

## CHAPTER 2 HEALTH BENEFITS EXCHANGE

### 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.<sup>a,b</sup> 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, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.<sup>c</sup> 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.<sup>d</sup>

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 promote competition on the basis of comparative value, price, 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; add to consumer education 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.

Individual and small group plans, including 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

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<sup>a</sup> 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.

<sup>b</sup> The constitutionality of the individual mandate along with the Medicaid expansion is being challenged in the United States 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. Kaiser Family Foundation. A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law. <http://www.kff.org/healthreform/upload/8270-2.pdf>. Published January 2012. Accessed February 23, 2012.

<sup>c</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1411(b)(5); Patient Protection and Affordable Care Act, Pub L No. 111-148, §1501(b), enacting Sec. 5000A(d),(e) of the Internal Revenue Code of 1986, 26 USC 5000A.

<sup>d</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1513(a), enacting Sec. 4980H(c)(2) of the Internal Revenue Code of 1986, 26 USC 4980H(c)(2).

devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).<sup>c</sup> Each state will be required to define its own essential health benefits package (using HHS defined benchmarks) that includes coverage of these services.<sup>1</sup> In addition, all insurance plans that are not grandfathered<sup>f</sup> must provide coverage of the clinical preventive services recommended by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee for Immunization Practices with no cost sharing.<sup>g</sup> Insurers must also provide additional preventive services for infants, children, adolescents, and women.<sup>h</sup>

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).<sup>i</sup> 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.<sup>j</sup>

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.<sup>k</sup> (Table 2.1) 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 plan 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

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<sup>c</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(a).

<sup>f</sup> 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.

<sup>g</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC 300gg.

<sup>h</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC 300gg.

<sup>i</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(d), 42 USC 18022.

<sup>j</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(e), 42 USC 18022.

<sup>k</sup> The Federal Poverty Level (FPL) is based on family size. The 2012 FPL is: \$11,170 /year (one person), \$15,130/year (two people), \$19,090/year (three people), \$23,050/year (four people), and \$3,960/year for each additional person. Thus 400% FPL would be: \$44,680 (one person), \$60,520/year (two people), \$76,360/year (three people), and \$92,200 (four people), and \$15,840/year for each additional person.

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

**Table 2.1**  
**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 <sup>€</sup>	Out-of-pocket cost-sharing limits (Proportion of the Health Savings Accounts (HSA) out-of-pocket cost-sharing limits) <sup>¥</sup> <sup>β</sup>
<b>Families eligible for subsidy</b>			
<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%	\$6,050/\$12,000
300-400% FPL	9.5%	30%	\$6,050/\$12,100
<b>Families not eligible for subsidies</b>			
400%+ FPL	No limit	30%	\$6,050/\$12,100 (HSA limit)

<sup>€</sup> Out-of-pocket cost sharing includes deductibles, coinsurance, and copays.

<sup>¥</sup> 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.

<sup>β</sup> The Center for Consumer Information and Insurance Oversight released Actuarial Value and Cost-Sharing Reductions Bulletin which indicated the United States Department of Health and Human Services’ intent not to reduce out-of-pocket limits for those with incomes between 250-400% FPL.

<http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>. Accessed April 13, 2012.

Lower income individuals and 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) if they enroll in a silver plan. American Indians with incomes below 300% FPL pay

no cost sharing.<sup>l</sup> The federal government will pay the premium tax credits and the cost-sharing subsidies directly to health plans. All families with incomes below 250% FPL 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.

In addition to the subsidies available to individuals, the ACA also includes tax credits to help small businesses purchase health insurance coverage.<sup>m</sup> 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 North Carolina 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 are expected to obtain their health insurance coverage through the HBE beginning in 2014.<sup>2</sup> (Table 2.2) Of these, slightly more than 51,000 people are expected to be covered by small businesses purchasing insurance for employees and their dependents through the HBE; more than 660,000 people are expected to purchase nongroup coverage through the Exchange. Approximately 300,000 of the individuals who are expected to enroll in the HBE in the first year are expected to have been uninsured in 2013.

Three quarters of the people who purchase coverage directly through the HBE are expected to 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.<sup>3</sup> Only 25% will have incomes above 400% FPL.

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<sup>l</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1402(d)(1)(2), 2901.

<sup>m</sup> 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.

