

**HEALTH BENEFIT EXCHANGE WORKGROUP**  
**Wednesday, October 26, 2011**  
**North Carolina Institute of Medicine, Morrisville**  
**10:00am-3:00pm**  
**Meeting Summary**

**Attendees**

*Workgroup Members:* Louis Belo (co-chair), Allen Feezor (co-chair), Tracy Baker, Vicki Bradley, Deby Dihoff, Teri Guitierrez, Mark Hall, Rep. Verla Insko, Linwood Jones, Fred Joyner, Michael Keough, Adam Linker, Mike Matznick, Sen Floyd McKissick, Barbara Morales-Burke, Kelly Nicholson, Carla Obiol, Elizabeth Phillips, Rebecca Whitaker, Bill Wilson

*Steering Committee Members:* Jean Holliday, Julia Lerche, Ben Popkin, Lauren Short, Rose Williams

*NCIOM Staff:* Pam Silberman, Jennifer Hastings

*Other Interested Persons:* Ryan Blackledge, Conor Brockett, Abby Carter Emanuelson, John Dervin, Russell Greene, Suzanne Hyman, Amy Jo Johnson, Markita Keaton, Andy Landes, Julia Lawhorn, Kathryn Millican, Shelli Neal, Susan Nestor, Ernest Nickerson, Melissa Reed, Pratyusha Rao, Susan Ryan, Robert Seehausen, Ashlee Smart, Chuck Stone, Sarah Thomas, Walker Wilson

**Federal Law Minimum Requirements**

*Pam Silberman, JD, DrPH*

*President and CEO*

*North Carolina Institute of Medicine*

Dr. Silberman presented the statutory and regulatory provisions for qualified health plans. This information had been presented previously, but was re-presented to provide the workgroup with a review and to lay the foundation for the other presentations and associated discussions. Qualified health plans have to meet certain requirements, which Dr. Silberman quickly reviewed. One of the requirements is that health plans must provide an essential benefits package. She noted, however, that the federal government has yet to define this.

Dr. Silberman's presentation can be found here: [Federal Law Minimum Requirements](#).

**State Law Health Plan Requirements**

*Jean Holliday, CPM, HIA*

*Health Care Reform Supervisor*

*Life and Health Division*

*North Carolina Department of Insurance*

Ms. Holliday presented health plan requirements under North Carolina state law. The North Carolina Department of Insurance (DOI) authorizes domestic and foreign insurers to operate within the state. Insurers must provide proof of minimum capital and surplus deposits, show financial projections, and provide evidence of successful business operations among other requirements. The DOI has authority

over rates in general, and insurers have to seek DOI approval before they can increase rates. There are some separate statutory provisions that apply to preferred provider organizations (PPOs), health maintenance organizations (HMOs), and nonprofit medical and hospital corporations (i.e., Blue Cross and Blue Shield of North Carolina).

Ms. Holliday's presentation can be found here: [State Law Health Plan Requirements](#).

### **Selected questions and comments:**

- Q: Are there specific rules about network adequacy? A: North Carolina does not have specific state law requirements for network adequacy. Instead plans that have provider networks (e.g., PPO, HMO, or Point-of-Service plans) must establish its own network adequacy standards. The DOI would use a test of reasonable adequacy if questions arose about the adequacy of any specific plans provider networks—using other insurers' network adequacy standards as examples of what is adequate in North Carolina.
- Q: Do all of these requirements apply to the State Health Plan (SHP)? A: Some may, but only if the NC General Assembly requires the SHP to comply with similar provisions. In general, the SHP operates as a public ERISA plan. How the SHP operates is determined by the North Carolina General Assembly and not the DOI.
- Q: To what degree over the years have HMO or PPO applicants been denied because the DOI determined they did not have adequate responses? A: Over the years, DOI has worked with entities that seek to be licensed as health insurers or HMOs. The companies may need to submit additional information or revise their procedures to meet the DOI requirements. However, Ms. Holliday did not recall any insurers who could not ultimately meet the DOI's requirements.
- Comment: The DOI has seen some interest from carriers in developing value-based insurance products. This might include multiple tiers, with lower out-of-pocket spending if the enrollee obtained care from specific high-value providers. This is also an issue being discussed in the New Models of Care Workgroup. State law currently requires that you can have no more than a 30 percent differential between in network and out of network. Another concern is that insurers could not currently create an Accountable Care Organization and shift insurance risk to providers without first seeking an HMO license. As the industry moves into different arrangements with providers, we will reach a point where providers will find current requirements to be a barrier.
- Q: If I am insured with a PPO product, and I want to move to shared risk with bundled payments or something different, do I move to HMO area or do I stay a PPO? A: Currently under law, a PPO would not be able to share risk with providers.
- Q: In terms of access and adequacy standards, the DOI has shown ingenuity in making sure the burden is on the carrier. As we get into the surge months in early 2014, will we have to think about suspension of network adequacy standards because of all the new enrollees? A: We have to be careful to make sure there are enough health care professionals to take care of people. One

suggestion might be to simplify utilization standards and insurance policies to reduce administrative burdens on the providers.

