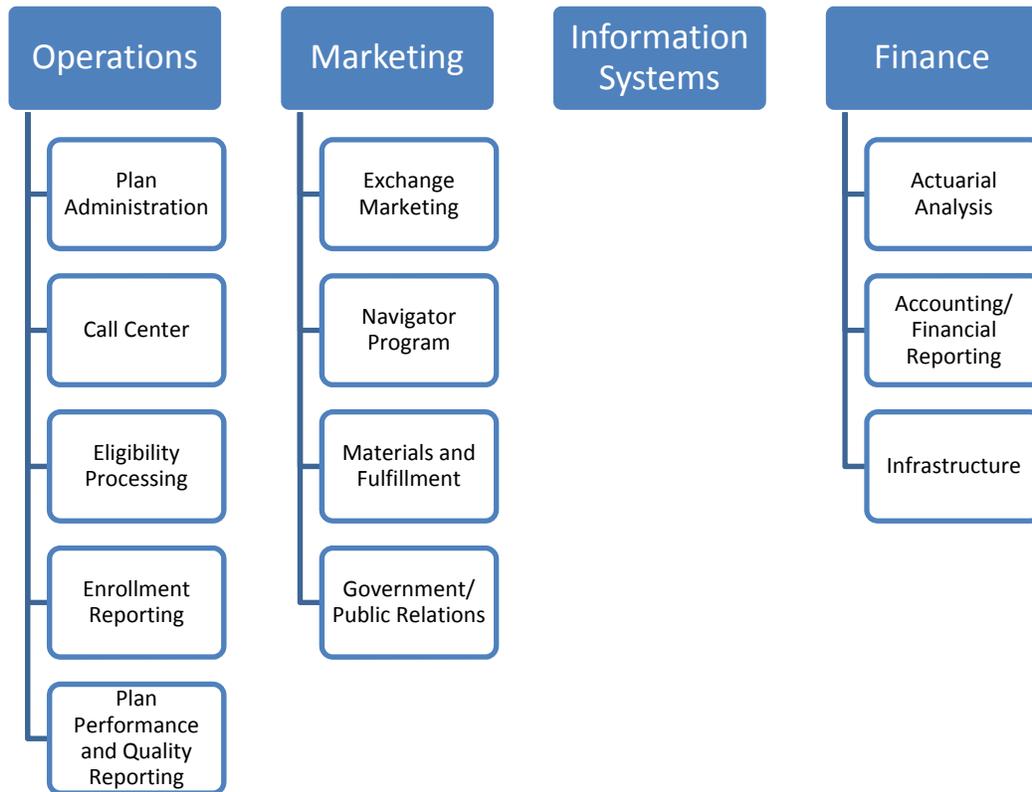
Over the next few pages we have described the numbers and types of people we expect the HBE may need to employ.

Executive Leadership Team

We envision that the HBE will be led by an executive leadership team comprised of a top executive (i.e. an Executive Director) and senior executives responsible for each of four major functional areas (operations, marketing, information systems, and finance). Staffing for the executive office (in full time equivalents or FTEs) is shown in the table below.

Title	Responsibility	FTEs
Executive Director	Responsible for overall management and strategy of the HBE. Member of the executive leadership team.	1
Director of Operations	Responsible for execution and strategy of all operations functions of the HBE. Member of the executive leadership team.	1
Director of Marketing	Responsible for execution and strategy of all marketing and community relations functions of the HBE. Member of the executive leadership team.	1
Director of Information Systems	Responsible for execution and strategy of all information systems functions of the HBE. Member of the executive leadership team.	1
Director of Finance	Responsible for execution and strategy of all finance, accounting, and actuarial functions of the HBE. Member of the executive leadership team.	1
Board Liaison	Coordinates interaction between HBE leadership and the HBE's Board of Directors. Coordinates development of annual reports.	1
Administrative Assistant	Provides administrative support for executive leadership team and subordinate departments	5

Separate units or staff responsible for execution will then report to each of these senior leaders. We envision that the Administrative Assistants would be shared positions serving the entire organization. The figure below illustrates the major functions and sub-functions anticipated for the HBE.



In the paragraphs below, we have described the various operational responsibilities for each function and the various sub-functions as well as the estimated staffing by position and the assumptions/methodology used to estimate staffing requirements.

Operations

The Operations department will be responsible for several important functions: (1) Plan Administration, (2) Call Center, (3) Eligibility, and (4) Enrollment Reporting.

Plan Administration

The HBE will be responsible for certification, recertification, and decertification of plans from the insurers participating or seeking to participate in the HBE. Certification requires plan compliance in five areas, plus any additional requirements imposed by the HBE:

- Marketing
- Network adequacy
- Accreditation for performance measures
- Quality improvement and reporting
- Uniform enrollment procedures

Personnel within the HBE will be responsible for evaluating the plans in accordance with defined criteria. We assumed that the plan certification activity would be supported by the NCDOI but that the HBE would need its own resources for certain analyses that would not be normally performed by the NCDOI, such as administration of the risk adjustment system. The extent of the HBE’s responsibilities for plan certification will depend, in part on the division of responsibilities between NCDOI and the HBE, the rigor of the analysis, and the standards used to qualify the plans. In addition to the evaluation activity, the HBE will be required to collect data from plans for reporting to the public. Staffing for this area will be dependent on the number of insurers participating in the HBE and the complexity/strictness of the certification criteria. In preparing this staffing estimate, we assumed that the HBE would place the onus for complete reporting of information on the insurers and that the HBE’s review would be limited to information submitted by the insurers, rather than intense analytics. We assumed that each Carrier Liaison and Plan Certification Analyst can support up to 20 plans.

Title	Responsibility	FTEs
Manager, Plan Administration	Supervises personnel in Plan Administration department. Reviews and certifies all plan certification/decertification decisions.	1
Carrier Liaison	Interfaces with the insurers offering plans through the HBE. Serves as the single point of contact for all insurer-related issues.	2
Plan Certification Analyst	Conducts administrative review of plans proposed for inclusion in the HBE. Guides insurers through the qualification process.	2
Clerk	Handles documentation, filing, and pre-processing of plan documentation.	2

Call Center

The HBE is required to provide a toll-free hotline available to answer consumer questions. This requirement can be met through establishment of a call center staffed by call center representatives taking telephonic inquiries. Ultimately, staffing for the call center is dependent on the volume of calls anticipated. Based on published reports for the Massachusetts Connector, approximately 20% of transactions required contact with a call center representative. For this model, we have assumed that 25% of consumers will contact the call center annually. We also assumed an average call duration of 480 seconds with call wrap-up time of 20 seconds, and a service level by which 80% of calls are answered in 20 seconds. Staffing for the call center is very sensitive to the average call duration, the percentage of enrollees requiring customer service, and the service level of the call center.

Title	Responsibility	FTEs in 2014
Manager, Call Center	Manages call center.	1
Supervisor, Call Center	Supervises call center representatives. Takes “speak to a manager” customer service calls.	1
Call Center Agent	Takes telephonic and e-mail inquiries from consumers.	26

We estimated that the number of call center agents would increase to from 26 in 2014 to 28 in 2016, due to enrollment growth.

Eligibility Processing

The HBE is responsible for determining consumer eligibility for Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs. This activity can generally be completed via an electronic transaction, but will require modifications to the State’s Information Systems to facilitate the function. For individuals without Internet access, the HBE must be prepared to handle written requests. In addition, the HBE will need to handle consumer appeals for eligibility determinations.

Additional definition of the appeals process is needed to fully estimate the workload requirement for appeals. The Massachusetts Connector has budgeted large sums to support administrative hearings for appellants. If such an approach is implemented in the State, then the costs of administering the appeals process could be substantially greater than the two FTEs proposed here.

Title	Responsibility	FTEs
Supervisor, Eligibility Support Unit	Oversees eligibility processing.	1
Eligibility Processor	Processes eligibility inquiries.	2
Eligibility Appeals Processor	Processes eligibility appeals.	2

Plan Performance and Quality Reporting

The HBE is required to generate a variety of reports for public disclosure regarding plan performance. It is also required to assign quality scores to plans. Personnel in this department will be responsible for meeting these requirements. In addition, we anticipate that the HBE will engage the services of a vendor to provide a system solution for the collection and storage of data, and the generation of reports.

Title	Responsibility	FTEs
Manager, Plan Performance and Quality Reporting	Responsible for executing plan performance and quality reporting strategy. Manages relationship with system vendor.	1
Quality Analyst	Ensures timely collection of administrative data and quality inputs from plans. Develops report specifications.	2
Report Developer	Pulls data and develops reports of plan performance and quality.	1

Enrollment Reporting

The HBE has a variety of responsibilities related to enrollment reporting, including reporting status on individuals meeting certain criteria (such as cases when the individual's employer is not providing minimum essential, affordable coverage, or when such an individual changes employers or has ended coverage within the HBE). The HBE is also required to coordinate with government agencies in granting exemptions to the individual mandate. In developing the staffing, we presume that the HBE's information system will collect and report information necessary to appropriately administer the subsidies and report information to relevant federal agencies. Notwithstanding this support, we believe the HBE will need an Enrollment Reporting unit responsible for ensuring that appropriate information is collected and reported. Staffing for this function assumes that the core system, as supported by other business processes, will be able to collect and report the necessary enrollment reporting information.

Title	Responsibility	FTEs
Manager, Enrollment Reporting	Oversees data collection and reporting for all subsidy-related requirements.	1
Enrollment Reporting Analyst	Responsible for preparing subsidy related reports.	2

Marketing

The Marketing department will serve three important functions: (1) HBE Marketing, (2) Navigator Program, and (3) Materials and Fulfillment.

HBE Marketing

Use and adoption of the HBE as a distribution channel will require an active marketing program designed to make potential consumers aware of the HBE and the function it provides. We envision the marketing strategy will be established by the senior leader responsible for marketing and then executed by subordinates. The execution strategy could include a media campaign and other traditional marketing activities as well as a community outreach campaign.

The expense estimate is based on typical health plan advertising and promotion and assumes marketing is limited to a single state.

Title	Responsibility	FTEs
Manager, Marketing	Oversees execution of HBE marketing plan.	1
Marketing Coordinator	Assists with execution of HBE marketing plan.	2

Navigator Program

The Navigator Program involves leveraging community resources to make information about the HBE available to potential consumers via existing channels such as community organizations and state agencies. Navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. Staffing for this function is based on a reasonable geographic distribution of Navigator Liaisons through the State.

Title	Responsibility	FTEs
Manager, Navigator Program	Oversees navigator program. Supervises Navigator Liaisons. Evaluates grant applications.	1
Navigator Liaison	Interfaces with community groups providing navigator functions. Facilitates the grant-making process.	4

In addition to personnel to administer the Navigator Program within the HBE, we included a budget line item for Navigator grants. We based this estimate on the Massachusetts Connector’s per-enrollee budget for “outreach.”

Materials and Fulfillment

The HBE will be responsible for providing a variety of information and content to potential consumers, such as information about Medicaid, CHIP, and other health programs. In addition, the HBE will be responsible for developing content for display on the website, through brochures, forms, and other marketing collateral. Personnel in this department will also support development of external marketing materials and reports as well as forms for plan and consumer interaction with the HBE. To support development of these materials, the HBE will require technical writing and graphics design resources.

Title	Responsibility	FTEs
Supervisor, Materials and Fulfillment	Oversees development of print and online marketing materials.	1
Copywriter	Develops consumer-focused copy for presentation via brochures, website, and other media. Materials must age, education, and language appropriate.	1
Graphics Designer	Develops marketing collateral.	1
Clerk	Responsible for materials fulfillment	2

The expense budget estimate includes a line item for Branding and Promotion that is based on the typical advertising expense for a regional health plan.

Government/Public Relations

It will be necessary for the HBE to ensure it maintains compliance with all government regulations and maintains an appropriate level of visibility at the state and federal levels. In addition, the HBE will be required to have an active public relations function responsible for coordinating with stakeholders and responding to inquiries from the public and the press.

Title	Responsibility	FTEs
Manager, Government/Public Relations	Develops and executes Government/Public Relations plan. Represents HBE interests, in collaboration with other members of the executive leadership team, at the State level.	1
Public Relations Coordinator	Assists with execution of Government/Public Relations plan. Interfaces with the public and press on matters related to the HBE.	1
Government Relations Coordinator	Assists with execution of Government/Public Relations plan.	1
Grant Writer	Coordinates grant applications on behalf of the HBE.	1

Information Systems

Operation of a successful HBE will require significant investments in Information Systems (IS). We anticipate that the HBE will outsource the development, implementation, and maintenance of the core information systems platform, including the website. This strategy is consistent with the approach taken by the Massachusetts HBE. For cost estimation purposes, we relied on the "Early Innovator" grants awarded to selected states by the U.S. Department of Health and Human Services. Grants ranging from \$6.3 million to \$54.6 million were awarded to seven states to fund the development of IS infrastructure to support HBE operations including

interfaces with existing Medicaid Management Information Systems (MMIS) and planned interfaces with Federal agency systems. The seven states receiving grants have agreed to share their solutions with other states. The cost of implementing the system is not contemplated in the budget estimate, however, an annual operational budget for vended services is included.