**Table 2.2  
Changes in Insurance Coverage (2013-2014)**

Market in 2013	Total Pop.	Market Changes in 2014							
		Medicaid/CHIP	Other Govt. Program	Employer Sponsor		Ind. Market		Un-insured	Undoc Un-insured
				HBE	Non-HBE	HBE	Non-HBE		
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
<b>Total</b>	<b>8,679,795</b>	<b>1,904,564</b>	<b>731,835</b>	<b>51,149</b>	<b>4,505,258</b>	<b>663,073</b>	<b>132,718</b>	<b>476,185</b>	<b>215,014</b>

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 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.<sup>n, o</sup>
- 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.<sup>p, q</sup>
- Develop and maintain a website that provides standardized comparative information on plan options including costs, quality, and provider networks.<sup>r, s</sup>
- Assign a quality rating to each qualified health plan offered through the HBE using criteria developed by the Secretary.<sup>t, u</sup>

<sup>n</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1301, 1311, 1321, 1322, 1334, 10104.

<sup>o</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.1010, 155.1075, 155.1080.

<sup>p</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).

<sup>q</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

<sup>r</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).

<sup>s</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

<sup>t</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(D).

- Determine eligibility for the premium tax credit and cost-sharing subsidies.<sup>v, w</sup>
- Conduct outreach and education to inform people about eligibility requirements for Medicaid and North Carolina Health Choice and, if eligible, enroll them directly into these programs.<sup>x, y</sup>
- Establish and make available an electronic calculator for determining the costs of coverage after applicable premium tax credits and cost-sharing reductions.<sup>z, aa</sup>
- Certify individuals who are exempt from the requirement to purchase health insurance.<sup>bb, cc</sup>
- 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.<sup>dd</sup>
- Provide the Secretary of the Treasury with 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.<sup>ee</sup>
- Provide information to employers of any employee who ceases coverage under a qualified health plan.<sup>ff</sup>
- Establish a navigator program to provide information to the public about health plan choices and to help them enroll.<sup>gg, hh</sup>
- Consult with relevant stakeholders to carry out required activities.<sup>ii, jj</sup>
- Publish average costs of licensing, regulatory fees, and other payments to the HBE and administrative costs.<sup>kk, ll</sup>

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<sup>u</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.200.

<sup>v</sup> 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.

<sup>w</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.300-155.355.

<sup>x</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(F), 1411, 1413.

<sup>y</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.

<sup>z</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(G).

<sup>aa</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.

<sup>bb</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(H).

<sup>cc</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.200(b), 155.705.

<sup>dd</sup> 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).

<sup>ee</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(I).

<sup>ff</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(J).

<sup>gg</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(K), 1311(i).

<sup>hh</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.210-220.

<sup>ii</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(6).

<sup>jj</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.130.

<sup>kk</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(7).

<sup>ll</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.

- Report on activities, receipts, and expenditures annually to the Secretary of the USDHHS.<sup>mmm</sup>
- Consider information from employers that contest the imposition of penalties.<sup>mm</sup>

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 federal regulations included some requirements that are exclusive to the SHOP. For example, under the 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.<sup>oo</sup> The SHOP can offer other employee choice options to employers (eg, 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 of plans.<sup>pp</sup> 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.<sup>qq,rr</sup> 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.<sup>ss</sup>

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.<sup>tt</sup> The Center for Consumer Information and Insurance Oversight (CCIIO), within the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, provided states guidance as to what will be required to show operational readiness.<sup>4</sup> To be certified, HBEs must show their ability to perform the following core functions:

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<sup>mmm</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1313.

<sup>mm</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§10108(d)(2), 1411(f)(2).

<sup>oo</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.705(b)(2)(3).

<sup>pp</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.240(c); 155.705(b)(4).

<sup>qq</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(a),(d)(5).

<sup>rr</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.160.

<sup>ss</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(5).

<sup>tt</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.105.

- *Consumer Assistance*, including education and outreach, navigator management, call center operations, website management, consumer support assistants, 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

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 house the HBE within an existing state agency.<sup>5</sup>

The North Carolina House of Representatives passed legislation in 2011 (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 establishment 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.

