HEALTH BENEFITS EXCHANGE WORKGROUP

Comment [MSOffice1]: Includes add'l comments from MK, BMB

OVERVIEW

Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Health Benefits Exchange (HBE). The ACA requires that each state have a HBE that will offer information to help individuals and businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own HBE, the federal government will create one to offer coverage to individuals and small groups in the state.

The ACA requires most people to have minimum essential health insurance coverage beginning in 2014 or pay a penalty.[1] [2] Certain individuals are exempt from the mandate, including but not limited to those who are not required to pay taxes because their incomes are less than 100% of the federal poverty line (FPL), those who qualify for a religious exemption, Indians, and those for whom the lowest cost plan would exceed 8% of their income.[3] Larger businesses, with 50 or more full-time equivalent employees, must also offer minimum essential coverage or pay a penalty for its full-time employees.[4]

The HBE was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The HBE also can help ~~change the dynamics of the health care marketplace to increase~~promote competition on the basis of comparative cost, value, quality of care, and customer service~~; and reduce competition based on risk avoidance, risk selection and market segmentation~~. The HBE can also help increase transparency in the marketplace; ~~increase~~ add to consumer education ~~and consumer protections~~efforts; promote meaningful choice; and assist individuals and employers in accessing health coverage, premium tax credits and cost-sharing reductions. The goal in establishing the HBE is to reduce the number of uninsured, promote improved competition in the health care marketplace, and engage consumers in care and coverage choices.

Qualified health plans (QHPs), offered through the HBE, must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services

[1] The penalty is $95/year or 1% of income (whichever is greater) in 2014. The penalty amount increases to $695/year or 2.5% of income by 2016.

[2] The constitutionality of the individual mandate along with the Medicaid expansion is being challenged in the US Supreme Court. The Supreme Court accepted two cases to consider the constitutionality of different provisions of the ACA, *National Federation of Independent Business v. Sebelius*, and *Florida v. Department of Health and Human Services*. The different challenges will be considered in late March. A decision is expected before the close of the Supreme Courts current term in June, 2012.{{3670 Kaiser Family Foundation}}

[3] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1411(b)(5), codified at 42 USC §18081; Patient Protection and Affordable Care Act, Pub L No. 111-148, §1501(b), creating Sec. 5000A(d)(e) of the Internal Revenue Code.

[4] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1513, adding Sec. 4980H(c)(2) of the Internal Revenue Code;

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(including oral and vision care).[5] Each state will be required to define its own essential health benefits package (using HHS defined benchmarks) that includes coverage of these services.{{3671 Center for Consumer Information and Insurance Oversight}} In addition, all insurance plans that are not grandfathered[6] must provide coverage of the clinical preventive services recommended by the US Preventive Services Task Force and immunizations recommended by the Advisory Committee for Immunization Practices with no cost sharing.[7] Insurers must also provide additional preventive services for infants, children, adolescents, and women.[8]

The ACA specifies that the essential health benefits package can be offered in one of four levels of coverage, including bronze (defined as having a 60% actuarial value of covered services), silver (70% actuarial value), gold (80% actuarial value), and platinum (90% actuarial value).[9] To meet the requirements for minimum essential coverage, an individual must have a health plan with at least a 60% actuarial value. That means that on average, the insurer pays for 60% of the total costs of covered benefits. The individual (or family) would be responsible, on average, for the other 40% of the costs of covered services in addition to their premium. (Typically, individuals or families would pay their 40% share through a combination of deductibles, coinsurance, and/or copayments.) Insurers that offer QHPs in the HBE must offer at least the silver and gold level of coverage, but can also choose to offer the bronze and platinum levels. In addition, insurers can offer catastrophic plans to young adults under age 30.[10]

The ACA includes subsidies to make health insurance coverage more affordable. The subsidies are available to single individuals or families with modified adjusted gross income (MAGI) of up to 400% of the federal poverty level (FPL), if they do not have access to affordable employer-sponsored insurance (ESI) and do not qualify for public coverage such as Medicaid. (Table X.1) Families that qualify for subsidies may be eligible for an advanceable premium tax credit to help pay for health insurance coverage. The premium tax credit is based on the second lowest cost silver plan offered in the HBE. As long as the family purchases the second lowest cost silver plans then the maximum that the family would have to pay is based on a percentage of their income (ranging from 2% for lower income families to 9.5% for those whose incomes are between 300-400% FPL). Families who choose to purchase a higher cost plan would pay the specified percentage of their income, plus the difference in the premium cost between what they

[5] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(a).
[6] Grandfathered plans—those that were in existence when the bill was signed into law on March 23, 2010, and which have not changed substantially since then. Over time, many insurance plans will lose their grandfathered status, and will be subject to the preventive services and minimum essential coverage requirements. Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule. 75 Fed. Reg. 34538-34570. June 17, 2010. Amendment to Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act. *Fed Regist.* 2010;75(221):70114-70122. To be codified at 26 CFR §54, 29 CFR §2590, 45 CFR §147.
[7] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC §§300gg.
[8] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC §§300gg.
[9] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(d), 42 USC §18022.
[10] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(e), 42 USC §18022.

chose to purchase and the second lowest cost silver plan. Conversely, families that purchase a lower cost plan would pay less.

Lower income families, those with incomes below 250% FPL, also receive subsidies to help pay for their out-of-pocket costs (such as deductibles, coinsurance, or copayments). The federal government will pay the premium tax credits and the cost-sharing subsidies directly to health plans. All families that receive a subsidy who purchase a silver plan also qualify for reduced out-of-pocket annual limits. Eligible families must purchase their health insurance coverage through the HBE in order to receive the premium tax credit and cost sharing subsidies.

Table X.1
Sliding Scale Premium Tax Credit and Cost-sharing Reduction
Based on Second Lowest Cost Silver Plan

Individual or Family Income (as percent FPL)	Maximum premium for second lowest cost silver plan (Percent of family income)	Out-of-pocket cost-sharing, on average[€]	Out-of-pocket cost-sharing limits (Proportion of the Health Savings Accounts (HSA) out-of-pocket cost-sharing limits)[¥]
Families eligible for subsidy			
<133% FPL	2%	6%	$2,017 (individual)/ $4,033 (family) (1/3 HSA limits)
133-150% FPL	3-4%	6%	$2,017/$4,033
150-200% FPL	4-6.3%	13%	$2,017/$4,033
200-250% FPL	6.3%-8.05%	27%	$3,025/$6,050 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	$3,025/$6,050
300-400% FPL	9.5%	30%	$4,033/$8,067 (2/3 HSA limit)
Families not eligible for subsidies			
400%+ FPL	No limit	30%	$6,050/$12,100 (HSA limit)

[€] Out-of-pocket cost sharing includes deductibles, coinsurance, and copays.
[¥] Out-of-pocket limits do not include premium costs. Annual cost sharing limited to $6,050 per individual or $12,100 per family in 2012 dollars (current Health Savings Account or "HSA" limits). Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1312(d), 1501, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1002.