In addition to the outsourced IT services, the HBE will require additional IS support for sub-functions such as network administration, desktop support, information security, ad hoc programming and database development, and reporting/analytics.

Title	Responsibility	FTEs
Network Administrator	Manages local area network infrastructure.	1
Desktop Support Specialist	Provides hardware and desktop software installation for HBE employees.	1
Systems Program Manager	Interfaces and manages relationship with core system vendor.	1
Application Developer	Conducts ad-hoc system development to support operational requirements not provided by the core system.	3
Database Administrator	Manages database infrastructure.	1
Database Developer	Develops ad-hoc databases for operational areas.	3
Plan Configuration Specialist	Loads and updates plan configuration in the core system.	1
EDI Specialist	Interfaces with third parties sending/receiving electronic data interchange transmissions.	2
HIPAA Compliance Officer	Develops HIPAA-related policies and procedures. Handles consumer HIPAA inquiries.	1

The expense budget includes line items for maintenance of a core system and maintenance of a website. These estimates were based, in part, on the Massachusetts Connector annual budget. The implementation cost of these systems are not included in the budget.

Finance

The Finance function is responsible for: (1) actuarial analysis, (2) accounting/financial reporting, and (3) infrastructure.

Actuarial Analysis

The HBE will require actuarial services as part of the plan qualification process and this risk adjustment process. The role of actuarial services would be significantly greater if the HBE is

designed as an active or selective purchaser, negotiating premiums with insurers offering plans through the HBE. Furthermore, we anticipate that certain actuarial studies, such as adverse selection monitoring and comparisons of the market inside and outside the HBE, will be necessary. We assumed the actuarial analysis for qualifying plans will be performed by the NCDOL. If this assumption is not accurate then the HBE would need additional actuarial and financial analysis personnel or could outsource this function to a vendor.

Title	Responsibility	FTEs
Chief Actuary	Establishes actuarial review policy. Serves as subject matter expert for actuarial matters.	1

Accounting/Financial Reporting

The accounting department will be responsible for traditional accounting functions such as cost accumulation, budgeting, accounts receivable, accounts payable, treasury, etc. In addition, the department is responsible for generating financial management reports and the HBE’s annual report.

Title	Responsibility	FTEs
Controller	Organizes, and directs general accounting, general business operations, statistical reporting, and banking and investment activities.	1
Staff Accountant	Performs day-to-day accounting functions such as journal entries, budget development, and handling accounts receivable/payable.	3
Financial Analyst	Prepares financial management reports.	1

The budget includes an expense line item for acquisition of an accounting system.

Infrastructure

If the HBE operates as a separate and standalone entity, it will have infrastructure needs such as Human Resources, Facilities, Purchasing, and Payroll. If the HBE operates as a unit of another entity, then likely these services would be provided on a marginal basis by that entity. We have included these positions here for modeling purposes.

Title	Responsibility	FTEs
Human Resources Generalist	Handles day-to-day human resources and benefits issues on behalf of HBE employees.	2
Payroll Specialist	Handles payroll processing for HBE employees.	1
Training Specialist	Develops and implements training curriculum for new employees.	1
Office Manager	Manages HBE office to include coordinating vendors.	1
Mail Clerk	Handles incoming and outgoing mail.	1
Attorney	Represents the HBE in legal actions. Provides input to contracts.	1
Compliance Officer	Monitors State and Federal legislation to ensure HBE compliance.	1

Estimated Administrative Expense Budget for 2014-2016

We projected an administrative expense budget for the period 2014-2016. The budget is presented in Appendix C. We used the following methodology:

1. Determined administrative requirements of the HBE based on the CCIIO guidance regarding required HBE functions
2. Developed an assumed organizational structure and approach for performing the required functions
3. Identified appropriate positions and job responsibilities necessary to carry out the work
4. Estimated the number of full time equivalents (FTE) for each position based on ratios, volumes, and professional judgment. We assumed a mid-level work intensity and typical work schedule
5. Determined reasonable mid-point salaries for each position. Wages in the Raleigh market appear to be relatively consistent with national average wage levels for HBE position and hence we did not make a cost of living adjustment. Where exact positions matches were not available we used other positions with similar responsibilities or expertise requirements as a proxy. We trended the 2010 salaries forward to 2014-2016 using an inflation factor.
6. Calculated the total salary cost as the sum product of the FTE counts and salaries by position
7. Added payroll taxes and benefits using 8% and 25% of salary factors, respectively.
8. Added in other salary driven costs using factors derived from our previous work and professional judgment
9. Added other direct costs derived using several different methodologies such as PMPM factors, estimated cost per FTE, or line item estimates. When costs of the Massachusetts Connector were believed to be comparable, we used cost per enrollee ratios

10. To project 2015 and 2016, we applied an inflation factor based on historical wage inflation from the prior ten years

Premium Subsidy Handling

The Massachusetts Connector takes an active role in the collection, aggregation, distribution, and reconciliation of premium subsidies. Although this activity is not a stated requirement of the HBE, many stakeholders believe it would be preferable for the HBE to serve as a clearinghouse for premium subsidies.

Our staffing model and budget analysis do not include funding for this activity. However, should the NCDI determine it is an appropriate activity we have provided an estimate of the annual cost.

The 2010 Massachusetts Connector operating budget includes line items for “Customer Service & Premium Billing” and “Enrollment & Eligibility” as it relates to consumers receiving premium subsidies.

2010 CommCare Enrollment: 160,318 *Per Report to Massachusetts Legislature	2010 Administrative Operating Budget
Enrollment & Eligibility – CommCare	\$ 5,935,590
Customer Service & Premium Billing – CommCare	\$ 7,531,158
Total	\$ 13,466,748
Cost Per Member Per Month (PMPM)	\$7.00

2010 enrollment in subsidized products was 160,318. The associated cost for the two line item expenses was approximately \$7.00 per member per month (PMPM) (\$13,466,748 / 160,318). We do not have sufficient detail to separate this expense into component parts using actual financial information from the Massachusetts Connector. We can, however, use health plan benchmark data as a proxy to estimate a reasonable split. The distribution of the Massachusetts Connector expense among Customer Service, Enrollment and Eligibility, and Premium Billing/Reconciliation is shown in the table below.

Functional Activity	PMPM Expense (Est)
Customer Service	\$ 4.69
Enrollment, Termination and Change	\$ 1.24
Premium Billing + Premium Reconciliation	\$ 1.07
Total	\$ 7.00

The expense level for Premium Billing + Premium reconciliation is \$1.07 PMPM. If applied to the entire HBE estimated enrollment for 2014, the cost associated with this activity would be approximately \$7.6 million. If the HBE only provided these services for members who are estimated to be subsidized, then the cost would be less.

Early Innovator Grants

The U.S. Department of Health and Human Services (HHS) on February 16, 2011 announced that seven cooperative agreements are to be awarded to a group of “early innovator” states for the purposes of designing and implementing the Information Technology infrastructure necessary to operate Health Insurance Exchanges. Approximately \$241 million will be allocated to the following grantees:

- Kansas;
- Maryland;
- New York;
- Oklahoma;
- Oregon;
- Wisconsin; and
- A consortium of New England states led by the University of Massachusetts Medical School.

The Early Innovator grants are intended to act as a catalyst for the development of Exchange IT systems, providing models and approaches for how these systems can be created. Each grantee has committed to the development of reusable and transferable technology that other states may leverage in the development of Exchanges in the future. The result of this initiative could reduce the administrative burden of website design and provide a blueprint for the IT function to be facilitated at each Exchange.

Navigator Outreach Grants

When establishing our budget estimates for a Navigator Program, we considered what the Massachusetts Connector (Connector) spent on member outreach programs. In their 2010 Administrative Operating Budget the Massachusetts Connector disclosed “Outreach Grants” of \$500,000, \$2.78 PMPY (per member per year). We used that amount, combined with our projections of HBE enrollment to estimate the cost of outreach grants in each year. The cost estimates are shown on the first page of Appendix C.

It is noteworthy that the Exchange must contract with and finance Navigators, but the Exchange may choose to charge a separate fee to compensate the Navigator. Therefore, depending on the Exchange's funding strategy with regard to Navigators, there may be a limited direct expense in funding a Navigator program.

RFP STATEMENT OF WORK ITEM #10

Study the expected impact of establishment of an Exchange upon insured grandfathered plans and the individuals and employers who keep coverage in them. This should include analysis of the expected impact upon the premium rates for such plans, and an estimate of the percentage of larger employers who may dump employer group coverage and push employees to the Exchange. Include recommendations for safeguards that should be considered by the State to address this issue.

RESPONSE

Once grandfathered status is lost, it cannot be regained. Therefore, the number of people covered by grandfathered plans will shrink over time. In the short term, however, many individuals and employers may try to retain their grandfathered status, which will keep them out of the Exchanges. This will result in different benefit packages being offered in and out of the Exchange. Premium rates will also differ, due to the benefit differences and possibly due to differences in the mix of participants by age, sex, health status, industry, and other variables.

The implications of grandfathering are different for small groups and individuals. We expect that only a small percentage of small groups will continue to maintain grandfathered status past 1-1-2014. Small groups tend to change their benefit plans relatively frequently to help offset inflation and keep premium rate increases low. Those plan changes will probably cause most groups to lose grandfathered status over the next three years, if they have not lost it already.

People with grandfathered individual plans may be more likely to keep their grandfathered plans past 1-1-2014, although individual insurance plan persistency rates have historically been low, with most policyholders terminating within their first two years. Assuming carriers do not simply cancel grandfathered plans and encourage people into their HBE plans, a person with individual insurance will be faced with the decision of whether to keep current coverage, change to some other non-HBE plan, purchase an HBE plan, or drop coverage. Since policies will be guaranteed issue without underwriting, the decision will probably be a function primarily of price and benefits, and possibly provider access or other variables. This freedom of choice and lack of new entrants into the grandfathered plans may accelerate adverse selection within the blocks of grandfathered plans. Depending on whether they are adequately compensated through the risk adjustment process, carriers may elect to cancel coverage on those blocks grandfathered policies, if the state allows them to do so.

Large Employer Reactions

We do not anticipate that significant numbers of large employers will simply drop their benefit plans and encourage employees into the HBE. Employers provide health plans now as a part

of the compensation packages that help them attract and retain employees. That dynamic seems unlikely to change in the near future, since employee perception may be different for an employer that provides their own benefit plan versus one that simply helps employees find coverage in the insurance market. Over the long term, those perceptions might change, if the percentage of employers offering their own benefit plans shrinks materially.

Safeguards Against Employers Dumping Coverage

If the State wants to implement safeguards against employers dumping their group plans, some possible methods might include:

- Monitoring exactly which large employers provide coverage
- Maintaining a public list of large employers that provide coverage
- Surveying people who enter the HBE or Medicaid to see if they came from an employer plan that was dropped
- Monitoring the average health status (e.g., via risk scores or self-reported health status) of people who are newly entering the HBE (employers with high per-employee costs may be the ones who are more likely to drop their plans, especially since employees can take advantage of the individual market being guaranteed issue with adjusted community rating)

RFP STATEMENT OF WORK ITEM #11

Study the possible governance structures for the Exchange (state government agency, non-profit entity, independent pseudo-government agency, federal government agency) and provide analysis relating to the challenges for the state associated with each structure.

RESPONSE

Governance Options

States have several options for establishing the HBE's administrative entity:

- A. The exchange can be established within an existing state agency, such as the Department of Insurance.
- B. The state can create a wholly independent non-profit organization to run the exchange.
- C. The state can create an independent quasi-government entity to run the exchange.
- D. If the state does not make enough progress toward creating an exchange, the federal government will step in to establish and run an exchange within the state.

In deciding which governance structure would be best for North Carolina, the State may wish to consider that the HBE will need to:

- Work with multiple government agencies and the legislature. Information needs to be transferred efficiently between the exchange and those other entities.
- Respond reasonably quickly to changing market conditions and consumer demands for new products.
- Maintain a positive public image.

As noted above, there are multiple options for the governance structure of the exchange. The pros and cons of each option are discussed below.

Option A: Existing State Agency

One option is to administer the exchange from within an existing state agency, such as the Department of Insurance or Department of Health and Human Services.

Pros

- An established agency might need less start-up funding and could have lower ongoing administrative costs.

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- An established agency provides easier communication and data transfer with other agencies such as the Department of Medical Assistance. There would also be fewer privacy concerns regarding data transfer.
 - State agencies are required to be transparent and accountable.

