



**HEALTH BENEFIT EXCHANGE AND INSURANCE OVERSIGHT WORKGROUP**

**Thursday, February 2, 2012**

**North Carolina Institute of Medicine, Morrisville**

**9:00am – 12:30 pm**

**Meeting Summary**

**ATTENDEES**

*Members:* Louis Belo (co-chair), Allen Feezor (co-chair), Tracy Baker, Steve Cline, Deby Dihoff, Teri Gutierrez, Ted Hamby, Mark Holmes, Linwood Jones, Fred Joyner, Michael Keough, Adam Linker, Mike Matznick, Barbara Morales-Burke, Aaron Nelson, Elizabeth Phillips, Gregg Thompson, Rebecca Whitaker

*Steering Committee and NCIOM Staff:* Krutika Amin, Thalia Fuller, Julia Lerche, Ben Popkin, Lauren Short, Pam Silberman, Anne Williams

*Other Interested people:* Leslie Boyd, Melanie Bush, Abby Carter Emanuelson, Lee Dixon, R. Russell Greene, Tia Jones, Markita Keaton, Andy Landes, Julie Lawhorn, Ann Lore, Shelli Neal, Susan Nestor, Ernest Nickerson, Elizabeth O'Dell, Heather Shankwiler, Ashlee Smart, Chuck Stone, Walker Wilson

**WELCOME AND INTRODUCTIONS**

*Allen Feezor*

*Senior Policy Advisor*

*North Carolina Department of Health and Human Services*

*Co-Chair*

Mr. Feezor welcomed everyone to the meeting and gave an overview of the items on the agenda. After inviting questions and additions to the agenda, Mr. Feezor asked everyone to introduce themselves.

**Update on NC Department of Insurance Exchange Activities**

*Lauren Short, MSPH*

*Exchange Coordinator*

*North Carolina Department of Insurance*

Ms. Short reported that NCDOI is working with the Cecil G. Sheps Center for Health Services Research (UNC-CH) to host a series of small business and agent/broker focus groups to look at potential value added services.

Ms. Short also reported that NCDOI hired new staff to help with the HBE implementation work.

The NCDOI Technical Advisory Group (TAG) is continuing to meet regarding health insurance market reforms. The last meeting discussed small group market issues. The next meeting will take place February 16<sup>th</sup>. Those interested in following NCDOI TAG's activities can give Ms. Short their contact information.

*Selected Questions and Comments:*

- Q: When is the next meeting with the legislative oversight committee? A: NCDOI spoke at the joint legislative committee in December and has made itself available to speak to legislature staff, but is not currently on the agenda.

**QHP CERTIFICATION ISSUES**

*Pam Silberman, JD, DrPH*

*President & CEO*

*North Carolina Institute of Medicine*

The workgroup used the QHP Certification Requirements Pro-Con Table to guide its discussion of the role of the exchange, and the authority of the Board to shape the market and plans offered through the exchange. The workgroup discussion and points of consensus are summarized below. The HBE workgroup reached consensus on a number of QHP certification requirements with the following caveats:

- 1) Workgroup members only felt comfortable giving the Board the authority to impose additional requirements if the Board is broadly constituted and includes some representation from insurers, agents, as well as consumers, employers, and other groups.
- 2) The Board should not impose any requirements on qualified health plans in 2014 over and above the ACA requirements. Thereafter, the HBE should have the authority to mandate, or incentivize, additional requirements if needed to meet the needs of consumers, reduce adverse selection into the HBE or among different health plan issuers, promote innovation that leads to reduced costs or improved quality, or otherwise ensure the proper functioning of the HBE.
- 3) Before imposing any new requirements on health plans, the HBE Board should consider the likelihood that the new requirements will have on:
  - a. Administrative costs and/or premiums
  - b. Consumer choice, including the ability of consumers to understand and compare different plan choices
  - c. Consumer protections
  - d. Quality
  - e. Coverage of the uninsured and use of the HBE
  - f. Participation of health plans in the HBE
  - g. Adverse selection into the HBE and/or among participating plans in the HBE
  - h. The non-HBE health insurance market
- 4) The HBE workgroup was generally supportive of efforts to develop insurance products that could help improve population health and health care quality, and reduce health care costs.

The following Pro/Con Table summarizes the workgroup's discussion:

Issue	Pros	Cons	Consensus
<p><b>Limit number or types of plan variations</b></p>	<p>Limiting the number or establishing similar criteria for plan designs could:</p> <ul style="list-style-type: none"> <li>• Make consumer choice easier and could promote meaningful choice. The more choices, the more difficult to make informed choices. Limiting the number of choices, and/or standardizing some of the plan design could help individuals make more informed choices.</li> <li>• Board needs authority to respond to changes as they understand more about how the HBE is operating and get more feedback from both consumers and issuers.</li> <li>• Easier to compare costs of different plans if plan designs are somewhat standardized. Can help drive competition in costs, rather than variation in plan design.</li> <li>• Reduces administrative costs to the HBE by limiting total number of plans.</li> </ul>	<p>Forcing strict plan designs or a limited number of plan options could:</p> <ul style="list-style-type: none"> <li>• Reduce consumer choice</li> <li>• Eliminate flexibility of plan design and could limit the introduction of new models of care</li> <li>• Cause significant system and IT changes for certain carriers thereby reduce the number of carriers participating in the HBE</li> <li>• Eliminate or reduce innovation that could lead to cost reduction. To enhance consumer choice, innovation, and competition--non-standard plans should be allowed.</li> <li>• Limit competition among carriers, and/or reduce the number of carriers willing to participate in the HBE</li> <li>• Reliance upon standardized benefit design may lead to other important determinants of plan value such as formulary, network providers and service being overlooked or undermined. ACA's essential health benefits coupled with metal tiers, other coverage provisions (eg, annual out of pocket max) and minimum MLR requirements provide a basis for some comparison without overstating comparability.</li> </ul>	<p><b>The HBE should have the authority to limit choices or plan designs but need to have reasonable choices</b></p> <p><i>Note: While the HBE workgroup recommended that the HBE have the authority to limit the number of plans, or place parameters around plan design, members also thought it was important to have a reasonable number of choices. The HBE can facilitate consumer choice by having good website sorting mechanisms, including, but not limited to: premiums, deductibles, cost sharing, providers, open or closed networks, and quality</i></p>

Issue	Pros	Cons	Consensus
			<i>ratings.</i>
<p><b>Require health plans participating in the HBE to offer all four precious metal plans</b></p>	<ul style="list-style-type: none"> <li>• Requiring all health plans to offer plans in all of the precious metal tiers could help reduce risk segmentation across insurers.</li> <li>• Requiring health plans to offer bronze and/or platinum plans could provide consumers with greater choice.</li> </ul>	<p>Requiring health plans to offer all four precious metal plans might:</p> <ul style="list-style-type: none"> <li>• Limit participation of insurers thus limiting consumer choice (for example, some insurers may not currently offer the platinum level plan due to utilization concerns or weaknesses in their provider contracts. Others may not want to offer the lowest level plan because of MLR concerns).</li> <li>• May cause plans to offer uncompetitive plans to meet requirements, but would attract little participation.</li> <li>• Encouraging plans to offer all four levels would be fine, but wouldn't want to discourage plans from participating in the HBE because of this requirement.</li> <li>• This decision could also have an impact on health insurance offered outside the HBE.</li> <li>• Large insurers could provide all 4 levels, but some of the small carriers may not.</li> </ul>	<p><b>The HBE should have the authority to require later if needed, but should not be required up front. The HBE should also have the authority to require participation in 3 of the precious metal plans (instead of all 4 levels) if needed.</b></p> <p>In 2014, the HBEs cannot require participation in all four levels. Generally, plans need 6-9 months before can change plans based on rating and actuarial analysis. So</p>

Issue	Pros	Cons	Consensus
		<ul style="list-style-type: none"> <li>• No one sells the .9 (platinum plans) in the market anymore, so why should we force these plans to be offered.</li> <li>• Because insurers can no longer price plans based on utilization, insurers will not be able to set the premiums for platinum plans based on the risk of people who choose the richer benefit package. Traditionally, people who have the most significant health problems choose richer benefit plans. Effectively, if the health plan can't base premiums based on health care usage, people at the lower metal plans (bronze, silver, gold) will effectively subsidize those with a platinum plan.</li> </ul>	probably couldn't require until 2016.
<p><b>Additional quality standards beyond accreditation and implementing quality improvement strategies (including enrollee satisfaction, data reporting)</b></p>	<ul style="list-style-type: none"> <li>• HBE should have the authority to offer additional quality standards sometime in the future, if conditions warrant it. "This should be an evolutionary process."</li> <li>• Need to allow HBEs to have discretion to remove "junk plans" from the market otherwise it reduces the value of the subsidies.</li> </ul>	<ul style="list-style-type: none"> <li>• New federal quality and accreditation standards will largely ensure that HBE members have access to high quality health plans.</li> <li>• HBE needs to weigh all the administrative requirements put on QHPs. Administrative expenses will ultimately be passed through in premium increases.</li> <li>• Open market will encourage new cost and quality innovations as QHPs encourage new members to choose plans. If state wants to encourage carriers to exceed the quality standards,</li> </ul>	<p><b>Allow the HBEs to incentivize insurers to offer new quality standards, rather than require additional quality standards.*</b></p> <p><i>Note: the HBE workgroup voted 8 to 5 vote to give the HBE the authority to mandate additional quality requirements</i></p>