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In addition to the subsidies available to individuals, the ACA also included tax credits to help small businesses purchase health insurance coverage.[11] Small businesses with 25 or fewer employees, with average wages of $50,000 or less, are eligible for sliding scale tax credits if they offer health insurance coverage to their employees and pay at least 50% of the premium. The tax credits are currently available to small businesses that meet these criteria. However, beginning in 2014, small businesses will only be able to obtain tax credits if they purchase health insurance coverage through the HBE.

The NC Department of Insurance contracted with Milliman, Inc., an actuarial consulting firm, to develop estimates of the number of people who might gain coverage in the HBE and examine other HBE operational and design issues. According to Milliman, approximately 715,000 North Carolinians will obtain their health insurance coverage through the HBE beginning in 2014.{{3672 Milliman, Inc.}} (Table X.2) Of these, slightly more than 51,000 people will be employees of small businesses purchasing insurance coverage through the HBE; and more than 660,000 people will purchase nongroup coverage through the Exchange. Approximately 300,000 of the individuals who are expected to enroll in the HBE in the first year were uninsured in 2013.

Table X.2: Changes in Insurance Coverage (2013-2014)

		Market Changes in 2014							
				Employer Sponsor		Ind. Market			
Market in 2013	Total Pop.	Medicaid/ CHIP	Other Govt. Program	HBE	Non-HBE	HBE	Non-HBE	Un-insured	Undoc Un-insured
Medicaid/ CHIP	1,418,183	1,415,697	0	14	1,994	144	15	317	0
Other Govt. Pgm	734,760	84	731,453	171	2,744	186	121	0	0
Employer Sponsored Ins.	4,609,264	5,497	381	50,793	4,480,365	68,591	1,117	2,519	0
Individual Market	444,422	16,530	0	8	1,719	294,612	131,403	149	0
Uninsured	1,258,153	466,755	0	163	18,435	299,539	61	473,200	0
Undocumented Uninsured	215,014	0	0	0	0	0	0	0	215,014
Total	8,679,795	1,904,564	731,835	51,149	4,505,258	663,073	132,718	476,185	215,014

Three quarters of the people who purchase coverage directly through the HBE will be eligible for the premium tax credit and cost sharing subsidies. Of all the individual market enrollees in the HBE, Milliman estimated that 3% of enrollees will have incomes of less than 138% FPL, 5% will have incomes between 138-149% FPL, 21% will have incomes between 150-199% FPL; 30 will have incomes between 200-299% FPL; and 16% will have incomes between 300-400% FPL.{{3673 Milliman, Inc.}} Only 25% will have incomes above 400% FPL.

[11] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1421, 1501, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §10105(e), creating Sec. 45R of the Internal Revenue Code of 1986.

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The number of people expected to obtain coverage through the HBE is expected to grow from , roughly 715,000 people in 2014 to more than 900,000 people by 2016. Over time, more people are likely to obtain health insurance coverage as they learn about their different insurance options and as the amount of the potential penalty for failing to have coverage increases.

HBE REQUIREMENTS

The ACA requires HBEs to perform certain functions to facilitate selection and enrollment into a health plan. For example, HBEs must:

- Certify, recertify, and decertify qualified health plans, Co-op plans, and federally approved multi-state plans as specified by the Secretary.[12] [13]
- Operate a toll-free telephone hotline to respond to requests for assistance and to provide eligibility and enrollment in person, via phone or fax, or electronically. .[14] [15]
- Develop and maintain a website that provides standardized comparative information on plan options including costs, quality, and provider networks.[16] [17]
- Assign a quality rating to each qualified health plan offered through the HBE using criteria developed by the Secretary.[18] [19]
- Determine eligibility for the premium tax credit and cost-sharing subsidies.[20] [21]
- Conduct outreach and education to inform people about eligibility requirements for Medicaid and NC Health Choice and, if eligible, enroll them directly into these programs.[22] [23]
- Establish and make available an electronic calculator for determining the costs of coverage after applicable premium tax credits and cost-sharing reductions.[24] [25]
- Certify individuals who are exempt from the requirement to purchase health insurance.[26] [27]

[12] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1301, 1311, 1321, 1322, 1334, 10104.
[13] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.1010, 155.1075, 155.1080.
[14] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).
[15] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §205.
[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).
[17] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §205.
[18] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(D).
[19] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.200.
[20] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1401(f)(3), 1411, 1412, 10105, as amended in the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1001, 1004.
[21] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.200, 155.155.400-.420.
[22] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(F), 1411, 1413.
[23] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.205.
[24] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(G).
[25] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.205.
[26] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(H).

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- Provide information to the Secretary of the USDHHS about anyone who is eligible for the premium tax credit or cost-sharing reductions and the level of coverage.[28]
- Provide the Secretary of the Treasury information about anyone who is exempt from the individual mandate, anyone who is receiving a subsidy who works for an employer required to offer insurance, and information about individuals who change employers and who cease coverage under a qualified health plan.[29]
- Provide information to employers of any employee who ceases coverage under a qualified health plan.[30]
- Establish a navigator program to provide information to the public about health plan choices and to help them enroll.[31] [32]
- Consult with relevant stakeholders to carry out required activities.[33] [34]
- Publish average costs of licensing, regulatory fees, and other payments to the HBE and administrative costs.[35] [36]
- Report on activities, receipts, and expenditures annually to the Secretary of the USDHHS.[37]
- Consider information from employers that contest the imposition of penalties.[38]

States can create one HBE that covers both individuals (nongroup) and small businesses, or can create two Exchanges. In general, the requirements for the HBE covering individuals and families (nongroup) and the Small Business Health Options Program (SHOP) exchange covering small businesses are the same. However, the proposed federal regulations included some requirements that are exclusive to the SHOP. For example, under the proposed regulations the SHOP must allow qualified employers to select a level of coverage (eg, bronze, silver, gold, platinum) so that their qualified employees could choose any plan within a specific tier.[39] The SHOP can offer other employee choice options to employers (e.g., single option, defined set of options within or across metal levels, or full choice). The SHOP must also provide an option for premium aggregation services for small businesses that choose to offer their employees a choice

[27] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.205, 155.705.
[28] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1401(f)(3), as amended in the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1004(c).
[29] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(I).
[30] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(J).
[31] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(K), 1311(i).
[32] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.210-220.
[33] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(6).
[34] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §155.130.
[35] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(7).
[36] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.205.
[37] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1313.
[38] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§10108(d)(2), 1411(f)(2).
[39] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §155.705(b)(2)(3).

of plans.[40] This reduces the administrative burden on small businesses, as they will only need to remit one combined premium check to the SHOP instead of multiple premium checks to different insurers. The SHOP Exchange will then aggregate the premiums from the different employers and submit premiums to the appropriate insurers.