Cons

- There is risk of decision making and operations being politicized. Even the appearance of politics within the exchange can hurt the public image of the exchange.
- State agencies have many administrative rules. For example, there are often numerous requirements for hiring and contracting employees. These can result in the exchange not being able to react quickly to market demands.
- Other state purchasing rules may inhibit the HBE's ability to operate efficiently.
- Administering the exchange within an existing agency can result in conflicts of interest. For example, the Department of Insurance is responsible for making sure that insurance companies remain solvent. However, the exchange may be responsible for encouraging competition within the market and making available the lowest possible premiums for consumers.
- If staff within a state agency is not dedicated exclusively to exchange operations, there may be competing demands on time and resources.

Option B: Non-Profit Organization

A non-profit organization would be a separate entity established by the government but operated separately from it. A non-profit organization would not be directly accountable to state government or subject to state government oversight.

Pros

- The lesser oversight and reduced applicability of state regulations might maximize the HBE's flexibility. It would be able to react more quickly to market changes. It would be able to hire and spend money when necessary with minimal hindrance from purchasing requirements.
- A non-profit would be more removed from government regulation or oversight. It would be more immune to political influence.

Cons

- Separation from state agencies might result in less efficient communication and transfer of information with state agencies.
- The HBE might have a reduced ability to influence pertinent state legislation.
- Public accountability and transparency might be reduced.
- There may be some question as to whether North Carolina lawmakers have the authority to establish a non-governmental non-profit organization.

Option C: Independent Quasi-Government Agency

Creating an independent quasi-government entity is another option.

Pros

- Establishing an independent quasi-government entity would allow for the exchange to be subject to only those State rules and laws that the legislature chooses to include in the entity's founding legislation. This would provide the exchange with greater flexibility in personnel, procurement and other matters than is the case with a State agency.
- Distance from existing State agencies would provide less chance of the exchange being politicized. Independence from existing agencies minimizes conflict of interest.
- Being a quasi-government agency might allow the exchange to work more closely with government agencies and politicians than entities not created by State law, facilitating exchange of data, information, and ideas.
- In creating a quasi-government entity, the legislature could require the exchange to comply with State law on transparency, accountability, and related matters.
- There is at least one similar precedent for this approach in North Carolina. The state high risk health insurance pool, Inclusive Health, is an independent, quasi-government non-profit entity.

Cons

- State regulations and oversight might limit market flexibility.
- An independent quasi-government entity will have to establish new working relationships with other agencies and legislature.

Option D: Federal Exchange

The federal Affordable Care Act requires an exchange be operational by 1/1/2014. A federal audit on the progress of the exchanges will be performed on 1/1/2013. The federal government will establish a federally run exchange in any state that has not made enough progress. States will end up with a federally run exchange through inaction.

Pros

- Many costs are associated with the establishment of the exchange. A state might be able to avoid some of those costs by allowing the federal government to set up the HBE.
- The federal government would be responsible for making it self-sustaining by 2015. The federal government would bring economies of scale that could reduce administrative costs.

Cons

-
- Allowing the federal government to set up the HBE might ultimately be more costly for the State, depending on how the start-up costs and ongoing expenses are funded.
 - The State forfeits control over the exchange. There would be no flexibility in how the exchange is run or funded.
 - State laws would need to be reviewed to determine where state authority may overlap with federal authority.
 - The State would need to determine what data could legally be provided to the federal government.
 - The state and federal governments would need to be able to coordinate. State regulatory and policy issues would need to be reviewed and revised to ensure coordination between state and federal agencies.

Options Elected by Other States

Several states have already established exchanges. The Massachusetts Commonwealth Connector was established as an independent quasi-government agency. The State of Washington has similarly established an independent agency for their exchange, the Washington Health Insurance Partnership. California has established the California Health Benefits Exchange (CHBE), also as an independent quasi-government entity. The Utah Health Exchange is administered under an existing state agency, the Office of Consumer Health Services. We know of no states that have established an exchange as a non-profit organization, although we understand that at least one state (New Mexico) may have considered that option.

RFP STATEMENT OF WORK ITEM #12

Provide two examples of cost-sharing provisions (copayments, deductibles, out-of-pocket limits) for each of the five levels of benefits for qualified health plans as defined by the Act. Indicate how the plans would compare to typical individual and group medical plans currently available in the individual and small employer group markets in North Carolina.

RESPONSE

We first identified a “typical” benefit plan currently offered in the North Carolina individual, small group, and large group markets. In reality, there is a wide variety of plans in each of the markets. For our purposes, we attempted to estimate the median plan in each market, which would have a premium rate approximately equal to the average baseline premium rates used in our health insurance market projections.

We identified the median plans using a variety of sources including AHIP surveys for the individual and small group markets, a Mercer benefits survey for the large group market, and other benefits surveys and data that we had specific to the North Carolina market. Key personnel at the NCDOT reviewed the median plans to confirm their reasonableness. The median plans are shown in Table 3.9 below.

Table 3.9 Estimated North Carolina Median Benefit Plan Designs in 2010 In-network Benefits			
	Market		
	Individual	Small Group	Large Group
Deductible	\$2,650	\$1,100	\$800
Member Coinsurance	26%	23%	20%
Member OOP Max (1)	\$5,650	\$3,600	\$2,800
<u>Selected Medical Copays</u>			
Emergency Room	\$150	\$150	\$150
Office Visits - PCP	\$20	\$20	\$20
Office Visits - Specialist	\$40	\$40	\$40
<u>Rx Copays (Retail)</u>			
Generic	\$10	\$10	\$10
Formulary	\$30	\$30	\$30
Non-Formulary	\$50	\$50	\$50
(1) Includes the deductible.			

We estimated the actuarial values for each of these plans. “Actuarial value” is the ratio of expected net benefit costs (after application of patient cost sharing such as deductibles, coinsurance, and copays) to expected total allowed charges (before application of patient cost sharing). The estimated benefit values are:

- Individual Median Plan = 76%
- Small Group Median Plan = 83%
- Large Group Median Plan = 85%

These percentages can be compared to the actuarial values that define the four “metal” benefit plan tiers defined in the ACA:

- Platinum = 90% actuarial value
- Gold = 80% actuarial value
- Silver = 70% actuarial value
- Bronze = 60% actuarial value

In addition, the ACA allows for a fifth type of qualified benefit plan, called a catastrophic plan, which is defined by its specific cost sharing provisions rather than by its actuarial value. The catastrophic plan must have a high deductible that is equal to the out-of-pocket limit for HSA-qualified high deductible health plans (\$5,950 in 2010). The deductible does not apply to at least the first three primary care visits.

Examples of benefit plans that fall into each of four qualified benefit plan tiers, and an example of a catastrophic plan, are presented in Table 3.10. The actuarial value of the catastrophic plan is approximately 50%.

Table 3.10
Examples of Qualified Benefit Plans for Each Tier

Plan Tier	Platinum	Platinum	Gold	Gold	Silver	Silver	Bronze	Bronze	Catastrophic
Plan Type	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO
Deductible	\$0	\$100	\$0	\$400	\$0	\$750	\$0	\$1,500	\$5,950
Coinsurance	0%	10%	0%	10%	0%	20%	0%	35%	0%
OOP Maximum (1)	n/a	\$100	n/a	\$5,000	n/a	\$6,500	n/a	\$6,500	n/a
Emergency Room	\$25 copay	\$50 copay	\$75 copay	\$100 copay	\$75 copay	\$100 copay	\$300 copay	\$100 copay	Ded + Coins
Office Visits - PCP	\$10 copay	\$5 copay	\$20 copay	\$15 copay	\$50 copay	\$15 copay	\$150 copay	\$10 copay	Ded + Coins after first 3 visits
Office Visits - Specialist	\$10 copay	Ded + Coins	\$40 copay	Ded + Coins	\$100 copay	Ded + Coins	\$150 copay	Ded + Coins	Ded + Coins
<u>Rx Copays (Retail)</u>									
Generic	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	Ded + Coins
Formulary	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	Ded + Coins
Non-Formulary	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	Ded + Coins

(1) Includes the deductible. Note: For PPO plans, only in-network cost sharing is listed in this table.

It is important to recognize that a benefit plan having an actuarial value of X% in one year may have an actuarial value of more than X% the next year, due to the leveraging effect of inflation, or healthcare trend, on fixed dollar cost sharing features such as deductibles and copays. For example, consider a gold plan having no cost sharing other than a \$1,000 deductible. If medical trend is 10% per year, the actuarial value might change from 80% in the first year to approximately 82% in the second year, calculated as follows:

$$\begin{aligned} & [(100\% \text{ of gross claim costs}) \\ & \times (1.1 \text{ trend}) \\ & - (20\% \text{ of untrended costs are consumed by the deductible})] \\ & / [(100\% \text{ of gross claim costs}) \\ & \times (1.1 \text{ trend})] \\ & = 82\% \end{aligned}$$

This is a simplistic example, but it illustrates a very real phenomenon. The State will need to develop a process for regularly adjusting benefit plans to offset the leveraging effects of trend.

RFP STATEMENT OF WORK ITEM #11

Estimate the range of commission that has historically been paid to agents/brokers/producers by insurers in the individual and small group health insurance markets. Include a separate range for commissions that have been paid in other creative purchasing arrangements or pools (public or private). Analyze and provide the pros and cons of flat fee compensation to agents/brokers/producers versus a percent of premium. Provide some judgment as to the additional (or lessened) work expected for agents/brokers/producers under the reforms given the probable increase in business from the individual mandate and government subsidies and the new information, comparability, and online eligibility functionality associated with the Exchange.

RESPONSE

Current Commission Rates

In the current individual and small group markets, agents are generally paid commissions that are a percentage of premium. For individual insurance, the rates may vary between first year and renewal. Based on a survey of carriers operating in North Carolina, individual plan first-year commission rates in 2010 varied from approximately 10% to 34%. The median rate across all carriers that reported was approximately 25%. Renewal commissions ranged from 2% to 13%, with the median across all reporting carriers at 5%.

In the small group market, commission rates are generally the same in for first-year and renewal. Rates may vary by group size or by total annual premium. For example, commission rates may be X% on the first five employees, and then Y% on additional employees. Carriers who responded to the survey reported their average rates across all small groups in 2010, ranging from approximately 5% to 8%. The median of those responses was approximately 6%.

Impact of MLR Requirements

Some carriers are reducing their commission rates to help ensure that they will comply with the federal minimum medical loss ratio (MLR) requirements. According to those requirements, MLRs must be at least 80% for individual and small group products (groups of less than 100 employees), both in and out of the HBE. In the same survey as referenced above, carriers were asked to report their projected commission rates in 2011. For carriers that reported both 2010 rates and projected 2011 rates, the range of individual plan median commission rates (averages for new issues and renewals) were expected to change from 13% in 2010 to 8% in 2011. Similarly, for small groups, median rates were expected to change from 6% to 5% in 2011.

Changes in Producer Roles

The roles of producers (agents and brokers), will almost certainly be different once the HBE is working. The extent of the change will be a function of many variables, including:

- The HBE's structure (e.g., separate for individual vs small group, multiple geographic Exchanges).
- The number and types of benefit plans the HBE allows. For example, if the HBE dictates the benefit packages that may be offered, then producers may need to spend less time educating consumers about the plan differences.
- Whether the individual and small group markets are merged. If the markets are merged, then there may be less consumer confusion about the two markets and less need for producers to educate and guide employers and individuals.
- Whether individual and small group insurance can still be sold outside the HBE. If a significant market continues to exist outside the HBE, then producers may need to spend more time educating consumers about the differences between the HBE and non-HBE markets.
- Whether the producer and consumer must interface only with the HBE, only with carriers, or both.
- The tools the HBE makes available to consumers and how easy it is to use them and understand their output. For example, the HBE may be able to provide an extremely sophisticated and valuable tool that allows consumers to electronically feed their health insurance claims from the past two years into a model that will then project their future out-of-pocket expenses under different benefit plans. However, using that tool, and understanding the output and its limitations (e.g., past claims may not be a good predictor or future costs), may require a lot of guidance from producers.
- Extent of infrastructure and outreach. The HBE will probably invest some money in infrastructure and direct consumer outreach for purposes of educating and enrolling consumers. Alternatively, the HBE could rely heavily on producers for those services.
- The ability of the North Carolina population to interface with the HBE. North Carolina has many people who live in relatively rural areas, and probably many people who do not have internet access or even telephone access. And yet those people will have the same requirements to purchase insurance as someone living in Raleigh. Producers may be the best way to reach those more rural populations. The total time required by a producer to enroll a person living in a rural area may be much more than the time required to enroll one person living in an urban area, due to travel time or other variables.
- Coordination with Medicaid enrollment. The ACA encourages everyone to have health insurance. Currently, however, producers are generally focused on the commercial insurance market and they do not spend time trying to enroll people in Medicaid. Once the HBE is running, it might make sense to compensate producers for assisting with Medicaid enrollment too. For example, if a producer visits a rural family having no

insurance and half the family qualifies for Medicaid, it might be most efficient if the producer could enroll half the family in Medicaid and half in commercial HBE plans. The producer should be compensated fairly for all of that work.