- Comment: There are certain regulatory barriers which make it difficult for insurers to test new products in the marketplace. We need to provide some flexibility, yet at the same time insure that insurers meet certain “safety” requirements intended to protect consumers (for example, financial solvency or network adequacy).

## **Driving Value Through Exchanges**

*Sarah Thomas, MS*

*Vice President for Public Policy and Communications*

*National Committee for Quality Assurance*

The National Committee for Quality Assurance (NCQA) is non-profit organization that drives improvement in US health care by offering programs and services, providing accreditation standards for health insurers, and working to develop consensus on health issues among key stakeholders. Ms. Thomas from NCQA presented the organization’s efforts around health benefit exchanges. She noted that exchanges represent a real paradigm shift and that consumers will be much more engaged than in the past. In addition, she said NCQA would like to see quality information made easily accessible and provided so that people consider both cost and quality when selecting a plan.

Ms. Thomas’s presentation can be found here: [Driving Value Through Exchanges](#).

### **Selected questions and comments:**

- Comment: The first set of federal regulations did not provide a lot of detail on the quality-related provisions. The states may have a lot of flexibility in establishing quality standards. A number of states are looking at this issue as they are working on their exchanges. There are some advantages to sticking with measures that are in use. We should use the same measures for HMOs and PPOs, and auditing is important to ensure that data are being reported accurately. We can always increase the quality standards over time. The NCQA would like to see information on quality front and center. The organization of options makes a huge difference in what people purchase.
- Comment: Qualified health plans will begin to be offered through HBEs in 2014. Because these are new organizations, data will not be available to judge quality. Thus, there are some discussions about how the HBE could use other quality data (e.g., from other commercial plans or Medicaid HMO plans) to help consumers make selections in 2014 (the first year).
- Comment: NCQA is in the process of developing new accreditation standards that will be released mid-2012. If plans want to become NCQA accredited, they will be able to see this information then and begin the process of seeking accreditation. Quality information reporting and scoring will be helpful to many different groups including regulators, consumers, etc. NCQA is also thinking about issues around multicultural care and innovations to continuously nudge and push plans to raise the bar.

- Q: Is any accreditation done at the state level or only at national level? A: NCQA generally accredits insurers at the state level based on state-level data (for example, Aetna or United Health Care would seek accreditation for its North Carolina plans separately from plans it offers in other states). However, if a multistate carrier uses the same centralized processes for quality assurance, NCQA will examine the company-wide quality assurance and quality improvement standards in making its state-level accreditation determination. Performance data would still be at the state level.
- Q: The accreditation process will be helpful for the exchange and regulators. However, do we have any evidence that consumers look at accreditation data in making their health plan selection? A: We do not think many consumers look for accreditation data, but this is a good protection to ensure that health plans meet certain quality standards.
- Q: How are we going to help consumers get enrolled in plans? Is quality review information too much information? A: States should think about simplifying the quality data into an aggregated quality score (using a star-rating system or a Consumer Reports-type of consolidated quality rating). Then, consumers should have the opportunity to dive deeper into the quality data to get more information about specific quality measures.
- Q: Does NCQA work with insurers that do not meet the standards? A: NCQA maintains a firewall between itself and the insurers, so it does not provide coaching. We don't want insurers to fail, and we make the accreditation expectations very clear. There are consultants aside from NCQA staff who can help insurers prepare for NCQA accreditation.
- Q: Are there generic types of insurers who have not sought NCQA-accreditation? A: A lot of carriers in the individual market have not come to NCQA. For example, Mutual of Omaha, and some of the PPO Blue Cross and Blue Shield plans have less interest in NCQA accreditation. In some states, Blue Cross and Blue Shield has decided they have enough market share that they do not seek the extra marketing help that accreditation would lend.
- Q: Maintaining the adequacy of a provider network is important; however, it is difficult to keep an up-to-date provider directory. Does NCQA have any suggestions for how to ensure minimum network adequacy and that provider networks are up-to-date? A: This is an active topic of discussion. Our current standard is that insurers should articulate their policies and show that they follow their policies. Some plans use GeoAccess program to monitor their network. We do require an online membership directory. However, merely having providers listed in a network does not guarantee access if the enrollee cannot obtain an appointment. We use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to get information about whether the plan is having access problems.
- Comment: Are there any drawbacks with the accuracy in quality data when the main data source is claims? A: There are issues with claims-based data. This should get better over time as more health care providers adopt electronic health records. There are also problems with certain clinical quality measures for conditions that do not affect large numbers of people.