The federal government will pay for expenses associated with the establishment and operations of a state-based exchange until 2015 (with the exception of Navigator grants, discussed more fully below). However, the HBE must be financially self-sufficient beginning January 1, 2015.[41] [42] The ACA envisions that the HBE would charge assessments, or impose user fees to participating health insurance issuers, or the state must otherwise be able to generate sufficient funds to cover operating costs.[43]

States that choose to operate their own HBE in 2014 must have an approved plan and be able to demonstrate operational readiness by January 1, 2013.[44] The Center for Consumer Information and Insurance Oversight (CCIIO), within the Centers for Medicare and Medicaid Services of the US Department of Health and Human Services, provided states guidance as to what will be required to show operational readiness.{{3674 Centers for Medicare & Medicaid Services}} To be certified, HBEs must show their ability to perform the following core functions:

- *Consumer Assistance*, including education and outreach, navigator management, call center operations, website management, consumer support assistors, and written correspondence with consumers to support eligibility and enrollment.
- *Plan Management*, including plan selection approach, collection and analysis of plan rate and benefit package information, issuer monitoring and oversight, ongoing issuer account management, issuer outreach and training, and data collection and analysis for quality.
- *Eligibility*, including the ability to accept applications, conduct verifications of applicant information, determine eligibility for enrollment into a qualified health plan and insurance affordability programs, connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP, and conduct redeterminations and appeals.
- *Enrollment*, including enrolling consumers into qualified health plans, transactions with QHPs and transmission of information necessary to initiate advance payment of the premium tax credits and cost-sharing reductions.
- *Financial management*, including user fees or assessments, or other arrangements to assure financial solvency, financial integrity, support of risk adjustment, reinsurance and risk corridor programs.

STATE DESIGN ISSUES

[40] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.240(c); 155.705(b)(4).
[41] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(a),(d)(5).
[42] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §155.160.
[43] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(5).
[44]US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §155.105.

The state has many options in implementing the HBE provisions of the ACA. **First and foremost, the state must decide whether it wants to create its own HBE or leave it to the federal government to implement.** The effective and efficient operation of the HBE will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the HBE. The HBE workgroup and Overall Advisory Committee believe that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government. In its interim report, the HBE workgroup and the Overall Advisory Committee recommended that the North Carolina General Assembly (NCGA) create a state based Health Benefits Exchange. The workgroup also recommended that the legislature create a separate quasi-state agency (public corporation), rather than to house the HBE within an existing state agency.{{3675 North Carolina Institute of Medicine Health Reform Workgroups}}

Last session, the North Carolina House of Representatives passed legislation, HB 115, which would have created a state-based HBE. This bill did not pass the Senate in the 2011 Session, but is still eligible for consideration in the 2012 Session. Although the legislature did not pass legislation creating a HBE, it did pass legislation stating its intent to create a HBE within the state, and directing the North Carolina Department of Insurance (NCDOI) and the North Carolina Department of Health and Human Services (NCDHHS) to continue to develop a state-based exchange. The statute, Sec. 49 of Session Law 2011-391, directing NCDOI and NCDHHS to continue its work reads as follows:

> **"DEPARTMENT OF INSURANCE AND AFFORDABLE CARE ACT**
> "**SECTION 23.3.** It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, collectively referred to as the Affordable Care Act (ACA). The Department of Insurance (DOI) and the Department of Health and Human Services (DHHS) may collaborate and plan in furtherance of the requirements of the ACA. DOI may contract with experts, using available funds or grants, necessary to facilitate preparation for an Information Technology system capable of performing requirements of the ACA.
>
> The Commissioner of Insurance may also study the insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations. If the Commissioner of Insurance conducts such a study, the Commissioner shall submit a report to the 2012 Regular Session of the 2011 General Assembly containing recommendations resulting from the study."

Based on this legislation, NCDOI submitted a Level I implementation grant to the federal government. North Carolina was successful in obtaining a $12.4 million dollar grant. Level I grants provide funding for one year to begin the process of creating a state-based HBE. North Carolina's Level I grant period runs from August 15, 2011 through August 14, 2012.

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The state can submit a proposal for a Level II implementation grant to pay for further development, as well as start up and initial operational costs (through 2014). In order to apply for a Level II grant, the state must have authorized the creation of the HBE with an appropriate governance structure. In addition, the HBE must submit a budget through 2014, and an operational plan that includes—at a minimum—plans to provide consumer assistance, prevent fraud and abuse, and to ensure financial sustainability beginning in 2015.{{3677 Center for consumer Information and Insurance Oversight}} Recent pronouncements from CMS have extended the deadlines for Level II grant applications. This said, the HBE workgroup recommends that to be operational by 2014, North Carolina General Assembly should create the HBE and pursue ~~Level II~~additional funding this summer.

If North Carolina is going to operate a state-based HBE in 2014, it must show operational readiness by mid 2013. The Level I implementation grant will be used to develop plans to build some of the key components needed to show operational readiness in 2013, including developing requirements for the necessary information technology (IT) systems, and strengthening the existing consumer assistance program. Specifically, the North Carolina Level I implementation grant will be used to:

- Engage stakeholders and perform policy analysis on policy issues
- Expand NCDHHS eligibility IT system to include needed HBE functionality and expanded user base
- Develop requirements to build non-eligibility IT systems
- Propose legislation and develop regulations for needed market reforms
- Prepare consumer assistance program
- Develop required elements for a Level II application
- Support start-up of the NCHBE, assuming that the NCGA creates a new legal entity during the Level I implementation period

NCDOI contracted with the NCIOM to continue the work of the HBE workgroup and solicit stakeholder input into some of the HBE policy and design issues. NCDOI has created a separate Market Reform Technical Advisory Group (TAG) to consider the market reform issues—particularly those that will impact on insurance coverage or ratings inside and outside the HBE. The two groups have been charged with examining different implementation and design issues. (Table X.3) In general, the HBE workgroup is considering those issues unique to the HBE, and the NCDOI TAG is considering those issues which affect health plans both inside and outside the HBE. The work of the NCDOI TAG will be presented to the North Carolina General Assembly in a series of separate reports.

Table X.3
Design Issues Considered by NCIOM HBE Workgroup and NCDOI Technical Advisory Group

NCIOM HBE Workgroup Issues	NCDOI TAG Issues
• Whether to operate a state-based HBE or create a partnership HBE • High level QHP certification options	• Whether to merge the individual and small group market within the HBE • Whether to allow groups of more than 50 to

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• HBE sustainability options • Preliminary evaluation planning necessary for a Level II implementation grant • The roles, training, and certification requirements for agents, brokers, navigators, volunteer counselors and other community based organizations • Operationalizing the QHP requirement to contract with essential community providers	purchase QHPs in the HBE in 2014 • Whether to change the North Carolina laws regarding self-funding and stop-loss coverage for small group plans • Whether to modify North Carolina small group insurance laws to comply with federal definitions for small group (eg, whether to include groups of one, definition of employee) • The role of the state, if any, in administering the risk adjustment program, and a preliminary plan for program development if applicable • Identifying potential reinsurance entities • Mechanisms for assuring a level playing field inside and outside the HBE (ie, to mitigate adverse selection) • Geographic rating areas • Network adequacy standards • Selection of an essential health benefits benchmark for North Carolina

HBE WORKGROUP RECOMMENDATIONS

The HBE workgroup has met seven times since the beginning of August, 2011 and will continue to meet through the spring. In addition, a subcommittee met on four occasions to examine options for eligibility and enrollment navigators. The following includes the *preliminary recommendations* from the HBE workgroup. Unlike the other chapters in this report, the recommendations contained herein are still preliminary. The NCIOM will issue a final report after the completion of the HBE workgroup's deliberations. This information will be presented to the NC General Assembly, as well as the HBE Board (if created).