Once the HBE has been operational for several years and public acceptance and understanding has grown, the number of people interfacing directly with producers may decline.

Examples of Producer Compensation in Other Purchasing Pools

Some examples of producer compensation arrangements used in other creative purchasing arrangements of pool (public or private) are:

- **Massachusetts Connector.** Offering only seven plans, the Connector charges administrative fees to participating insurers and uses the money to pay broker commissions. For group coverage, commissions are \$10 per person per month for employers having 1 to 5 employees and 2.5% of the total premium for employers having 6 to 50 employees.
- **Utah Exchange.** Producers are paid a flat fee of \$37 per employee per month. Producers work with the employer to set up a plan, and with individual employees to tailor their benefits. It is important to note that this is a per-employee rate, which makes sense for small group insurance but not for individual insurance. For individual insurance, a per-member rate could make sense, possibly even with a graded commission rate by household size (e.g., \$50 for the first person, and \$25 for each additional person).
- **Inclusive Health, the North Carolina High Risk Health Insurance Pool.** Producers receive a one-time fee of \$150 per policy for their first four policyholders referred to the pool, and \$200 for subsequent policyholders. The counts of policyholders are accumulated each calendar year, separately for the State Option and the Federal Option.
- **Connecticut High Risk Health Insurance Pool.** Producers are paid a flat \$50 per applicant they assist.
- **Texas High Risk Health Insurance Pool.** Producers are paid a flat \$50 referral fee for each policy issued.
- **Washington High Risk Health Insurance Pool.** Producers are paid a flat \$75 fee.
- **Medicare Advantage.** Medicare has defined maximum fixed-dollar commission rates allowable per enrollee. The maximums vary by state, but most are \$403 (in 2011). Connecticut, Pennsylvania, and Washington DC are higher at \$454. California and New Jersey are at \$504. These rates apply to people joining Medicare Advantage for the first time. In all other cases, renewal commissions are paid at one-half of the new issue rates. It is important to understand that total benefit costs are much higher for an average Medicare Advantage enrollee than for an average commercial health plan enrollee who is age less than 65, which is part of the reason that the Medicare

Advantage commission rates may seem high relative to the other commission rate examples provided above.

Flat Fee vs Percent of Premium

There has been much debate about producer compensation methods. Common notions are that they should be a flat fee, a percentage of premium, or some combination thereof. There has also been some discussion about eliminating commissions, and instead having producers charge fees directly to those people who seek their consultation. Some arguments for or against these methods are:

- A flat fee may be easier to understand and administer.
- A flat fee might make it difficult for some carriers to satisfy the minimum MLR requirements. For example, if one carrier primarily sells bronze policies with an average premium rate of \$60 and another carrier primarily sells platinum policies with an average premium rate of \$90, then a fixed \$10 producer commission would present approximately 17% of the first carrier's premium and approximately 11% of the second carrier's premium. The first carrier would have a more difficult time satisfying the minimum MLR requirement.
- A consultation fee paid by the consumer to the producer is also easy to understand, although it might make individual consumers less likely to engage the services of a producer, even when they could significantly benefit from the help.
- Percentage of premium commissions would give producers an incentive to steer consumers to higher tier and higher cost benefit plans. That might help mitigate adverse selection among the benefit tiers.
- A flat fee avoids giving a producer an incentive to steer a consumer to a higher cost benefit plan that might not be in the consumer's best interest.
- A flat fee avoids giving a producer an incentive to steer a consumer to a carrier with higher premium rates.
- Percentage of premium commissions might produce a better matching of producer work load with producer compensation. Higher premium individuals (e.g., older people) may have the greatest financial consequences of their insurance decisions, and may therefore make greater use of producer guidance. Producers should therefore be compensated more for the additional time of working with those people.
- A flat fee gives producers more incentive to enroll even the youngest, healthiest people (e.g., people who might be interested in the "catastrophic plan"). Bringing those people into the risk pool will help keep costs lower for other people.

Other Producer Compensation Issues

Other issues the State may need to address are:

-
- How will commission rates differ (if at all) in the HBE versus outside the HBE? Differences in commission structures in and out of the HBE may have undesirable consequences, such as creating incentives for producers to steer applicants to products that yield higher commissions but which are not the best option for the consumer.
 - The State may want to do commission modeling under a variety of enrollment and premium rate scenarios to estimate the reasonableness of the HBE's compensation system versus non-HBE compensation systems, and today's compensation system.
 - If the individual and small group markets are not merged, should they have different commission structures, like the current market? If the markets are merged, would it still make sense to have different compensation structures when an employer is involved? For example, for an employer with 20 to 50 employees, the commission could be a flat \$1,000, plus \$20 per employee.
 - How often should commissions be paid? Examples include:
 - Once, at time of issue.
 - Monthly, as long as the consumer stays enrolled in an HBE plan.
 - At each anniversary.
 - Anytime a plan change occurs.
 - Anytime a producer is involved in a change in coverage.
 - Any time a producer spends time educating a consumer.

RFP STATEMENT OF WORK ITEM #14

Given the list of mandated benefits provided in Appendix B and using your estimate of participation in the Exchange, estimate the cost (on a per member per month basis) of each of the mandated benefits for coverage sold through the Exchange.

RESPONSE

Appendix B presents estimated costs for each of the mandated benefits that were listed in the RFP.

The PMPM costs are for an average person age less than 65 living in North Carolina in 2011 and having comprehensive major medical insurance in an employer-based or individual insurance plan. The costs are based on allowed charges (i.e., billed charges for covered services, reduced by average provider discounts, but before application of patient costs sharing such as deductibles, coinsurance, or copays).

It is important to understand the PMPM costs were estimated for each benefit independently. In reality, some of the benefits overlap each other, such that the total cost of all of the mandates, when covered together, is less than the sum of the PMPMs shown. Based on our previous work for the State of North Carolina, and our previous work in pricing mandated benefits in other states, we would estimate the total cost of all of the mandates, when covered together, to constitute approximately 3% to 5% of costs for an average insured person.

We estimated the costs shown in Appendix C using a variety of data and resources, including mandated benefit pricing work that we have completed for the California Health Benefits Review Program (CHBRP) and other entities.

Many of the North Carolina mandated benefits would likely be considered essential benefits, and would therefore need to be covered by any health plan sold in the HBE. The value of additional benefits that North Carolina might mandate could have material cost consequences for the HBE, partly due to the direct addition of benefits and partly due to possible adverse selection. Requiring extremely rich benefits in the HBE may increase costs enough to encourage more healthy people to seek coverage outside 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.

RFP STATEMENT OF WORK ITEM #15

Identify and analyze the challenges (i.e. risks) and rewards of joining with one or more other states to establish a regional interstate Exchange. Primarily focus on what functionalities of the Exchange lend themselves to economies of scale, and what are the cost savings associated with what levels of scale. (Such an Exchange should be assumed to provide the administration of the marketplace only and should not be assumed to be a merging of the health insurance markets (rating pool, etc.) in one or more states.)

RESPONSE

As listed below, there are opportunities and challenges associated with establishing interstate Exchanges. It should be noted that North Carolina could probably establish joint administrative functions without merging risk pools with other states, as PPACA allows. As requested in the SOW question, our response is focused just on those administrative efficiencies, assuming the states do not combine their risk pools, do not necessarily offer the same benefit plans, and may have other structural differences. Some opportunities and challenges associated with having an interstate HBE are:

Opportunities

- Economies of scale. As described later in this section, some administrative expense savings might be achieved.
- Having multiple perspectives may lead to more creative ideas.
- Development time may be reduced if potential partner states are already further along in the development process than North Carolina.

Challenges

- Joint coordination may slow the HBE development.
- Multiple political views and authority may hinder the HBE's ability to quickly respond to new challenges.
- There may be disputes about cost equity among the participating states.
- Administrative oversight by each state might be more difficult.
- North Carolina would have less direct control over administration of its own HBE.

Possible Administration Efficiencies

Based on our experience with health plans, which we believe provide a reasonable proxy for some HBE functions, scale economies are most impactful when moving from a small plan (e.g.

25,000 members) to a medium-sized plan (e.g. 500,000 members). At that membership level (500,000), we find that plans have extracted most of the possible scale economies. Although this is not an exact science, in our research, we do not find material additional administrative cost differences attributable to scale economies until a plan reaches approximately 2,000,000 members, and then only for a limited subset of functions (generally overhead functions such as Finance and Accounting or Human Resources, Legal, Compliance, Risk Management, etc.) where staffing is fixed or near-fixed and costs can be spread over a very large base.

If these findings are applicable to the HBE, and if North Carolina enrollment exceeds 500,000 members, then we would not expect to see material benefits from scale economies due to a regional interstate exchange (RIE), unless the RIE included 2 million or more members.

However, we believe there are some opportunities for administrative cost savings that could be achieved by the RIE that may not be fully reflected in the health plan comparisons described above. For example, given the limited functionality of an HBE compared to that of a health plan, the HBE Executive Office is substantially smaller than it would be for a comparably sized health plan. As a result, we might expect significant scale economies due the need for only one Executive Office rather than one for each State.

A summary of potential economies and their relative magnitudes is shown in the following table:

Functional Area	Justification	Estimated Impact
Executive Office	Duplication within the executive office would be eliminated for each State participating in the RIE. Given the limited number of functions to be performed by the HBE, we believe the executive office could easily support a substantially larger membership base.	Significant
Plan Administration	We would expect it to be difficult to consolidate the plan review process due the need to certify plans for each state participating in the RIE.	Limited
Call Center	Typically, call centers are an area where scale economies can be achieved. Tripling the number of enrollees would drive a unit cost reduction of approximately 10%.	Moderate
Eligibility Processing	As eligibility processing is highly automated in the exchange environment and does not constitute a major portion of the administrative budget, we do not anticipate a significant scale economies opportunity.	Limited
Enrollment Reporting	The enrollment reporting workload is dependent on the number of enrollees. We do not believe the staffing requirement for this function is sufficient to generate significant scale economies.	Limited

Functional Area	Justification	Estimated Impact
Plan Performance and Quality Reporting	The plan performance and quality reporting workload is dependent on the number of plans to be reported on. Unless the RIE was able to consolidate the number of plans reporting, economies would be limited.	Limited
Exchange Marketing	If the RIE is expected to provide state-specific marketing, we would not expect significant economies of scale. There may be some benefit in media buying discounts.	Moderate
Navigator Program	We would expect each state to partner with unique Navigators and hence the economies of scale would be limited.	Limited
Materials and Fulfillment	If the RIE is expected to produce state-specific materials, we would not expect significant scale economies for staffing. There may be some benefit from volume purchasing of materials and fulfillment services.	Moderate
Government/ Public Relations	We believe the economies of scale for this function is comparable to that of the health plan data, which suggests scale economies are exhausted for an HBE having the enrollment level we have projected for North Carolina. If the RIE was to have significantly higher enrollment, a greater cost reduction could be achievable.	Moderate
Information Systems	The ability to achieve economies of scale in this functional area would be dependent on the systems environment among the states. The implementation of a single system would definitely generate scale economies. However, if the HBE system was required to interface with different systems for each state, then this would dampen that impact.	Significant
Actuarial Analysis	We would expect it to be difficult to consolidate the actuarial review and risk adjustment responsibilities across the region, and hence it would be difficult to achieve scale economies for this function.	Limited
Accounting/ Financial Reporting	If the RIE operated a single accounting system and was able to generate state-specific and consolidated financial statements and analyses, we believe there may be an opportunity to achieve economies of scale.	Moderate
Infrastructure		Significant

Perhaps the most important factor in achieving scale economies for a regional interstate exchange is standardization. Only through standardization of rules, processes, and systems can economies be maximized.

RFP STATEMENT OF WORK ITEM #16

Identify and analyze the challenges and rewards of establishing regional Exchanges within the State, including a recommendation for the number of regional Exchanges and their locations. Include an analysis of the range of current expected premiums (as of January 1, 2011) across the State, and provide the basis for your recommendations, i.e. demographics, risk factors, medical costs, medical referral patterns, etc.

RESPONSE

For purposes of this discussion, we assume that the State is considering Exchanges 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 Exchanges that are separate in terms of administration, IT systems, marketing, and other functions.