Issue	Pros	Cons	Consensus
		<p>it should be done through market-based incentives rather than through regulatory requirements.</p> <ul style="list-style-type: none"> <li>• If the state believes that quality standards are important, it should apply to all plans (not just those inside the HBE).</li> <li>• Don't know what the reach of "quality" means. If it's limited, then not as problematic.</li> </ul>	<p><i>sometime in future, if needed. However, the tally did not reach the 2/3rds "consensus" threshold.) All the workgroup members felt comfortable allowing the HBE to try to incentivize additional quality standards, if needed.</i></p>
<p><b>Additional requirements to foster innovation (ie, quality, health outcomes, better consumer service, and reduce costs)</b></p>	<ul style="list-style-type: none"> <li>• HBE should have the authority to add additional requirements to meet broader health goals, such as ensuring health or health insurance literacy, helping bend the cost curve, or participating in a multipayer data base to ensure data available to monitor utilization and health care trends.</li> <li>• Should be able to foster innovation.</li> </ul>	<ul style="list-style-type: none"> <li>• Not sure this is the role of the HBE. The HBE should be the clearinghouse to promote choice, simplicity, and assistance to consumers. It should not be the health policy driver for the state.</li> <li>• What do we mean by fostering state health policy goals? Who gets to define this?</li> <li>• HBE should be a connector, should not go beyond this role.</li> <li>• If state interest, should apply across the whole market (not just the HBE). So, legislature should apply inside and outside the HBE.</li> </ul>	<p><b>Allow the HBE to incentivize insurers to foster innovation that meets state health goals, but not mandate</b></p> <p><i>Note: it was difficult for the HBE members to provide meaningful input into this without further defining what authority the HBE would have.</i></p>
<p><b>Phasing in accreditation standards (if states</b></p>	<ul style="list-style-type: none"> <li>• Currently, over half of the carriers operating in NC today are not accredited by any agency. The HBE</li> </ul>		<p><b>If states have discretion to phase in the accreditation</b></p>

Issue	Pros	Cons	Consensus
<p>have discretion).</p>	<p>should not require accreditation before 2016, thus allowing all carriers an opportunity to become accredited.</p> <ul style="list-style-type: none"> <li>• Short accreditation standards could serve to discourage entry and competition by new market players.</li> <li>• Should only delay if plans are actively pursuing accreditation.</li> <li>• Some standards may require a phase-in.</li> <li>• Need to balance need for accreditation (to meet minimum quality and operational standards) with competition, and not necessarily exclude issuers that could meet the requirements in a few years.</li> </ul>		<p><b>requirement, the HBE should give qualified health plans up to 2 additional years* to meet the accreditation requirement. The health plan must show that it is making progress in seeking accreditation (in order to be allowed extra time)</b></p> <p><i>*Note: the HBE should have the authority to allow additional time beyond 2 years in extenuating circumstances (eg, accrediting agencies are backlogged and cannot accredit all the insurers in a timely manner).</i></p>
<b>Network Adequacy</b>	Pros of having DOI set standards:	DOI setting standards:	<b>NC DOI set</b>

Issue	Pros	Cons	Consensus
<p><b>standards (Which organization should set standards, and should the network adequacy standards be the same inside and outside the HBE)?</b></p>	<ul style="list-style-type: none"> <li>• NCDOI should set standards. The carriers currently file their networks with NCDOI, so this is an opportunity to reduce potential duplication.</li> </ul> <p>Pros of having same standard:</p> <ul style="list-style-type: none"> <li>• More stringent network adequacy standards inside the HBE could discourage health plans from participating. Therefore, standards should be the same.</li> <li>• To ensure more level playing field inside/outside HBE, network adequacy standards should be the same.</li> <li>• Network adequacy and consumer hold harmless provisions should be the same inside/outside HBE.</li> </ul>	<ul style="list-style-type: none"> <li>• One person suggested both DOI and HBE set network adequacy standards</li> </ul> <p>Cons of having same standard inside/outside HBE:</p> <ul style="list-style-type: none"> <li>• Allowing different network adequacy standards inside and outside the HBE allows more flexibility to develop innovative models.</li> <li>• Some plans may experiment with offering models with more limited provider networks (to control costs and improve efficiency). We shouldn't limit new models outside the HBE (but should have strong consumer protections inside HBE).</li> </ul>	<p><b>minimum network adequacy standards; should allow differential networks for limited network plans.</b></p> <p><b>In the absence of statewide standards, HBE should be able to set standards.</b></p> <p><b>The network standards should be the same inside and outside the HBE*</b></p> <p><i>*Generally network standards should be the same inside and outside the HBE, but the HBE/DOI should have some flexibility to allow variation in network adequacy standards in order to test new innovations.</i></p>

Note: The workgroup did not have time to consider the following issue. This will be considered at a subsequent meeting:

Issue	Pros	Cons	Consensus
<p><b>Limiting catastrophic plans to HBE</b></p> <p><i>Note: this question was not clear to the respondents.</i></p>	<p>Some catastrophic plans should be available in the HBE. All eligible consumers should be able to choose a catastrophic plan and benefit from the subsidy (if eligible).</p>	<p>To maximize innovation, competition and choice for the consumer, the offering of catastrophic plans should not be restricted to carriers participating in the exchange</p>	<p>Of the 11 people who submitted comments:</p> <ul style="list-style-type: none"> <li>• 5 thought catastrophic plans should be limited to insurers offering in HBE</li> <li>• 3 voted to allow any insurer (inside/outside HBE) to offer catastrophic plans</li> </ul>