State-Based or Partnership HBE

As noted earlier, the ACA gives states the authority to create its own HBE or leave it to the federal government to operate an HBE on the state's behalf. However, in subsequent regulations and policy guidance, the US Department of Health and Human Services (USDHHS) set forth a proposed hybrid approach—called a "partnership" HBE option.{{3676 Center for Consumer Information and Insurance Oversight}}{{3674 Centers for Medicare & Medicaid Services}} With the partnership option, USDHHS gave states more flexibility to select those functions that it wants to provide directly and those which it wants the federal government to assume. Table X.4 gives a brief overview of the different HBE operational options: state operated, federally facilitated, or partnership. More detailed information is provided below.

Table X.4

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Overview of Different HBE Operational Arrangements

	State Operated HBE	Federally Facilitated HBE	State-Federal Partnership
Consumer Assistance	State	Federal, with some harmonization to state laws	State option on some functions
Plan Management	State	Federal, with some state interaction	State Option
Eligibility	State, with option for federal support	Federal, with state option for final Medicaid/CHIP determination	Federal, with state option for final Medicaid/CHIP determination
Enrollment	State	Federal	Federal
Financial Management	State, with option for federal risk adjustment	Federal, with option for state reinsurance	Federal, with option for state reinsurance
Sustainability	State option	Federal user fees	Federal user fees

The HBE workgroup examined the partnership option, as currently understood, to determine if there were any functions that could best be handled by the federal government**. In general, as outlined below, the workgroup confirmed its earlier recommendation that North Carolina create and operate its own HBE. However, there were a few functions which work group members thought would better be handled by the federal government**.

Consumer assistance. The workgroup recommended that the state provide consumer assistance directly to enrollees. A state-based exchange would be better equipped to provide outreach and education to North Carolinians, as a state organization would already have knowledge of the state, the insurance industry, key consumer and small business groups, and other consumer support and eligibility sources such as those provided by the North Carolina Department of Health and Human Services (NCDHHS) and local social services agencies.. In addition, NCDOI already operates a successful consumer assistance program—Health Insurance Smart NC — which helps consumers with insurance related questions or complaints. Not only does Smart NC provide key services to North Carolinians, but the information it collects as part of the complaint process is essential for NCDOI's regulatory responsibilities. The workgroup also recommended that the HBE contract to operate the call-center in state, as North Carolinians have a better understanding of the state's health insurance marketplace and health care infrastructure. In addition, workgroup members recommended operating a state-based call center so that the state would benefit from the new jobs created. Some of the HBE workgroup members thought the federal government might be in the better position to create the "shop and compare" interface for the HBE website, but they also recognized that the federal government would need to get a lot of the underlying data from the NC Department of Insurance. Thus, there was more of a consensus that the state-based HBE take responsibility for creating the shop and compare website.

Plan management. The workgroup recommended that the responsibility for certifying and decertifying qualified health plans be done at the state-level. NCDOI traditionally monitors the operations of insurers, including plan licensure and solvency. Many of the HBE plan management functions will be similar to traditional regulatory oversight functions, and are integral to the oversight of health plans offered through the HBE. Further, the NCDOI will

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continue to regulate insurers outside the HBE. Thus the state should also regulate and oversee plans operating within the HBE. To minimize the possibility of conflicting rules operating inside and outside the HBE; the workgroup recommended that a state-based HBE, along with NCDOI, assume responsibility for plan management. In addition, the workgroup recommended that the HBE rely on the NCDOI for several of the HBE functions, including but not limited to policy form and rate approval, evaluation of plans against the QHP certification standards (e.g., accreditation, quality, etc.), for analysis of data submitted to identify discriminatory benefit design, and for market regulation, as NCDOI regularly performs these functions as part of it regulatory oversight of plans. This will help streamline the certification process, and reduce duplicative regulatory oversight of insurers.

The HBE imposes new responsibilities that may not be fully addressed as part of the current NCDOI regulations. For example, the HBE must establish network adequacy standards to ensure that the QHP offers a sufficient choice of providers.[45] If the state does not create its own network adequacy standards, the federal government will create standards for plans operating in the HBE.{{3674 Centers for Medicare & Medicaid Services}} The NCDOI does not have specific network adequacy rules, rather it requires health plans with networks to develop their own standards and measures the plans against those standards.[46] It is unclear whether this will be sufficient to meet the federal requirements that HBEs have network adequacy standards. If needed, the workgroup recommended that the state create its own specific network adequacy standards, as it has a better understanding of the availability of health care professionals and providers across the state, as well as consumer access issues reported through NCDOI. Absent adoption of statewide standards, the HBE Board should have the authority to adopt standards for qualified health plans offered in the HBE. In addition, the workgroup also recommended that a state-based HBE assign quality ratings to the different plans, within the criteria established by the USDHHS. A state-based HBE should assume this responsibility to ensure that North Carolina can monitor the overall quality of the plans. One of the other advantages of having the state HBE assign quality ratings is that North Carolina would then have access to the underlying quality data. This would help ensure that the state has access to data that could drive state-level quality improvement activities, if it so chooses.

Eligibility for subsidy determinations. Workgroup members recommended that a state-based HBE take applications and help consumers with the verification process if questions arise. Workgroup members believed that this function could be handled better through a state-based HBE that could more easily establish working relationships with community based organizations serving as navigators, departments of social services, and local agents and brokers. Further, North Carolina should maintain its role in making final Medicaid/CHIP determinations, as the state is responsible for a share of the Medicaid and CHIP costs. While the workgroup members believed that the state should have primary responsibility for taking and processing the applications and making the final Medicaid/CHIP eligibility determinations, workgroup members did recommend that the federal government take the lead in determining eligibility for the premium tax credit and cost sharing subsidies. Eligibility for the premium tax credit and cost sharing subsidies is based on the IRS rules for modified adjusted gross income (MAGI). The IRS

[45] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §§155.1050, 156.230.
[46] 11 NCAC §§20.0301-.0302.