The regional Exchanges might also offer different benefit plans, although such differences could also occur under a single Exchange since some carriers might only be able to offer certain plans in certain geographic areas due to provider network limitations (e.g., HMO plans will tend to be offered primarily in urban areas). For purposes of this discussion, we assume that administration of the regional exchanges would still be largely centralized, as it would if there were not separate regional exchanges.

Opportunities and Challenges of Regional Exchanges

Regional Exchanges 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. Having regional exchanges would avoid one geographic area subsidizing another area, which is particularly important for carriers that operate in more than one rating area. 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. For example, if the Exchange only allows one rating area for the entire state, but carriers outside the Exchange can quote premium rates that reflect actual cost differences by county, then people in high cost counties will tend to purchase through the Exchange and people in low cost counties will tend to purchase

outside the Exchange. 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 the rating areas the fewer covered lives each carrier will have in each area. 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.

Possible Geographic Divisions for Regional Exchanges

A typical North Carolina carrier has premium rates that vary among 6 to 10 different geographic areas. Some carriers have more rating areas and some have fewer. The areas may be defined by groupings of ZIP codes or groupings of counties that have similar costs or that are geographically contiguous. The highest cost areas have premium rates that are approximately 15% to 50% higher than the lowest cost areas, with differences varying significantly among carriers. The differences may have been developed over time based on each health plan's actual costs by area, or they may have been projected based on actuarial rating tool or other information. Milliman's own rating tools and research suggests that the highest cost areas might have claim costs that are approximately 50% higher than the lowest cost areas, when reviewed by MSA.

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

3. Require the same rating areas for business sold in and out of the HBE.
4. Solicit input from the carriers to aid in the decision process.
5. Strike a balance between too many and too few rating areas. A reasonable compromise might be to allow rating by MSAs (metropolitan statistical areas), which are based on groupings of counties and are defined by the U.S. Office of Management and Budget. Areas that fall outside of MSAs could be grouped into a single rating area, or could be separated into several rating areas, based on carrier input.

RFP STATEMENT OF WORK ITEM #17

Provide analysis of whether State law should require that all comprehensive health insurers participate in the Exchange. Identify the issues and rewards of such a requirement and the impact, if any, such a requirement would have upon insurers' decisions to market health insurance in North Carolina. Include analysis of how this requirement may or may not be used to alleviate anti-selection as described in #7.

RESPONSE

Our response discusses:

- The impact of mandatory carrier participation in the HBE
- The HBE as an active purchaser versus an open market

Impact of Mandatory 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 limited to being the source for public coverage for the low-income population. 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.

For the discussion in this section, we have assumed that the mandatory participation requirements would apply only to individual and small group business. For example, we are assuming that a carrier who currently has both large and small group business could decide to exit the small group market and not participate in the HBE, but continue to participate in the large group market outside the HBE.

We have further assumed that North Carolina will not restrict purchasing of individual and small group insurance to the HBE only, thereby eliminating the non-HBE individual and small group markets.

If carrier participation in the HBE is mandatory, then:

- Some carriers might choose to exit the North Carolina individual or small group markets rather than participate in the HBE. It seems unlikely that carriers which currently have a significant volume of individual and small group business in North Carolina would choose that option. However, smaller carriers, or carriers having a relatively small volume of individual and small group business in North Carolina might seriously consider exiting the market if they feel like that cannot compete in a more commoditized market where

less value is placed on service, flexibility, or other areas where they might currently fill a need. It is likely that the total number of carriers offering individual and small group business in North Carolina would shrink below current levels.

- The number of carriers and members in the HBE might be higher than if participation was not mandatory. We say “might be” because we do not know how many carriers would decline to participate if participation was voluntary, and we do not know how many carriers would exit the market if participation was mandatory.
- Carrier participation in the HBE would be accelerated. If participation in the HBE is voluntary, some carriers might take a “wait and see” approach, staying out of the HBE during the initial years.
- 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.
- Adverse selection risk among carriers may be less. There is some concern that the HBE population will be less healthy than the non-HBE insured population. For example, on January 1, 2014, Inclusive Health (the North Carolina high risk pool) will cease covering people, and all of those people will likely seek individual insurance in the HBE. They tend to be very high cost individuals. Additionally, an analysis of Medicaid expansion in Indiana showed that uninsured individuals (those who will be attracted to the Exchange) have higher morbidity than the currently insured population and that uninsured demonstrate pent-up demand when coverage is made available to them. All of these effects will tend to result in higher average costs for HBE enrollees. Insurers may recognize this and avoid participating in the Exchange (at least initially) to maintain a healthier block of business. This may cost the carriers membership in the first few years, but that membership could be regained as consumers realize they can find less expensive coverage elsewhere with carriers that avoided the adverse selection that comes with the Exchange. If carrier participation in the HBE was mandatory starting January 1, 2014, then all carriers would be likely to enroll some of the higher cost members. Risk adjustment can be used to help reallocate revenue to carriers with the most morbid members, but as previously discussed under SOW item #6, risk adjustment is unlikely to compensate perfectly for all morbidity differences.
- If the number of carriers participating in the HBE is higher, then consumers will have more choice and competition will be more robust. This may be particularly important for consumers who live in rural areas where the number of carriers offering coverage may be fewer. Increased competition may help keep premium rates lower.

HBE as an Active Purchaser versus an Open Market

In contrast to requiring carriers to participate in the HBE, the State may also wish to consider various methods for restricting which insurers can participate in the Exchange. For example the State could use competitive bidding, or could accept all carriers meeting minimum qualification standards. In Massachusetts, the Connector uses a selective contracting process for its nonsubsidized products – small group and individual. For its subsidized products, it uses an active purchaser process.

ADD MORE IF WE HAVE TIME...

RFP STATEMENT OF WORK ITEM #18

Provide analysis of the pros and cons of requiring that qualified health plans offered in the Exchange use standardized benefit designs. Provide the analysis for each market place (individual and small employer group) as well as for a combined market place.

RESPONSE

The federal requirements require some degree of benefit plan standardization. Specifically, plans are restricted to having specific actuarial values (i.e., platinum, gold, silver, bronze, and catastrophic). However, there are many combinations of cost sharing features that could equate to these benefit values. For example, one platinum plan might have a \$200 deductible and 90% coinsurance, while another platinum plan might have a \$0 deductible and 80% coinsurance, with both plans having the required platinum actuarial value of 90%.

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 within a given benefit tier (e.g., platinum, gold, etc.), if the number of standardized plans within each tier is reasonable. For example, if there are only two standardized gold plans, then comparisons may be simple. If there are twenty standardized gold plans, then comparisons may still be very difficult.
- Consumers should have an easier time making price comparisons among carriers.
- Ease of comparison might help keep administrative expenses, and thus prices, lower.
- There may be significantly less product diversity than if plans were not standardized. That could possibly result in reduced consumer satisfaction and value. Alternatively, it might also help reduce consumer confusion from the many different benefit options they are currently offered.
- Carriers will have less ability to differentiate themselves from other carriers.
- Carriers may not have the ability to offer a custom benefit package to a given employer. Such customization is not common in small group coverage, but may be more common for smaller carriers or niche carriers for whom customization is very much a part of their business plan.
- 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.

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- Standardization might make it impossible for carriers to offer products that take advantage of a unique market situation or provider arrangement. For example, a carrier might want to offer extremely low cost sharing (e.g., a \$0 copay) when members get their high cost scans (e.g., MRIs or CT scans) at a single provider that offers those services at deeply discounted rates.
 - 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.
 - HBE enrollment may be less if consumers find more attractive plan designs outside the Exchange.

Standardized benefit plans have been required in the Medicare Supplement market since 1992. In that market, standardization has worked relatively well, partly because those policies are supplemental, relatively low cost, and generally leave the insured with little or no out-of-pocket expenses. In contrast, comprehensive major medical plans provide primary coverage at a relatively high cost, and generally leave the insured with significant out-of-pocket expenses (e.g., a bronze plan would be designed to cover only 60% of the average insured's total healthcare costs, leaving 40% for the insured to pay out-of-pocket, in addition to their premium). Because of the higher out-of-pocket costs in a comprehensive major medical plan, and because it is the primary coverage, there are many more plan designs that can be created which would be reasonable and appealing to a significant portion of the population.

The HBE could also postpone plan standardization for one or more years. Postponing would give carriers time to adapt to the new regulations and respond to consumer preferences in the market. In later years, the HBE might choose to allow only standardized plans. Some disruption would be inevitable when the change is implemented, but that disruption might be relatively easy bear once the HBE has achieved some stability and has experience regulating the new benefit tiers.

The leveraging effects of medical trend (inflation) on fixed dollar cost sharing features (e.g., deductibles and copays), will cause the actuarial value of benefit plans to increase over time. This effect is discussed near the end of our response to SOW item #12. The State will need to consider how their methods for offsetting trend leveraging will interact with their rules for allowable benefit plan designs.

This leveraging effect can also occur from changes in the mix of members by age, health status, geographic area, or other variables that affect average claim costs per member. When the State tests plans for compliance with the target actuarial values, they should normalize for any such changes or differences in the mix of enrollees among the benefit tiers.

RFP STATEMENT OF WORK ITEM #19

Provide an overall assessment specifically identifying how the Exchange(s) might separately or collectively with other public and private payers in the State drive system efficiencies, promote quality of care improvement and a more engaged consumer as well as a more competitive health care payer marketplace.

RESPONSE

Please see the response to SOW item #8 for discussion of how the non-HBE market could benefit from administrative and quality initiatives promoted by the HBE.

SOW item #19 asks about consumer engagement, efficiency, competitiveness, and quality. These areas are addressed one at a time in the following pages.

Consumer Engagement

The HBE might have a variety of goals related to consumer engagement, such as:

1. Maximizing the number of people covered by insurance, either in or out of the HBE.
2. Promoting understanding of employer and individual options, costs, and processes for enrollment, premium payment, and claims payment.
3. Matching consumers with insurance options that best fit their needs.
4. Maximizing consumer satisfaction.

To achieve these goals, the HBE will need to reach out to consumers via:

- Advertising
- Direct mail
- People contacting people via telephone or in person
- Using newsletters. The Exchange can promote wellness and consumer engagement by offering electronic newsletter subscriptions. Newsletters could cover general health topics (flu shot reminders, recommended screenings, nutrition, exercise, weight management). Or, consumers could sign up for specific issues such as well-child care and development, or information on specific disease management. Provider networks could have the option to take turns writing these newsletters, giving them a chance to promote their credentials.
- There are many other opportunities the Exchange may have in building relationships with organizations, business, and celebrities in the state to promote consumer engagement. For example, in Massachusetts, the Connector partnered with the Boston Red Sox which promoted the program during baseball games.

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- As another example, to reach a diverse range of consumers, brochures should be available at public libraries in multiple languages which would provide basic information about the Exchange and where to get more information by phone or online. Library staff, though not trained to give information about the Exchange or health plans, would be able to guide consumers to Navigators and public access computers.

The HBE will also need multiple modalities for consumers to actively access information and enroll. Having a consumer friendly and fast web site will be key. Physical outlets will also be needed for people who do not have, or do not want to use, internet access. For some consumers (e.g., people living in extremely rural areas, homebound people, very ill people), the HBE may need to send representatives to those people's homes to help educate them on their options and assist them with enrollment.

The effectiveness of consumer outreach efforts should be continually monitored and adjustments should be made. Steps the HBE can take to help ensure effectiveness include:

- Vetting communication materials and other ideas with focus groups.
- Engaging all stakeholders (including producers and carriers) in the development and planning process. Navigators will serve a crucial role by educating the public about subsidies and plans offered in the Exchange. Many consumers will be purchasing insurance for the first time, and their education needs may be extensive.
- Thoroughly testing websites or other outreach using focus groups or other test populations.
- Investing sufficiently in technology and infrastructure such that those physical elements do not become barriers to success.
- Coordinating with existing State programs (e.g., CCNC) or carriers that are interested in joint efforts.
- Continually monitoring satisfaction and problems via survey or other methods.

Efficiency

The HBE's success will be judged partly by its efficiency. At a minimum, it will need to accomplish certain tasks at least as well as an insurance company or large brokerage. At a more involved level, it might also be able to achieve administrative saving for the entire health insurance system by providing services that each carrier would have to provide if the HBE did not. Possible areas for such savings might include:

- Advertising
- Education
- Eligibility assessment
- Enrollment

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- Tracking of past insurance coverage
 - Eligibility for premium or cost sharing subsidies
 - Premium collection
 - Coverage verification for health care providers

The opportunity for savings in these functions will be defined by the extensiveness of the HBE's role. The HBE can identify these opportunities and coordinate with payers and other stakeholders to assess which functions the HBE should assume and to what degree. For example, will the HBE assume responsibility for:

- Enrolling consumers, or just direct them to carriers for enrollment
- Collecting premiums and subsidies and getting the money to the correct parties
- Administering risk adjustment

Efficiency in direct administrative expenses is both important and highly visible. Less visible, and yet possibly equally important to the HBE's acceptance and success, is efficiency of consumers' time. The HBE should help consumers get exactly what they need in the minimum possible amount of time. For consumers with the least complicated needs, this may mean being able to quickly and easily navigate through a website that allows them to view benefit plan options, view carrier options, compare carrier-specific plan characteristics (e.g., provider networks), select a plan, enroll, and set up their premium payments. For consumers with more complicated needs, they might also need to consider employer contributions, low income premium or cost sharing subsidies, enrollment of family members when more than one parent has employer sponsored insurance, eligibility for Medicaid or the Basic Health Plan, or other issues. They HBE will need to efficiently help all such consumers, at all levels of education, and in multiple languages.