- Comment: The network adequacy standard is a concern from the community health center perspective. Because the ACA requires health plans to pay FQHCs at Medicaid prospective cost-based reimbursement level, there is some concern that federally qualified health plans will be left out of health plan contracts. We need to look at network adequacy and how they will impact with some of the previously uninsured people.
- Q: Do FQHCs currently receive the prospective payment rate when they have contracts with commercial carriers? A: No.
- Q: Accrediting organizations often have a tension between setting standards at the lowest common denominator and advancing best practices. How does NCQA address this? A: NCQA has three accreditation levels. That means that we can differentiate between different types of organizations based on their performance. In fact, we changed our reporting methodology this year, which would have resulted in a lot of plans moving to a lower accreditation level. We plan on phasing in the new standards in a year.

**Related Information:**

[North Carolina plans that are NCQA accredited](#)

[A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey](#)

(See Appendix 8: MCO Network Adequacy Requirements by Type of Care, by State.)

**Update on Navigator Subcommittee**

*Pam Silberman, JD, DrPH*

*President and CEO*

*North Carolina Institute of Medicine*

Dr. Silberman provided an update on the work of the Navigator Subcommittee. The subcommittee reviewed navigator requirements, including contracting requirements, and roles of navigators. Entities that serve as patient navigators must already have connections with small employers and/or individuals that are likely to gain insurance through the HBE, or be able to quickly connect with these groups. The NC Senior Health Insurance Information Program (SHIIP) is similar to this model and includes education, competency exams, and ongoing training. SmartNC, the DOI consumer assistance program, also does education, outreach, and helps with grievances and appeals processes. The Navigator subcommittee discussed potential training and competency requirements. The subcommittee will meet one more time and then bring recommendations back to this group.

**Selected questions and comments:**

- Comment: Affordable Care Act grant money cannot be used to pay for navigators. We do not know, however, if the federal grant funding can be used for training. This restriction on the use of federal grant funding may cause problems, given that the navigators have to be trained and certified and begin to help people enroll in the fall of 2013.
- Q: Will navigators have the ability to steer people in and out of the exchange network? A: Navigators cannot really steer individuals to health plans outside of the HBE, as this would

require an agent's license; however, they can provide information about plans offered through the HBE. The SHIIP program navigators do not and cannot make recommendations.

- Comment: We need to talk about how to create a system that provides people with a way to get more information with an agent or a broker. Remember, there should be no wrong door; agents and navigators need to know about Medicaid and those at the exchange need to know about what is available outside.
- Comment: The small employer market inside or outside of the HBE will be very complicated. We may need two different navigators. Most HBE lives will come through non-group coverage.

### **Review of NAIC Information**

*Jean Holliday, CPM, HIA*

*Health Care Reform Supervisor*

*Life and Health Division*

*North Carolina Department of Insurance*

Ms. Holliday presented options for financial sustainability of the HBE based on a white paper by the National Association of Insurance Commissioners (NAIC). The NAIC white paper addresses several different funding mechanisms and summarizes what some states have done. For example, exchange fees can be charged to issuers. She noted that it is important to consider who will benefit from the exchange and that cost should be spread out among all these groups. The ACA says the state shall insure that the exchange is self-sustaining by 2015. Grant funds can be used through 2014, but cannot be used after that. Ms. Holliday's presentation was based on HBE cost figures developed by Milliman.

### **Selected questions and comments:**

- Q: What were the assumptions of the Milliman report in terms of the function of the HBE? A: Based on required functions of the exchange, it assumed most functions would be done in house and not shopped out. Milliman looked at Massachusetts as a guide to the necessary functions to develop the numbers, but these numbers are not *based* on Massachusetts's numbers.
- Comment: We have to have a revenue flow that starts in 2014 so you can maintain operational flow through to 2015.
- Q: Does the \$25 M cost developed by Milliman include the HBE paying commissions to the navigators or agents? A: This is not clear.