has responsibility for reconciling the amount of the premium tax credit that the individual received through the HBE with the amount they are ultimately eligible to receive based on year-end taxes. As the IRS will be responsible for this reconciliation function, work group members thought it made more sense for the federal government to also make the initial eligibility decision about the premium tax credit and cost sharing subsidy. Similarly, the workgroup members recommended that the federal government determine whether a person is exempt from the mandate, as for many people, the person's MAGI will be critical to this determination. (The federal government has provided preliminary indications that it will provide this service as an option for state-operated Exchanges.{{3674 Centers for Medicare & Medicaid Services}})

In addition, the workgroup also recommended that the federal government assume responsibility for determining whether an employer is offering minimum essential coverage. In order to make this determination, the HBE will need to obtain a copy of the employer's health plan offering to determine if the coverage meets the 60% actuarial value standard and whether the coverage is affordable to all of the full-time employees. CMS is exploring whether they can assume this responsibility for states that choose to operate their own HBE.{{3674 Centers for Medicare & Medicaid Services}} The workgroup members believed it made more sense to let the federal government make this determination for North Carolina businesses, if this option is offered to states. This will be difficult for a state-based HBE to determine, as it has no mechanism to collect health plan information from employers (particularly for self-funded employers). The federal government will need to collect this data in other states (for federally-facilitated HBEs).

Enrollment: In general, the workgroup members recommended that the state-based HBE maintain responsibility for enrolling and disenrolling people into qualified health plans. Workgroup members believed that a state-based HBE could provide better customer service helping people enroll and disenroll. Further, the HBE and NCDOI need data on enrollment and disenrollment as part of regulatory oversight. NCDOI needs to monitor plan growth to assure adequate reserves. Conversely, if too many people are disenrolling from a plan, it may be an indication of underlying quality or service problems necessitating HBE or NCDOI review.

Financial management: Again, the workgroup members supported having the state-based HBE have primary responsibility for financial management of the HBE, specifically setting and collecting any assessments. Preliminary information from CCIIO suggests that the federal government will finance the operational costs of federally-operated HBE through assessments on insurers. The workgroup was particularly concerned that if the federal government operates the HBE, that North Carolinians not be assessed for costs that are incurred in other states. If the state operates the HBE, it has greater control over the costs of the HBE and how the HBE is financed. The operation of risk adjustment and reinsurance programs is also part of the financial management function. Due to their technical nature and impact both inside and outside the Exchange, these programs are being discussed with NCDOI's Market Reform TAG.

Based on the HBE workgroup's analysis, the workgroup recommended:

Recommendation HBE 1: State and Federal HBE Operational Responsibilities

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a) **The North Carolina General Assembly should create a state-based Health Benefits Exchange. The state-based HBE should be responsible for most of the operational aspects of the HBE, including consumer assistance, plan management, eligibility, enrollment, and financial management. However, after the HBE Board is created, the Board should consider whether the state, or the federal government, is in the best position to:**
    i. **Determine eligibility for advance payment of the premium tax credit and cost-sharing subsidies**
    ii. **Determine whether individuals are exempt from the coverage mandate**
    iii. **Determine whether employers are offering coverage that meets minimum essential coverage.**
    iv. **Develop and operate the shop and compare consumer website.**

In making this determination, the HBE Board should consider the costs of providing these functions through a state-based versus federally facilitated HBE, which entity would be able to most effectively provide these services, and the impact of the decision on consumer access, consumer protections, and the rest of the North Carolina insurance marketplace.

QHP Certification Requirements

The workgroup also explored the issue of whether the HBE should have any discretion to modify QHP participation requirements if necessary to enhance HBE operations. Specifically, the workgroup explored the question of whether the HBE Board should have the authority to: limit the number or type of plan designs, require insurers participating in the HBE to offer all four tiers of health plans, require insurers to meet certain quality standards beyond what is already required in the ACA, or require insurers to meet additional requirements intended to foster innovation. The workgroup also discussed whether the HBE should have the flexibility to give health plans more time to meet the ACA's accreditation standards, and whether the NCGA, NCDOI or the HBE should establish network adequacy standards.

With some caveats, the workgroup members reached consensus about giving the HBE Board the authority to either impose new requirements or to incentivize health plans to meet additional standards if needed to improve plan competition, the functioning of the HBE, meet the needs of consumers, reduce adverse selection into the HBE or among different insurers, or promote health plan innovation that could reduce costs or improve quality. However, HBE workgroup members only felt comfortable giving the HBE Board the authority to impose additional requirements if the Board was broadly constituted and included representation from consumers, employers, insurers, agents, providers, and other knowledgeable individuals. Further, the workgroup members recommended that the Board should not impose any additional requirements other than those already required under the ACA until 2016 at the earliest. Insurers will already have a challenge meeting all of the ACA's requirements by 2014, so the workgroup did not want to impose new requirements for 2014 that could discourage broad insurer participation in the HBE. Thereafter, before imposing new requirements on health plans, the HBE Board should consider the likely impact of those requirements on administrative costs and premiums, consumer choice (including the ability of consumers to understand and compare different health plans), consumer protections, access to essential community providers, quality, coverage of the uninsured and enrollment into the HBE, participation of health plans in the HBE, appropriate competition

among plans, adverse selection into the HBE and/or among participating plans in the HBE, the overall functioning of the HBE, and the impact of any changes on the non-HBE health insurance market.

A more detailed description of the workgroup's recommendations is provided below.

Limiting the number or types of plan design. One of the advantages of the Health Benefit Exchange is providing consumers and small businesses with a choice of health plans—both in terms of premium levels, out of pocket costs, and plan design. To facilitate meaningful choice, the HBE website should have a good preference testing or sorting mechanism to help consumers first decide what decision elements are most important to them, and then to compare health plans. For example, the HBE website should include, but not be limited to, sorting mechanisms based on premiums, deductibles and other point-of-service cost sharing levels, participating providers, open or closed networks, and quality ratings. Even with a good sorting mechanism, workgroup members recognized that unlimited choice may make the plan choice process difficult for consumers. Limiting the number of choices and/or standardizing some of the plan designs can make it easier for consumers to make meaningful comparisons among health plans. Further, limiting the number of plan choices or variations could help spur competition in costs (rather than small variations in plan design) and would also help reduce administrative costs to the HBE. However, if the HBE imposed strict limits on the number or types of plan design, it could reduce consumer choice, create barriers to the introduction of innovative insurance models, and limit the number of carriers participating in the HBE.

Thus, workgroup members recommended that the HBE Board have the authority, beginning in 2016, to limit the number of choices or plan designs if needed to assure meaningful choice and the proper functioning of the HBE or based on consumer or employer feedback. The HBE Board needs to balance any potential limits on the number or variety of health plans with: the need for a reasonable level of choice; ability to introduce innovative insurance plans; and the need to increase meaningful competition based on value, quality, and/or cost among health plans. While the workgroup recognized that the HBE Board may choose to limit the number or types of different health plans offered by any insurers, the group did not recommend that the HBE exclude any insurer from participating in the HBE if it otherwise met the certification requirements.