Competitiveness

Market competitiveness will be maximized if consumers have multiple carriers and products to choose from, and if they can quickly and easily make comparisons. If the HBE provides information to consumers, it will be most likely to promote efficiency if that information is:

- Easily understood
- Actionable
- Up to date
- Transparent in its source, giving it credibility
- Trustworthy

Producers and carriers are already adept at providing helpful comparisons to consumers, and the State would probably be best served by engaging them in the HBE planning and ongoing

administration, building on their vast experience and expertise. Examples of information that consumers might find helpful include comparisons of:

- Benefits
- Networks
- Premium rates
- Estimated out-of-pocket expenses with a given carrier and benefit plan
- Carriers' historical membership counts
- Carriers' target medical loss ratios
- Carriers' historical incurred medical loss ratios
- Carriers' historical administrative expenses, as a percentage of revenue
- Carriers' historical profits, as a percentage of revenue

Some of these measures would need to be interpreted carefully, however, or consumers might draw inappropriate conclusions. For example, there may be a perception that a higher loss ratio is good for consumers, suggesting lower administrative expenses or carrier profits. However, a high medical loss ratio might really mean that a carrier's benefit costs have been higher than they expected, and that a corrective premium rate increase should be expected soon. This risk of unanticipated interpretations and reactions underscores the need for careful vetting and testing of consumer outreach.

Quality

Please see the response to SOW item #8 for discussion of how the non-HBE market could benefit from quality initiatives promoted by the HBE.

RFP STATEMENT OF WORK ITEM #20

Provide a cost analysis of the Basic Health Plan option, whereby North Carolina could provide a Basic Health Plan to individuals with family incomes between 138% and 200% FPL in lieu of subsidized coverage through the Exchange. Include an estimate of the aggregate and per capita amount of federal funding that could be redirected to this program in North Carolina. Include analysis of having a fourth benefit plan in the Medicaid realm (Medicaid, CHIP, the Basic Health Plan and the Exchange) providing the pros and cons of such a move.

RESPONSE

Our response provides discussion of considerations regarding the Basic Health Plan. NCDOI and NCDHHS (the North Carolina Department of Health and Human Services) will need to evaluate the Basic Health Plan option in the context of its current and future expanded Medicaid and CHIP programs and other state priorities to develop a coordinated health care system for the population under 200% of FPL.

Our discussion covers the following issues related to the Basic Health Plan option:

- Potential Basic Health plan population in North Carolina
- Design flexibility
- Funding of the Basic Health Plan
- Pros and cons of implementing a Basic Health Plan

This report is not a comprehensive examination of the Basic Health Plan option. Such a review would need to be done in cooperation with the NCDHHS and is beyond scope of this report.

Potential Basic Health Plan Population

PPACA allows states to create a Basic Health Plan for residents under 200% of FPL who are not eligible for Medicaid and lack affordable access to comprehensive employer based coverage. The population eligible to enroll in the Basic Health Plan includes two groups, both of which are eligible for federal premium tax credits under PPACA:

1. Adults with incomes from 138% - 200% of FPL
2. Lawfully present immigrants below 138% of FPL who are ineligible for Medicaid

If North Carolina implements a Basic Health Plan, the eligible population must obtain coverage through the Basic Health Plan. Eligible individuals cannot purchase coverage through the

Exchange. If North Carolina does not opt to implement the Basic Health Plan, this population would be eligible for subsidized coverage under the Health Benefit Exchange starting in 2014.

We identified the target population for the Basic Health Plan in North Carolina by identifying adults expected to enroll in the Exchange with incomes below 200% of FPL plus the remaining uninsured population shown in our model. The table below shows our estimate of the eligible population by age group for 2014.

Potential Basic Health Plan Population in 2014			
138% to 200% of FPL			
Age Group	Projected Population in Exchange	Remaining Uninsured Population	Total Population Eligible for Basic Health Plan
20-29	23,000	3,600	26,600
30-39	27,000	19,800	46,800
40-49	37,600	18,300	55,900
50-59	27,300	9,100	36,400
60-64	9,600	4,200	13,800
Total	124,500	55,000	179,500

Basic Health Plan Design Flexibility

States will have some flexibility regarding the premiums and benefits offered in the Basic Health Plan within the following constraints:

- The Basic Health Plan must provide at least the essential benefit package.
- Member premiums can be no more than what individuals would have paid in the Exchange.
- Member out-of-pocket cost sharing can be no more than what an individual would have paid in the Exchange.
- Plans may be offered by licensed HMOs, insurers, or networks of providers (such as an Accountable Care Organization).
- A minimum medical loss ratio standard of 85% will be applied to Basic Health Plan insurers.

States can design aspects of the Basic Health Plan to address the needs of the 138% to 200% of FPL population, which may be different than the needs of the rest of the population eligible to purchase coverage through the Exchange. Examples of issues to address through program design include:

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- Affordability of coverage can be enhanced by leveraging Medicaid provider and managed care contracts.
 - Continuity of coverage for individuals and families moving between Medicaid, CHIP, and the Basic Health Plan.
 - Delivery system continuity related to access to care and provider networks.

Many decisions must be made with the NCDHHS considering North Carolina's existing Medicaid and CHIP programs to develop a coordinated healthcare system for the under 200% of FPL population. Such decisions are related to:

- Whether to contract with managed care organizations. North Carolina currently does not contract with managed care organizations to cover its Medicaid population. Instead, most of the Medicaid population is served through a medical home delivery system called Community Care of North Carolina / Carolina ACCESS.
- Identifying provider networks to use for the Basic Health Plan.
- Identifying the proper member cost sharing in the Basic Health Plan compared to coverage available through the Exchange, CHIP, and Medicaid.
- Coordinating with the CHIP program. North Carolina's CHIP program (Health Choice for Children) is administered through Blue Cross Blue Shield of North Carolina as a separate program, including member cost sharing and premiums.

Funding of the Basic Health Plan

Funding for coverage under the Basic Health Program would come from the following sources:

- States would receive funding from the federal government equal to 95% of the federal subsidies that the enrolled population would have received if enrolled in the Exchange. Subsidies will be adjusted for differences in age, income, health status, and geographic differences to adjust for the acuity of the Basic Health Plan population.
- Member premiums as determined by the State.

We estimated the federal subsidy per individual in the target population for a Basic Health Plan (adults expected to enroll in the Exchange with incomes below 200% of FPL). The table below shows the estimated annual federal subsidy per individual by age group in 2014. The estimates assume each individual is enrolled for 12 months in each year.

Potential Basic Health Plan Population in 2014 Estimated Annual Federal Subsidy per Individual in Exchange 138% to 200% of FPL	
Age Group	2014
20-29	\$3,850
30-39	5,000
40-49	6,600
50-59	9,850
60-64	12,200
Total	\$6,900

North Carolina would receive 95% of these average subsidies to fund the Basic Health Plan. If the entire eligible population enrolls in the Basic Health Plan, we estimate the federal funding for 2014 would be approximately \$1.2 billion (179,500 x \$6,900 x 95%).

To the extent that the federal subsidies collected by the State are in excess of the cost to provide coverage through the Basic Health Plan, PPACA requires states to reduce member premiums, reduce member cost sharing, and/or provide additional benefits compared to coverage available in the Exchange. The reduced member costs and enhanced benefits under the Basic Health Program would ease the transition from full Medicaid coverage to leaner commercial coverage for enrollees whose income level changes, which occurs frequently in this population.

Many people in the industry assume that states could provide coverage through the Basic Health Plan for a lower cost than options available through the Exchange for the following reasons:

- States may use their existing Medicaid delivery system for the Basic Health Plan. Using the same delivery system would take advantage of existing Medicaid managed care programs and Medicaid provider reimbursement.
- Medicaid provider reimbursement is much lower than commercial provider reimbursement.

We have not tested the validity of these assumptions in North Carolina. Based on our past work for the State, however, we believe Medicaid provider payment rates are lower than commercial health plan payment rates.

As NCDOI and NCDHHS consider the Basic Health Plan option, they will want to conduct more detailed cost-vs-subsidy comparisons that include adjustments for population acuity, delivery system, provider reimbursement, benefits, member cost sharing, member premiums,

administrative costs, and other factors. Those comparisons should also include sensitivity testing to changes in key variables, such as the estimated HBE subsidies and medical trend rates.

Pros and Cons of Offering a Basic Health Program

Some pros and cons of offering a Basic Health Plan are listed below. Note that CMS has not issued regulations governing the Basic Health Plan option, so the pros and cons could change.

Pros

- The State can likely offer more affordable coverage than is available in the Exchange due to leveraging Medicaid existing provider agreements, although this conclusion should be validated by more detailed analysis.
- The Basic Health Plan will likely be able to offer more comprehensive coverage to participants than is available in the Exchange.
- 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 coverage available in the Exchange.

Cons

- Fiscal advantages rely on continued federal support.
- The State would take on the pricing risk of the Basic Health Plan, 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 Basic Health Plan removes a portion of the Exchange population, which may have an influence on the operation of the Exchange.
- The Basic Health Plan creates an additional state administration burden.
- Access to providers and multiple insurers will likely be greater for consumers in the Exchange.

Appendix A Technical Details on Health Care Reform Modeling

This appendix provides information on some of the key data sources, tools, and assumptions used to make the projections presented in this report.

CPS Data

The initial census data was developed using the Current Population Survey (CPS). To mitigate the risk of population fluctuation based on the relatively small sample size responding to this self-reported survey, we used CPS data for the North Carolina market for both 2008 and 2009. We used the data to determine the composition of the North Carolina population by age, gender, income level, insurance coverage type (e.g., individual, employer, Medicaid, other coverage such as CHAMPUS, Medicare disabled), family status, race, and self-reported health status.

MEPS Data

We used MEPS data to supplement the census data and include splits regarding whether the employer insurance is small group, large group, self-funded, or fully-insured.

Medical Costs

Medical cost curves by age and gender were developed using an assumed set of benefits and research underlying Milliman's *Health Cost Guidelines (HCGs)*. To calibrate the costs to North Carolina experience, we used benefit designs consistent with those offered by carriers in North Carolina (identified through various benefits surveys), geographic area adjustments from Milliman's HCGs, and North Carolina-specific provider discounts estimated by Milliman using health insurance claims data from North Carolina.

We assumed that the majority of individual policies do not currently cover uncomplicated maternity care. Effective 1-1-2014, we assumed that all individual maternity policies would cover all maternity care.

Premiums were developed from the estimated medical costs, minus the estimated cost sharing in the modeled benefit plans, plus an estimated administrative load based on data collected by the NCDOI. We also adjusted the medical costs in respective markets to produce average premiums by market consistent with average premium rate data collected by the NCDOI.

Experience Adjustment for Costs

The NCDOI collected data via a survey the major insurance carriers operating in the state. The data included (among other items) premiums and medical loss ratios from 2008, 2009, and 2010 experience. Using that information, we estimated average administrative costs and net

medical costs for each carrier and for each year. We calibrated our projections to reflect these data points.

Pent-up Demand

We assumed that people moving from an uninsured status to insured status would have first-year costs that are 10% higher than normal, due to pent-up demand for healthcare services.

Status Quo Benefit Plans

To model benefit plans, we used national average benefit plan information reported in AHIP benefit surveys for the individual and small group markets and Mercer surveys for the large group market. We also used other prevailing benefits information collected by Milliman and information collected via the NCDOL carrier survey. We adjusted the national average benefit plan reported to reflect differences in North Carolina market, such as differences in average deductible and coinsurance levels than reported in the surveys. Furthermore, for copays used in the plan designs (i.e., emergency room, office visits, prescription drugs), we estimated minimal the variation from market to market. We confirmed these median plan designs with key personnel at the North Carolina Department of Insurance to confirm that these plan designs were consistent with what they have observed.

Trend

We estimated annual medical trend rates for each major service category (inpatient, outpatient, professional, prescription drug, and other) based on Milliman's ongoing trend research.

Births and Mortality

We used birth assumptions based on 2008 nationwide census data and mortality assumptions as reported in the 2008 U.S Mortality Tables.