## Questions for/from Workgroup

*Pam Silberman, JD, DrPH*

*President and CEO*

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- Q: Are there other standards NC should include in certifying health plans over time? (Examples that the workgroup discussed include network adequacy, or special rules for essential community providers (ECP), number or types of plans, participation in four different precious metal plan, additional quality standards, fostering state health goals, fostering innovations (do we need to change state laws?), phase-in for accreditation requirements.)  
A: The HBE needs to have flexibility to be able to respond to some of these issues. We also need to consider the costs of new requirements as well as additional benefits that new requirements would provide. The workgroup will consider this question and discuss it at a subsequent meeting.
- Comment: A major barrier to innovation is the anti-steering provision large provider systems have in their provider contracts. For example, it would be difficult for health plans to set up tiered provider networks which incentivize consumers to seek services through lower cost and higher quality providers if the large systems have an anti-steering provision in their contract.
- Q: Should providers be assessed since they will have more insured patients (for example, hospitals will have decreased uncovered costs when more people gain insurance coverage)?  
A: Historically, many hospitals have received Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, (additional reimbursement intended to provide some compensation to hospitals that have a high proportion of uninsured and Medicaid patients). However, under the ACA, DSH funds will be phased out as the state reduces the proportion of uninsured individuals. Thus, hospitals are already helping to subsidize coverage of the uninsured through the loss of DSH funds.
- Q: Should a pmpm fee be added to all the people who purchase coverage through the HBE?  
A: If the fee is built into the HBE premium, then the federal government would effectively pay the additional costs for anyone who is receiving a subsidy. That is because the amount that an individual or family pays is based on a percentage of their *income* (not a percentage of the premium costs). The federal government pays the full difference between what the individual pays and the actual premium cost for the second lowest cost silver plan. Thus, if an additional pmpm were added to the premiums of everyone in the HBE, the federal government would pay that additional cost for anyone who receives a subsidy. However, any cost built into the HBE premium would also have to be built into the premium costs for individuals who purchase coverage in the individual and small group market outside the HBE (as insurers must charge the same premium inside and outside the HBE). Since the premium must be the same inside and outside the HBE, then the pmpm fee would effectively be subsidized by people purchasing coverage outside the HBE. Some in the group argued that this was appropriate—as everyone will gain benefits by being able to compare insurance quality and costs through the HBE (even if a person ultimately chooses to purchase coverage outside the HBE). However, others argued that

people who purchase coverage outside the HBE should not have to subsidize the operational costs of the HBE.

- Comment: Others were concerned that if the additional costs were considered to be part of the premium, it would be counted as administrative costs as part of the MLR determination; but if it were added as a separate “fee,” it would not be counted in the MLR determination. (The group discussed that a fee is assessed on someone using the service, whereas a tax is more generally applicable to everyone).
- Comment: If the fee is built into the premium, then it may not be obvious to the consumer that part of the premium cost is to help subsidize the costs of the HBE. This is an issue of transparency for people inside the exchange and outside the exchange.
- Comment: The North Carolina General Assembly needs to understand our reliance on their funding. We should build in a review with the NCGA after a certain period of time. There are two ways of looking at funding issue. One way is for NCGA to specify where the money will come from. The other way is for the NCGA to give the HBE the power to come up with the needed funding (e.g. in the case of increased needs).
- Comment: We do not know how many people will actually come in to the exchange initially. However, if the Milliman estimates are correct, approximately 500,000 people are expected to gain new coverage through the HBE (e.g., they had not previously had insurance coverage). Carriers already pay a premium tax of 2%. The existing premium tax for the new people who gain coverage through the HBE may be enough to offset all, or a large portion of the HBE costs. One carrier noted that 2% of their companies’ premium would be about \$84/pmpy. If 500,000 people gain coverage as a result of the HBE, it could generate close to \$42 million in new premium dollars. If the HBE could capture those new dollars, it should be sufficient to pay for the HBE operational costs without any new taxes or fees. This new funding would have to be put into a dedicated trust fund, and designated for the use of the HBE (rather than general operating funds).
- Comment: Because of the uncertainty of the HBE initial costs and the number of new covered lives, some of the workgroup members argued that North Carolina should provide the HBE with the authority to raise funds from other sources in addition to a premium or fee. For example, some people in the group argued that the HBE should have the authority to advertise on the website. However, others were concerned that advertising might cause confusion, and reduce the impartiality of the HBE. If advertising were allowed, the HBE should provide clear guidelines as to what types of advertising would be permissible. Some also argued that the HBE should have the authority to raise user fees if needed.
- Comment: We need to ensure that the HBE expenses are not inflated. One way is to require the HBE to submit the budget to the Insurance Commissioner annually.
- Potential Recommendation (Note: this is still a work in progress and will be discussed further at a future work group meeting):

- 1) Funding for the HBE operations should come from the existing premium tax on health insurers. The funding that is generated from the newly insured should be put into a special trust fund, used solely for operational costs of the HBE. (Note: this is similar to the funding stream that the NCGA established for Inclusive Health in the first few years).
- 2) The DOI should run estimates on the revenues that would be generated from a premium tax on insurance.
- 3) The NC General Assembly should give the HBE the authority to raise additional revenues if the estimated funding from premiums is not sufficient to pay for the HBE's reasonable operating costs. If advertising is allowed, the HBE needs to include guidelines to ensure consumer protections.
- 4) The HBE budget needs to be approved prior to the beginning of the new fiscal year.

### **Public Comments**

- It is in the public's best interest that there is no distinction between plans that are "outside" and "inside" the exchange.
- The individual and the small group markets should be combined into one large pool.