Require insurers participating in the HBE to offer three or four of the metal plans. The ACA requires all issuers participating in the HBE to offer the silver level plan (70% actuarial value), and the gold level plan (80% actuarial value). In addition, issuers can—but are not required to under the ACA— offer bronze level plans (60% actuarial value), or platinum level plans (90% actuarial value). Workgroup members discussed whether the HBE Board should have the authority to require issuers to offer the bronze and/or the platinum level plans in addition to silver and gold to help maximize consumer and employer choice and mitigate risk segmentation across insurers. Requiring issuers to offer three or four of the precious metal plans could limit participation among insurers (particularly small insurers who may have a harder time developing bronze or platinum level plans). Further, there are very few platinum level plans available in the commercial market; some workgroup members questioned the rationale of forcing insurers to offer plans that are no longer attractive in the commercial market. Richer benefit packages (eg,

platinum level plans) tend to attract people with more significant health problems. The ACA prohibits insurers from pricing plans based on the health status of the enrollees or an individual's utilization of health services.[47] Thus, the higher costs of people enrolled in the platinum level plans would be passed along in higher premiums for those who enroll in bronze, silver, or gold plans. Members also raised the concern that requiring health plans to offer all four levels could force insurers to offer uncompetitive plans to meet HBE participation requirements, but which would attract few enrollees. While there were significant concerns raised about requiring health plans to offer all four of the metal level plans, the workgroup members did reach consensus that **the HBE Board should have the authority to require health plans to offer 3 or 4 of the metal levels if needed to reduce risk segmentation across insurers or if needed to provide consumers and employers greater choice (based on consumer and employer feedback). As noted earlier, this should not be a requirement for health plan participation in 2014; the earliest that the Board should be able to require this is 2016.**

Require insurers participating in the HBE to meet quality standards in addition to those required by the ACA or Secretary of the US DHHS. The ACA requires that all plans be accredited, implement a quality improvement strategy, report certain quality measures, and limit contracts to providers that meet specified quality standards.[48] HBEs must assign a quality rating to each plan on the basis of relative quality and price.[49] The Secretary of USDHHS will establish standards for the quality rating system, and will also collect enrollee satisfaction information on all health plans.[50] In addition, the ACA directs the Secretary to develop strategies to further reward quality of care through market based incentives.[51]

The HBE workgroup discussed whether the HBE should have the authority to impose any new quality standards in addition to those standards specified in the statute. Workgroup members recognized that North Carolina may have specific health problems that are not addressed as part of national quality standards. In addition, some members wanted the HBE to have the authority to remove poor quality plans from the plan offerings, as low-quality, lower-cost plans could reduce the value of the advanceable premium subsidies. ~~If~~ These workgroup members were concerned that if the lowest quality plans are also the lowest cost plans, and subsidies are set at the second lowest cost silver plan, many North Carolinians could be forced into ~~poor~~ lower quality plans because they may not be able to afford a more costly plan. While some members of the group believed that the HBE should have flexibility to require that insurers meet additional quality standards, the group could not reach consensus[52] on this point. Some members of the group argued that the federal standards will greatly enhance current quality standards and imposing additional requirements would increase costs to the plans. Instead, **the group agreed that, beginning in 2016, the HBE should have the authority to incentivize, rather than mandate, insurers to meet higher standards (for example, by giving those plans that meet the higher standard special recognition on the HBE shop and compare website).**

[47] Need to check to see if utilization can be considered in the premium, if due to difference in plan design and not health risk? Need to double check accuracy of this statement.
[48] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c),(h).
[49] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4).
[50] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c).
[51] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(g).
[52] For purposes of the HBE workgroup discussion and decision making, we limited "consensus" decisions to those that were supported by at least two-thirds of the members.

Require insurers participating in the HBE to meet other requirements, such as customer service, improved health outcomes, or reduced costs, in addition to those required by the ACA or Secretary of the US DHHS. For the reasons stated above, **the workgroup believed that, beginning in 2016, the HBE should have the authority to incentivize health plans to meet higher standards, but not mandate any additional requirements in addition to those required under the ACA and supporting regulations.**

Phasing in accreditation standards. The proposed federal regulations give HBEs the authority to establish the length of time in which an insurer must receive outside accreditation following initial certification in the HBE.[53] **The workgroup recommended that insurers be given two years to obtain accreditation if the insurer can show they are making reasonable progress towards that goal.** Members were concerned that in the early years, the accreditation bodies may be overloaded with health plans seeking accreditation; and that this could slow down the normal accreditation process (typically 12-18 months). Therefore, **the workgroup also recommended that the HBE Board, in exceptional circumstances, have the flexibility to provide plans with additional time beyond two years to obtain initial accreditation.**

Network adequacy standards. The proposed federal regulations require that HBEs establish network adequacy standards to ensure that enrollees have a sufficient choice of providers. The Secretary proposed that these standards be established at the state level, rather than at the federal level, because states have a better understanding of the geography, local patterns of care, array and distribution of health care professionals and providers, and market conditions.[54] Qualified health plans must meet the state established network adequacy standards.[55] If the state does not have or create a network adequacy standard that meets federal requirements, the federal government will do so. As noted earlier, North Carolina's existing procedures may not be sufficient to meet the federal network adequacy standard. The workgroup discussed whether the HBE should establish standards for plans offered in the HBE, or whether the NCDOI should establish standards for all commercial insurers. **The workgroup recommended that NCDOI establish objective minimum network adequacy standards that satisfy the requirements of the ACA, and that these standards should be the same for plans operating inside and outside the HBE. The workgroup also recommended that NCDOI include some flexibility in the network adequacy standards, if needed to test innovative or quality driven delivery models.**

After examining the different options, and assuming that the HBE Board is broadly constituted with diverse membership, the HBE workgroup recommended:

[53] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR §155.1045.
[54] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR 155.1050.
[55] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR 156.230.

Recommendation HBE 2: HBE Board Authority for HBE Certification

a) **The North Carolina General Assembly should give the Health Benefits Exchange (HBE) Board the authority to:**
   i. **Require insurers offering qualified health plans in the HBE to limit the number of plan offerings or types of plan designs if needed to facilitate health plan selection or promote meaningful competition among insurers, but only after the HBE determines that there is a reasonable level of choice and meaningful competition in the HBE market.**
   ii. **Require that the insurers offer the bronze and/or the platinum level plan, in addition to the silver and gold level plans, if needed to reduce risk segmentation across insurers, and or to give consumers and employers greater choice.**
   iii. **Incentivize insurers to meet state set quality standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services (USDHHS).**
   iv. **Incentivize insurers to meet other state standards, such as customer service, participation in health information technology, improved health outcomes, or reduced costs in addition to those required by the ACA or Secretary of the USDHHS.**

b) **In no event should the HBE Board impose any new requirements earlier than 2016. Thereafter, before imposing new requirements on health plans, the HBE Board should consider the likely impact of those requirements on the overall functioning of the HBE, the needs of consumers and/or employers purchasing in the HBE, administrative costs and premiums, consumer choice (including the ability of consumers to compare different health plans), consumer protections, access to essential community providers, quality, coverage of the uninsured and enrollment into the HBE, participation of health plans in the HBE, adverse selection into the HBE and/or among participating plans in the HBE, and, in consultation with the North Carolina Department of Insurance, the impact of any changes on the health insurance market operating outside the HBE.**

c) **The HBE Board should give all QHP applicants that are not already accredited two years to meet the accreditation standards assuming that the insurer can show that it is making reasonable progress in obtaining accreditation. The HBE Board can choose to extend this time for extenuating circumstances, for example, if the accreditation agencies are unable to make timely accreditation decisions.**

HBE Recommendation 3: NCDOI Objective Network Adequacy Standards
The North Carolina Department of Insurance should develop objective network adequacy standards as may be required by the ACA that apply to all health insurers operating inside and outside the HBE. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.