Take-up Rates

Take-up rates describe the probability of people changing from uninsured to insured, or from one market to another (e.g., from the individual non-HBE market to the individual HBE market). Milliman has conducted research to determine what percentage of people, for each combination of representative age, gender, and health status, will tend move to switch markets, based on the ACA provisions and the modeled individual's expected healthcare costs, subsidies, and premium rate choices. Using that research, we modeled all possible movements, such as from uninsured to individual HBE coverage, uninsured to individual non-HBE coverage, individual coverage to HBE individual coverage, etc.

Movement between Carriers and Plans

The movement between carriers and benefit plans in the individual market is based on a series of inertia factors developed by Milliman. The factors describe how individuals move from plan to plan based on changes in the population make-up and resulting costs and premiums for each carrier and plan combination. In particular, individuals are driven to change plans and carriers based on the rate increases experienced for their current plan design, based on their

age, gender, and health status. The movement between carriers and plans in the small group and large group markets are driven by the inertia factors underlying employer group decision points. In particular, employer groups are projected to respond to the rate increases for their particular membership groups by moving from plan to plan and carrier to carrier based on their underlying inertia factors.

Movement between Markets Due to Aging

The causes of age-related movements between markets are formerly dependent children who reach an age where they are emancipated to other markets, adults who reach age 65 and join the Medicare market (assumed 100% of individuals join the Medicare market at age 65), and individuals in other markets who lapse to the uninsured market because of premium rate increases.

Appendix B
Costs of North Carolina Mandated Benefits

This appendix contains the detailed descriptions of North Carolina mandated benefits that were provided in Appendix B of RFP number 12-001065 issued by the NCDOI.

***** DRAFT #4 *****

**Appendix B
Estimated Value of Mandated Benefits**

From RFP # 12-001065			Estimated % of Claim Costs	Per Member Per Month Costs in 2011
Statute/Reg Number	Short Description	Longer Description		
58-3-121	TMJ Joint Dysfunction Coverage	Requires coverage for diagnostic, therapeutic, or surgical procedures involving any bone or joint of the jaw, face, or head, so long as the plan provides such services for any other bone or joint, the procedure is medically necessary to treat a condition which prevents normal functioning of the particular bone or joint involved, and the condition is caused by congenital deformity, disease, or traumatic injury.	0.14%	\$0.56
58-3-122	Anesthesia and hospital charges for dental procedures for certain individuals	Requires payment for anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for qualified individuals.	0.05%	\$0.20
58-3-168	Coverage for postmastectomy inpatient care.	The decision whether to discharge a patient following mastectomy shall be made by the physician and the patient and based upon the individual situation presented.	0.02%	\$0.06
58-3-169 + federal mandate	Minimum inpatient stays following delivery of a baby	Requires that when a plan provides maternity coverage is provided with respect to a mother and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.	0.00%	\$0.00
58-3-170	Treat maternity as any other illness	Requires that when a plan provides maternity coverage that the benefits for the necessary care and treatment of maternity are no less favorable than physical illness in general.	0.27%	\$1.06
58-3-174	Coverage for bone mass measurement	Requires coverage for qualified for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass.	0.14%	\$0.54
58-3-178	Coverage for prescription drug contraceptives or devices	Requires coverage for prescription contraceptive drugs or devices when a plan provides prescription drug coverage.	0.40%	\$1.58
58-3-179	Coverage for colorectal cancer screening	Requires coverage for colorectal cancer examinations and laboratory tests for cancer in accordance with the most recently published American Cancer Society guidelines.	0.05%	\$0.19
58-3-190	Coverage for emergency care	Requires coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person. This includes requiring treating emergency care provided at an out-of-network provider as an in-network benefit.	0.00%	\$0.00
58-3-200(d)	Coverage for services provided outside provider networks	Prohibits penalizing an insured or subjecting the insured to the out-of-network benefit levels offered under the insured's plan unless contracting health care providers able to meet the health needs of the insured are reasonably available to the insured without unreasonable delay.	0.00%	\$0.00

***** DRAFT #4 *****

**Appendix B
Estimated Value of Mandated Benefits**

From RFP # 12-001065			Estimated % of Claim Costs	Per Member Per Month Costs in 2011
Statute/Reg Number	Short Description	Longer Description		
58-3-220	Mental Illness Minimum Coverage Requirements (Applicable only to group policies)	Mandates equitable coverage for mental illness benefits in group health benefit plans providing that the plan shall provide benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally, including the application of the same limits which include the deductible, co-payments, lifetime and annual dollar limits, maximum out-of-pocket limits, and any other dollar limits or fees for covered services. Permits for most mental illness conditions a 30-day inpatient/outpatient limit of visits per year and a 30 office visits per year. For certain specified conditions, the durational limits must be the same as for general physical illness.	2.00%	\$7.88
58-3-220(i) + federal mandate	Equity in benefits for Mental Health in employer group health benefit plans covering 51 or more employees.	Requires when a plan that provides both surgical and medical benefits AND mental health benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees.	0.00%	\$0.00
58-3-221	Access to nonformulary drugs	Requires when an insurer who maintains one or more closed drug formularies, to establish and maintain a process that allows an enrollee to obtain, without penalty or additional cost-sharing, specific nonformulary drugs or devices determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer.	0.00%	\$0.00
58-3-228	Coverage for prescription drugs during an emergency or disaster	Provides that all health benefit plans must develop and implement a procedure to waive time restrictions on filling or refilling prescriptions for medication if request by the covered person or subscriber when there is an emergency or disaster declared. The procedure must permit for the waiver or override of "refill too soon" edits to pharmacies, and the procedure must include a provision for payment to the pharmacy for any prescription dispensed under the statute.	0.00%	\$0.00
58-3-255	Coverage for certain clinical trials	Requires coverage for participation in phase II, phase III, and phase IV covered clinical trials for qualified individuals.	0.05%	\$0.20
58-3-260	Coverage for newborn hearing screening	Requires coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125	0.00%	\$0.02
58-3-270	Coverage for ovarian cancer surveillance tests	Requires coverage for surveillance tests for women age 25 and older at risk for ovarian cancer.	0.20%	\$0.80
58-3-280	Coverage for the diagnosis and treatment of lymphadema	Requires coverage for the diagnosis, evaluation, and treatment of lymphadema, including benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education if the treatment is determined to be medically necessary.	0.01%	\$0.03
58-3-285	Coverage for hearing aids	Requires coverage for one hearing aid per hearing-impaired ear up to \$2500 dollars per hearing aid every 36 months for covered individuals under the age of 22 years of age.	0.04%	\$0.15
58-51-5(a)(8)	Limits on exclusion of claims that are subject to Workers' Compensation Act	Prohibits an exclusion of claims that are subject to the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes unless the exclusion extends to only specific medical charges for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under that Article or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.	0.00%	\$0.00

***** DRAFT #4 *****

**Appendix B
Estimated Value of Mandated Benefits**

From RFP # 12-001065			Estimated % of Claim Costs	Per Member Per Month Costs in 2011
Statute/Reg Number	Short Description	Longer Description		
58-51-16	Coverage for Intoxicants and narcotics	Prohibits an exclusion in medical expense policies for claims related to or resulting from being intoxicated or under the influence of any narcotic.	0.00%	\$0.00
58-51-30	Coverage for congenital defects and anomalies	Requires coverage for benefits for any sickness, illness, or disability shall be provided with the moment of the child's birth or placement in the home as a foster child. Benefits in such plans shall be the same for congenital defects or anomalies as are provided for most sicknesses or illnesses suffered by minor children that are covered by the plans. Benefits for congenital defects or anomalies shall specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.	0.00%	\$0.00
58-51-37	Pharmacy of Choice	Provides "any-willing-provider" type requirements for pharmacies.	0.00%	\$0.00
58-51-50	Minimum benefit offering for Alcoholism/Drug Abuse Treatment (Applicable only to group and blanket policies)	Provides for a minimum benefit offering for chemical dependency treatment for a group or blanket accident and health insurance policy.	0.12%	\$0.47
58-51-50(f) + federal mandate	Equity in benefits for Chemical Dependency/Addiction in employer group health benefit plans covering 51 or more employees	Requires when a plan that provides both surgical and medical benefits AND chemical dependency/addiction benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees.	0.00%	\$0.00
58-51-57	Coverage for mammograms and cervical cancer screening	Requires coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography.	0.77%	\$3.04
58-51-58	Coverage for prostate cancer screening	Requires coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer	0.03%	\$0.11
58-51-59	Coverage for certain off-label drug use for the treatment of cancer	Prohibits the exclusion of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug does have to be approved by the FDA and the efficacy must have been proven and accepted for treatment in an established compendium.	0.20%	\$0.79
58-51-61	Coverage for certain treatment of diabetes	Requires coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes.	0.30%	\$1.18
58-51-62 + federal mandate	Coverage for reconstructive breast surgery following a mastectomy	Requires coverage for reconstructive breast surgery following a mastectomy if the plan provides coverage for the mastectomy	0.00%	\$0.00
T11 12.0323	Coverage for complications of pregnancy	Requires that a complication of pregnancy may not be treated any differently from any other illness or sickness under the contract. Specifically includes a non-electing cesarean section as a complication.	0.00%	\$0.00
T11 12.0324	Coverage to treat HIV/AIDS	HIV infection and AIDS must be treated as any other illness or sickness under the contract.	0.00%	\$0.00

Appendix C
Projected HBE Administrative Expense Budget for 2014-2016

**Appendix C
North Carolina Health Insurance Exchange
Administrative Expense Budget Estimate 2014-2016**

Direct Labor and Related Costs	2014	2015	2016
Benefits	\$1,508,080	\$1,566,896	\$1,610,887
Bonus	\$0	\$0	\$0
Payroll Tax	\$482,586	\$501,407	\$515,484
Total Direct Labor and Related Costs	\$8,022,984	\$8,335,885	\$8,569,916
Salary Driven Costs			
Communications	\$30,162	\$31,338	\$32,218
Education	\$15,081	\$15,669	\$16,109
Equipment Rent	\$105,566	\$109,683	\$112,762
Insurance	\$90,485	\$94,014	\$96,653
Outside Legal Fees	\$30,162	\$31,338	\$32,218
Postage	\$30,162	\$31,338	\$32,218
Repairs	\$60,323	\$62,676	\$64,435
Supplies	\$30,162	\$31,338	\$32,218
Boards, Bureaus, and Association Fees	\$15,081	\$15,669	\$16,109
Financial Auditing	\$45,242	\$47,007	\$48,327
Bank Fees	\$6,032	\$6,268	\$6,444
Travel	\$15,081	\$15,669	\$16,109
Utilities	\$15,081	\$15,669	\$16,109
Total Salary Driven Costs	\$488,618	\$507,674	\$521,927
Other Direct Costs			
Rent	\$231,750	\$242,883	\$249,701
Branding and Promotion	\$3,557,658	\$3,854,208	\$3,951,624
Leased Lines	\$12,000	\$12,337	\$12,683
Navigator Grants	\$1,647,064	\$1,784,356	\$1,829,456
Website Maintenance & Development	\$1,000,000	\$1,028,075	\$1,056,938
Consulting & Professional Support	\$3,000,000	\$3,000,000	\$3,000,000
Furniture	\$206,000	\$4,000	\$0
Core System Maintenance and Support	\$3,000,000	\$3,084,224	\$3,170,813
Plan Performance/Quality Reporting Vendor	\$500,000	\$514,037	\$528,469
Computer Workstations	\$133,900	\$2,600	\$0
Computer Equipment	\$100,000	\$102,807	\$105,694
CAHPS Audit	\$11,700	\$12,028	\$12,366
Lobbying	\$10,000	\$10,000	\$10,000
Accounting System	\$50,000	\$51,404	\$52,847
Recruiting	\$51,500	\$6,000	\$5,500
Total Other Direct Costs	\$13,511,572	\$13,708,959	\$13,986,090
Total Annual Expense	\$22,023,174	\$22,552,518	\$23,077,933

***** DRAFT #4 *****

**Appendix C
North Carolina Health Insurance Exchange
Administrative Staffing and Salary Assumptions**

Executive Office	Baseline FTEs	Staffing Ratio	2014 FTEs	2015 FTEs	2016 FTEs	2010 Salary/FTE	2014 Salary/FTE	2014 Salary	2015 Salary	2016 Salary
Executive Director	1.0	0.0000016	1.0	1.0	1.0	\$ 200,000	\$ 217,322	\$ 217,322	\$ 223,423	\$ 229,696
Director of Operations	1.0	0.0000016	1.0	1.0	1.0	\$ 144,000	\$ 156,472	\$ 156,472	\$ 160,865	\$ 165,381
Director of Marketing	1.0	0.0000016	1.0	1.0	1.0	\$ 110,000	\$ 119,527	\$ 119,527	\$ 122,883	\$ 126,333
Director of Information Systems	1.0	0.0000016	1.0	1.0	1.0	\$ 121,000	\$ 131,480	\$ 131,480	\$ 135,171	\$ 138,966
Director of Finance	1.0	0.0000016	1.0	1.0	1.0	\$ 140,000	\$ 152,126	\$ 152,126	\$ 156,396	\$ 160,787
Board Liaison	1.0	0.0000016	1.0	1.0	1.0	\$ 71,000	\$ 77,149	\$ 77,149	\$ 79,315	\$ 81,542
Administrative Assistant	5.0	0.0000079	5.0	5.0	5.0	\$ 45,000	\$ 48,897	\$ 244,487	\$ 251,351	\$ 258,408
	11.0		11.0	11.0	11.0			\$ 1,098,563	\$ 1,129,404	\$ 1,161,113

Operations	Baseline FTEs		2014 FTEs	2015 FTEs	2016 FTEs	2010 Salary/FTE	Annual Salary	2014 Salary	2015 Salary	2016 Salary
Plan Administration										
Manager, Plan Administration	1.0	0.0000016	1.0	1.0	1.0	\$ 80,000	\$ 86,929	\$ 86,929	\$ 89,369	\$ 91,878
Carrier Liaison	2.0	0.0000032	2.0	2.0	2.0	\$ 45,000	\$ 48,897	\$ 97,795	\$ 100,541	\$ 103,363
Plan Certification Analyst	2.0	0.0000032	2.0	2.0	2.0	\$ 35,000	\$ 38,031	\$ 76,063	\$ 78,198	\$ 80,394
Clerk	2.0	0.0000032	2.0	2.0	2.0	\$ 29,000	\$ 31,512	\$ 63,023	\$ 64,793	\$ 66,612
	7.0		7.0	7.0	7.0			\$ 323,810	\$ 332,901	\$ 342,247
Call Center										
Manager, Call Center	1.0	0.0000016	1.0	1.0	1.0	\$ 75,000	\$ 81,496	\$ 81,496	\$ 83,784	\$ 86,136
Supervisor, Call Center	0.0	NA	1.0	1.0	1.0	\$ 46,500	\$ 50,527	\$ 50,527	\$ 51,946	\$ 53,404
Call Center Agent	14.0	Erlang	26.0	28.0	28.0	\$ 29,500	\$ 32,055	\$ 833,430	\$ 922,739	\$ 948,644
	15.0		28.0	30.0	30.0			\$ 965,453	\$ 1,058,469	\$ 1,088,184
Eligibility Processing										
Supervisor, Eligibility Support Unit	1.0	0.0000016	1.0	1.0	1.0	\$ 46,000	\$ 49,984	\$ 49,984	\$ 51,387	\$ 52,830
Eligibility Processor	2.0	0.0000032	2.0	2.0	2.0	\$ 38,000	\$ 41,291	\$ 82,582	\$ 84,901	\$ 87,284
Eligibility Appeals Processor	2.0	0.0000032	2.0	2.0	2.0	\$ 38,000	\$ 41,291	\$ 82,582	\$ 84,901	\$ 87,284
	5.0		5.0	5.0	5.0			\$ 215,148	\$ 221,189	\$ 227,398
Plan Performance and Quality Reporting										
Manager, Plan Performance and Quality Rep	1.0	0.0000016	1.0	1.0	1.0	\$ 83,000	\$ 90,189	\$ 90,189	\$ 92,721	\$ 95,324
Quality Analyst	2.0	0.0000032	2.0	2.0	2.0	\$ 58,000	\$ 63,023	\$ 126,047	\$ 129,586	\$ 133,224
Report Developer	1.0	0.0000016	1.0	1.0	1.0	\$ 50,000	\$ 54,331	\$ 54,331	\$ 55,856	\$ 57,424
	4.0		4.0	4.0	4.0			\$ 270,567	\$ 278,163	\$ 285,972
Enrollment Reporting										
Manager, Enrollment Reporting	1.0	0.0000016	1.0	1.0	1.0	\$ 70,000	\$ 76,063	\$ 76,063	\$ 78,198	\$ 80,394
Enrollment Reporting Analyst	2.0	0.0000032	2.0	2.0	2.0	\$ 47,000	\$ 51,071	\$ 102,141	\$ 105,009	\$ 107,957
	3.0		3.0	3.0	3.0			\$ 178,204	\$ 183,207	\$ 188,351

***** DRAFT #4 *****

**Appendix C
North Carolina Health Insurance Exchange
Administrative Staffing and Salary Assumptions**

Marketing	Baseline FTEs		2014 FTEs	2015 FTEs	2016 FTEs	2010 Salary/FTE	Annual Salary	2014 Salary	2015 Salary	2016 Salary
Exchange Marketing										
Manager, Marketing	1.0	0.0000016	1.0	1.0	1.0	\$ 86,000	\$ 93,449	\$ 93,449	\$ 96,072	\$ 98,769
Marketing Coordinator	2.0	0.0000032	2.0	2.0	2.0	\$ 50,000	\$ 54,331	\$ 108,661	\$ 111,712	\$ 114,848
	3.0		3.0	3.0	3.0			\$ 202,110	\$ 207,784	\$ 213,617
Navigator Program										
Manager, Navigator Program	1.0	0.0000016	1.0	1.0	1.0	\$ 85,000	\$ 92,362	\$ 92,362	\$ 94,955	\$ 97,621
Navigator Liaison	4.0	0.0000063	4.0	4.0	4.0	\$ 51,000	\$ 55,417	\$ 221,669	\$ 227,892	\$ 234,290
	5.0		5.0	5.0	5.0			\$ 314,031	\$ 322,847	\$ 331,911
Materials and Fulfillment										
Supervisor, Materials and Fulfillment	1.0	0.0000016	1.0	1.0	1.0	\$ 55,000	\$ 59,764	\$ 59,764	\$ 61,441	\$ 63,166
Copywriter	1.0	0.0000016	1.0	1.0	1.0	\$ 51,000	\$ 55,417	\$ 55,417	\$ 56,973	\$ 58,572
Graphics Designer	1.0	0.0000016	1.0	1.0	1.0	\$ 47,000	\$ 51,071	\$ 51,071	\$ 52,504	\$ 53,979
Clerk	2.0	0.0000032	2.0	2.0	2.0	\$ 27,000	\$ 29,338	\$ 58,677	\$ 60,324	\$ 62,018
	5.0		5.0	5.0	5.0			\$ 224,929	\$ 231,242	\$ 237,735
Government/Public Relations										
Manager, Government/Public Relations	1.0	0.0000016	1.0	1.0	1.0	\$ 85,000	\$ 92,362	\$ 92,362	\$ 94,955	\$ 97,621
Public Relations Coordinator	1.0	0.0000016	1.0	1.0	1.0	\$ 69,000	\$ 74,976	\$ 74,976	\$ 77,081	\$ 79,245
Government Relations Coordinator	1.0	0.0000016	1.0	1.0	1.0	\$ 69,000	\$ 74,976	\$ 74,976	\$ 77,081	\$ 79,245
Grant Writer	1.0	0.0000016	1.0	1.0	1.0	\$ 56,000	\$ 60,850	\$ 60,850	\$ 62,559	\$ 64,315
	4.0		4.0	4.0	4.0			\$ 303,164	\$ 311,676	\$ 320,426

***** DRAFT #4 *****

**Appendix C
North Carolina Health Insurance Exchange
Administrative Staffing and Salary Assumptions**

Information Systems	Baseline FTEs		2014 FTEs	2015 FTEs	2016 FTEs	2010 Salary/FTE	Annual Salary	2014 Salary	2015 Salary	2016 Salary
Actuarial Analysis										
Network Administrator	1.0	0.0000016	1.0	1.0	1.0	\$ 63,000	\$ 68,456	\$ 68,456	\$ 70,378	\$ 72,354
Desktop Support Specialist	1.0	0.0000016	1.0	1.0	1.0	\$ 45,000	\$ 48,897	\$ 48,897	\$ 50,270	\$ 51,682
Systems Program Manager	1.0	0.0000016	1.0	1.0	1.0	\$ 110,000	\$ 119,527	\$ 119,527	\$ 122,883	\$ 126,333
Application Developer	3.0	0.0000048	3.0	3.0	3.0	\$ 88,000	\$ 95,622	\$ 286,865	\$ 294,919	\$ 303,199
Database Administrator	1.0	0.0000016	1.0	1.0	1.0	\$ 75,000	\$ 81,496	\$ 81,496	\$ 83,784	\$ 86,136
Database Developer	3.0	0.0000048	3.0	3.0	3.0	\$ 58,000	\$ 63,023	\$ 189,070	\$ 194,378	\$ 199,835
Plan Configuration Specialist	1.0	0.0000016	1.0	1.0	1.0	\$ 47,000	\$ 51,071	\$ 51,071	\$ 52,504	\$ 53,979
EDI Specialist	2.0	0.0000032	2.0	2.0	2.0	\$ 53,000	\$ 57,590	\$ 115,181	\$ 118,414	\$ 121,739
HIPAA Compliance Officer	1.0	0.0000016	1.0	1.0	1.0	\$ 77,000	\$ 83,669	\$ 83,669	\$ 86,018	\$ 88,433
	14.0		14.0	14.0	14.0			\$ 1,044,232	\$ 1,073,548	\$ 1,103,690
Finance	Baseline FTEs		2014 FTEs	2015 FTEs	2016 FTEs	2010 Salary/FTE	Annual Salary	2014 Salary	2015 Salary	2016 Salary
Actuarial Analysis										
Chief Actuary	1.0	0.0000016	1.0	1.0	1.0	\$ 90,000	\$ 97,795	\$ 97,795	\$ 100,541	\$ 103,363
	1.0		1.0	1.0	1.0			\$ 97,795	\$ 100,541	\$ 103,363
Accounting/Financial Reporting										
Controller	1.0	0.0000016	1.0	1.0	1.0	\$ 110,000	\$ 119,527	\$ 119,527	\$ 122,883	\$ 126,333
Staff Accountant	3.0	0.0000048	3.0	3.0	3.0	\$ 44,000	\$ 47,811	\$ 143,433	\$ 147,459	\$ 151,599
Financial Analyst	1.0	0.0000016	1.0	1.0	1.0	\$ 49,000	\$ 53,244	\$ 53,244	\$ 54,739	\$ 56,276
	5.0		5.0	5.0	5.0			\$ 316,204	\$ 325,081	\$ 334,208
Infrastructure										
Human Resources Generalist	1.0	0.0000016	2.0	2.0	2.0	\$ 48,000	\$ 52,157	\$ 104,315	\$ 107,243	\$ 110,254
Payroll Specialist	1.0	0.0000016	1.0	1.0	1.0	\$ 42,000	\$ 45,638	\$ 45,638	\$ 46,919	\$ 48,236
Training Specialist	1.0	0.0000016	1.0	1.0	1.0	\$ 46,000	\$ 49,984	\$ 49,984	\$ 51,387	\$ 52,830
Attorney	1.0	0.0000016	1.0	1.0	1.0	\$ 95,000	\$ 103,228	\$ 103,228	\$ 106,126	\$ 109,106
Compliance Officer	1.0	0.0000016	1.0	1.0	1.0	\$ 77,000	\$ 83,669	\$ 83,669	\$ 86,018	\$ 88,433
Officer Manager	1.0	0.0000016	1.0	1.0	1.0	\$ 58,000	\$ 63,023	\$ 63,023	\$ 64,793	\$ 66,612
Mail Clerk	1.0	0.0000016	1.0	1.0	1.0	\$ 26,000	\$ 28,252	\$ 28,252	\$ 29,045	\$ 29,860
	7.0		8.0	8.0	8.0			\$ 478,109	\$ 491,531	\$ 505,331
Functional Area			2014 FTEs	2015 FTEs	2016 FTEs			2014 Salary	2015 Salary	2016 Salary
Executive Office	11.0		11.0	11.0	11.0			\$ 1,098,563	\$ 1,129,404	\$ 1,161,113
Operations	34.0		47.0	49.0	49.0			\$ 1,953,182	\$ 2,073,929	\$ 2,132,152
Marketing	17.0		17.0	17.0	17.0			\$ 1,044,234	\$ 1,073,549	\$ 1,103,689
Information Systems	14.0		14.0	14.0	14.0			\$ 1,044,232	\$ 1,073,548	\$ 1,103,690
Finance	13.0		14.0	14.0	14.0			\$ 892,108	\$ 917,153	\$ 942,902
Total Staff All Functional Areas	89.0		103.0	105.0	105.0			\$ 6,032,319	\$ 6,267,583	\$ 6,443,546

**Appendix D
Detailed Projections**