In addition to the network adequacy standards, the ACA require health plans to contract with essential community provider (ECP) in order to be certified.[56] ECPs include, but are not limited to, federally qualified health centers, rural health clinics, health departments, and certain

[56] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031.

hospitals. However, the ACA includes contradictory language. The ACA requires QHPs to contract with essential community providers, but states that QHPs need not contract with ECPs if such provider refuses to accept the generally applicable payment rates.[57] However, in another part of the statute, it states that QHPs must pay FQHCs "not less than the amount of payment that would have been paid to the center [under Medicaid's prospective payment system rate] for such item or service."[58]

The proposed federal regulations noted this contradictory language.[59] Under the proposed regulations, QHPS must contract with sufficient numbers of ECPs that serve low-income, medically underserved people. USDHHS noted that while QHPs must contract with ECPs, they need not contract with all ECPs. In addition, Indian health providers are also eligible for special reimbursement arrangements. USDHHS asked for comments on how to address these provisions in their notice of proposed rulemaking. The HBE workgroup will be examining this issue at a future workgroup meeting, and result of the group's discussion will be included in the final report.

HBE Sustainability Options

Federal funding necessary to create and operate the HBE is only available through 2014. Thereafter, the HBE must be fully self-sufficient at the state-level. The ACA identified certain methods of ensuring financial sustainability, including assessments or user fees on participating insurers, but does not limit states if they want to identify other financing mechanisms.[60] The proposed federal regulations parallel the statutory requirements by noting that states may fund Exchange operations by charging assessments or user fees on participating insurers, or otherwise generate funding for Exchange operations.[61] HHS guidance suggests that HHS will charge insurers users fees if the federal government establishes the HBE in a state.{{3676 Center for Consumer Information and Insurance Oversight}}

Milliman Inc. prepared a preliminary estimate of the HBE's ongoing operational costs beginning in 2014. Milliman estimated that the North Carolina HBE would cost approximately $23.8 million in 2014, $25 million in 2015, and $26.7 million in 2016. {{3672 Milliman, Inc.}} The Milliman estimates were among the first estimates developed across the country; and did not reflect the experiences of some of the early adopter states. In addition, Milliman's estimates do not include the initial start-up costs. The estimates were based on the HBE providing bare minimum services, including functions related to HBE operations (such as plan administration, call center, eligibility processing, enrollment reporting, and plan performance and quality reporting), marketing (including exchange marketing, navigator program, outreach and education, and public relations), information systems, and finance (including actuarial analysis, accounting/financial reporting, and infrastructure).

[57] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(2), 42 USC 13031
[58] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(g), 10104(b)(2), 42 USC 18022.
[59] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR 156.235.
[60] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(5).
[61] US Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(136):41866-41927. To be codified at 45 CFR 155.160.

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Milliman noted, however, that this estimate could be changed depending on the HBE's design and operational features. Because Milliman prepared its estimate before the preliminary regulations were issued, it did not include all of the HBE operational requirements specified in the federal regulations. For example, the Milliman estimate does not include the costs of premium aggregation for small businesses (a HBE requirement specified in the proposed federal regulations). Further, the HBE workgroup was concerned that some of the estimates may be too low—including the estimates of the volume of calls which the call center would field in the initial years.

NCDOI asked one of its consultants, Public Consulting Group (PCG), to examine Milliman's initial assumptions underlying their estimates in light of the new guidance the state received from the federal government. In addition, PCG was asked to examine other state's HBE cost estimates. Table XX reflects the information provided to the HBE workgroup from PCG Health.

Table XX: Comparison of North Carolina estimated HBE costs with other states

	NC	IL	MA	DE	WY	MD	AL
Estimated Administrative Costs	$25.2 M	$56.2M	$27.5M	$7.8M	$4.2M	$41.8M	$44.5M
Average Estimated Enrollment*	807,212	589,000	190,000	66,433	30,500	312,244	330,000
Per Member Per Month Cost	$2.60	$7.95	$12.04	$9.74	$11.46	$11.16	$11.24

*The estimated enrollment was not reported consistently across states. Some states provided estimated enrollment for one year, others for multiple years. Thus, PCG produced an average estimated enrollment for each state. In North Carolina, for example, enrollment was averaged over three years (2014-2016).

PCG cautioned that it was difficult to compare the HBE cost estimates across states, as the states did not include all the same expenses in their estimates. For example, some of the states included the IT costs, whereas others did not. Nonetheless, North Carolina's HBE operational expenses appear to be disproportionately lower than other states, after adjusting for expected enrollment. The average of the other states that were reviewed was approximately $10 per member per month, whereas the Milliman cost was only $2.60 per member per month. NCDOI will be working with PCG to develop a more detailed cost estimate as part of its Level I grant.

In order to obtain a Level II grant, the state must have a detailed budget and plans to assure financial self-sufficiency in 2015. Thus, the workgroup examined options for different ways to raise the necessary revenues to support the HBE operations. **The group recommended that any new premium tax revenues generated as a result of the implementation of the Affordable Care Act be put into a trust fund and designated for the HBE operations. This would include premium tax dollars raised as a result of the new people gaining coverage as well as the increase in costs of health insurance premiums due to ACA implementation.**

Currently, all insurers pay a 1.9% premium tax. Milliman estimated that approximately 360,000 uninsured people would gain health insurance coverage inside and outside the HBE in 2014. Milliman also estimated that the average health insurance premiums, across all markets, would

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increase by roughly 17% from 2013 to 2014 as a result of normal increases in premium costs as well as expected changes in premium costs as a result of the new ACA requirements (including new benefit coverage, and guaranteed issue). Approximately XX% of the 17% increase would be due to annual expected premium cost increases, but the other YY% would be due to changes in the benefit design or other factors directly related to the implementation of the ACA. The workgroup recommended that the increase in the premium tax due to the regular trend factor on non-ACA related health insurance premiums (~~e~~g.i.e., the expected increase in health insurance premiums ~~unrelated to the implementation~~that would have occurred in the absence of the ACA) would go into the state's General Funds. However, the percentage increase due to implementation of the ACA should be set aside into the HBE Trust Fund. Based on the average premium of $5,800 in 2013, and the assumptions above, the increase in premium tax revenues would be approximately $XX million. However, this estimate is contingent on the number of new people who obtain coverage and the increase in premium costs. For example, if only 200,000 new individuals enter the market, the increase in premium tax revenue would be $XX million, and if the average premium increase due to implementation of the ACA was only X%, then the premium tax increase would only be $XX million (assuming only 200,000 people gained coverage).

Capturing the increase in premium tax revenues from 2013 as a result of the new ACA coverage requirements is similar to the process that the North Carolina General Assembly established when it created Inclusive Health, North Carolina's high risk pool. The NCGA created a special trust fund and deposited an amount equal to the growth in net revenue from the increase in all premium taxes collected between SFYs 2007 and 2008.[62] For the first two years, the North Carolina Health Insurance Risk Pool received 100% of the growth in premium tax revenues collected (above what the state had collected in SFY 2007). Beginning in SFY 2010, the High Risk Pool only received 30% of the increase. The high risk pool funds have come from existing premium tax revenues.

In contrast, the HBE workgroup recommended that the HBE ~~continue to~~ receive ~~all~~ only the new health insurance premium tax revenues generated as a result in the growth in the number of covered lives and increase in costs of health insurance premiums due to the ACA over the 2013 baseline year. **~~In addition~~Because of the concern that this may not prove adequate to meet the HBE's budget requirements, the HBE workgroup also recommended that the North Carolina General Assembly pass through the revenues it ~~currently~~ uses to support Inclusive Health.** According to staff in fiscal research, the state payment to Inclusive Health is scheduled to be approximately $15.2 million in SFY 2012, $24.4 million in SFY 2013, and $34.2 million in SFY 2014.[63] Beginning in 2014, individuals who were receiving coverage through the state or federal high risk pool will gain coverage through the HBE. Inclusive Health will no longer be needed to provide coverage to these high risk individuals. Thus, any remaining funds should be transferred to the HBE to support operations, net reserves needed to pay outstanding health bills.

One of the primary advantages of financing the HBE operational costs through the premium tax dollars is that this financing structure is already in place. Most of the initial financing will come

[62] NCGS §105-228.5B.
[63] M. Keough. Executive Director, Inclusive Health. Electronic Communications. February 28, 2012.

from the increase in covered lives, which was unlikely to occur absent the ACA coverage and financing provisions. Another advantage is that the federal government will cover much of this cost for those who are eligible for the premium tax credit. As noted earlier, people who are eligible for subsidies pay premiums based on their income (eg, not based directly on the costs of the premiums). The federal government subsidizes the difference between the individual's required premium (as a percentage of their income), and the second lowest cost silver plan. Effectively, this means that the federal government will pay for the increase in premium costs associated with the premium tax (for those eligible for the subsidy), assuming the person or family purchases one of the two lowest cost silver plans.

Workgroup members recognized that the funding resulting from any increase in health insurance premium tax revenue could be highly variable and funding levels would be dependent on some market forces outside the control of the HBE. **Thus, workgroup members also recommended that the HBE be given other mechanisms to raise needed funding if the HBE trust fund does not generate sufficient revenues to cover the HBE's operational expenses from the premium taxes.**

The workgroup members recognized that there were advantages and disadvantages of different financing mechanisms. For example:

- *Advertising fees*. These fees may not generate significant revenues. Further, the administrative costs of collecting and selling advertising would reduce the revenues that could be used for HBE operations. In addition, advertising health plans that were offered through the HBE could reduce the effectiveness of the HBE shop and compare website, if consumers are given the impression that the website is trying to promote one plan over another. Thus before accepting advertising revenues, the HBE board should establish criteria for the types and placement display of potential advertising.
- *User fees on insurers operating within the HBE*. Workgroup members discussed the imposition of additional user fees on insurers operating within the HBE. Some members were concerned that adding additional user fees on insurers offering coverage within the HBE might discourage health plans from participating in the HBE (depending on the size of the user fee). In addition, because insurers are required to charge the same premium for health plans offered inside and outside the HBE, an additional user fee charged to health plans operating in the HBE might result in higher premiums outside the HBE. On the other hand, it is possible that imposing an additional fee on insurers would ~~likely~~ be built into the premium costs, and ~~ultimately much of the fee would be~~therefore passed onto the federal government for people eligible for a subsidy. The workgroup members also discussed the possibility of charging additional user fees on health plans that offer more than a specified level of health plan options per metal level, as the HBE would incur additional administrative costs in certifying and overseeing each plan offered within the HBE. While most of the workgroup members were supportive of that option, some members noted that health plans were unlikely to offer large number of health plans at any level, so the HBE would be unlikely to generate significant funding through this mechanism.
- *User fees on individuals purchasing within the HBE*. Workgroup members also discussed the possibility of charging a user fee to individuals who purchased coverage

within the HBE. However, workgroup members were concerned that imposing a fee on users in the HBE would discourage people from purchasing coverage in the HBE. Further, many individuals could be gaining the benefits of the HBE (for example, by using the shop and compare website to examine the costs and quality of different health plans), even if they ultimately choose to purchase coverage outside the HBE. Thus, workgroup members also discussed the ~~need~~ option to charge fees for individuals both inside and outside the HBE.

After considering the different financing mechanisms, the workgroup members recommended that the HBE Board be given the authority to exercise different options to help pay for reasonable operational costs. Most, if not all of the funding should come through the premium tax revenues. If that was insufficient, then the HBE Board should have the authority to allow advertising, or charge user fees on insurers or individuals. The workgroup was also supportive of using any of the funds ~~remaining~~ that may remain in the Inclusive Health Trust Fund after it closes down operations for ~~use in~~ HBE ~~operations~~operational costs.

Thus, the workgroup recommended:

Recommendation HBE 4: HBE Financial Sustainability

- **a) The North Carolina General Assembly should establish a HBE Trust Fund. Any new premium tax revenues generated as a result of the implementation of the Patient Protection and Affordable Care Act (ACA) should be deposited into the HBE Trust Fund to pay for reasonable HBE operations.**
  - **i. The trust fund should include premium tax revenues generated as a result of the increase in the number of people who purchase health insurance coverage inside and outside the HBE from a base year of 2013.**
  - **ii. The increase in the costs of the premium due to the implementation of the ACA.**
- **b) The North Carolina General Assembly should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the HBE Trust Fund.**
- **c) The North Carolina General Assembly should give the HBE Board the authority to raise other revenues if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for the reasonable HBE operations. These additional revenue sources should include, but not be limited to:**
  - **i. Fees on individuals or insurers who offer or purchase coverage in the HBE, up to a maximum threshold established by the North Carolina General Assembly**
  - **ii. Advertising revenues**

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