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 ensure financial sustainability beginning in 2015.<sup>6</sup> 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, the North Carolina General Assembly should create the HBE and pursue 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 establishment 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 establishment 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 or procure non-eligibility IT systems.
- Propose legislation and develop regulations for needed market reforms.
- Establish capacity to provide assistance to individuals and small businesses seeking health insurance.
- 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 establishment 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 rating inside and outside the HBE. The two groups have been charged with examining different implementation and design issues. (Table 2.3) 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 2.3**  
**Design Issues Considered by NCIOM HBE Workgroup and NCDOI Technical Advisory Group**

<b>NCIOM HBE Workgroup Issues</b>	<b>NCDOI TAG Issues</b>
<ul style="list-style-type: none"> <li>• Whether to operate a state-based HBE or create a partnership HBE</li> <li>• High level QHP certification options</li> <li>• HBE sustainability options</li> <li>• Preliminary evaluation planning necessary for a Level II implementation grant</li> <li>• The roles, training, and certification requirements for agents, brokers, navigators, volunteer counselors and other community based organizations</li> <li>• Operationalizing the QHP requirement to contract with essential community providers</li> </ul>	<ul style="list-style-type: none"> <li>• Whether to merge the individual and small group market within the HBE</li> <li>• Whether to allow groups of more than 50 to purchase QHPs in the HBE in 2014</li> <li>• Whether to change the North Carolina laws regarding self-funding and stop-loss coverage for small group plans</li> <li>• 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)</li> <li>• The role of the state, if any, in administering the risk adjustment and reinsurance programs, and preliminary plans for program development if applicable</li> <li>• Mechanisms for assuring a level playing field inside and outside the HBE (ie, to mitigate adverse selection)</li> <li>• Geographic rating areas</li> <li>• Analysis of essential health benefits options for North Carolina</li> </ul>

**HBE WORKGROUP RECOMMENDATIONS**

The HBE workgroup has met nine times since the beginning of August, 2011. In addition, a subcommittee met on four occasions to examine options for the navigator program. The following includes the recommendations from the HBE workgroup. This information will also be presented to 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 United States Department of Health and Human Services (USDHHS) set forth a proposed hybrid approach—called a “partnership” HBE option.<sup>74</sup> With the partnership option, USDHHS gave states flexibility to assume some functions that they want to provide directly and those which they want the federal government to assume. The partnership option is considered a federally-facilitated, and not a state-operated Exchange. Table 2.4 gives a brief overview of the different HBE operational options: state operated, federally facilitated, or partnership. More detailed information is provided below.

**Table 2.4  
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 North Carolina 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 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 (eg, 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 its 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.<sup>uu</sup> If the state does not create its own network adequacy standards, the federal government will create standards for plans operating in the HBE.<sup>4</sup> 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.<sup>vv</sup> Additionally, there are protections in place for consumers who are not able to access network providers.<sup>ww</sup> Based on the final HBE regulations, it appears that North Carolina’s current network adequacy standards will be sufficient. If North Carolina’s existing network adequacy requirements are not considered sufficient to meet federal requirements, 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

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<sup>uu</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.1050, 156.230.

<sup>vv</sup> 11 NCAC §§20.0301-.0302.

<sup>ww</sup> NCGS §58-3-200(d).

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 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, workgroup 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.<sup>4</sup>)

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.<sup>4</sup> 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 NCDOT's Market Reform TAG.

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

**RECOMMENDATION 2.1: STATE AND FEDERAL HBE OPERATIONAL RESPONSIBILITIES**

- 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.**
- b) 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, NCDOT, 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, enhance 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.

The workgroup was aware of the dramatic changes and considerable uncertainty that the Exchange environment poses to insurers in what is already a difficult market. Accordingly, the workgroup urged that the HBE Board should pursue an “evolutionary approach” to the Exchange environment to the extent that the ACA permits. To this end, the workgroup urges (as noted later) that the board delay consideration of any additional or higher plan standards until 2016 (at the earliest), and that where possible, incentives be considered rather than mandates. 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.

Notwithstanding the above, the workgroup agreed that the HBE Board should have the authority to standardize terminology, definitions, benefits design or array for QHPs offered in the Exchange in 2014 (or thereafter), if it is determined to be helpful to improve consumer understanding or more enlightened or comparable choice. Further, the workgroup recommended that the HBE have the authority to limit the number of plan or benefit designs within each metal level that an individual insurer can offer, based on its judgment as to what best serves meaningful consumer engagement and choice, or improves competition among plans. Benefit limits are not interpreted to limit simple differences in co-pays nor products that use different (more cost-effective or high performing) provider networks.

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 of different health plan designs may make the plan choice process difficult for consumers. Limiting the number of choices, standardizing terminology, definitions, 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, and potentially create barriers to the introduction of innovative insurance models.

Thus, workgroup members recommended that the HBE Board have the authority to standardize terminology, definitions, benefit design or array, or 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 more cost-effective or high performing 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 non-group market today; some workgroup members questioned the rationale of forcing insurers to offer plans that are not currently available 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. Thus, it is possible that 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). 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.<sup>xx</sup> HBEs must assign a quality rating to each plan

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<sup>xx</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(c),(h).

on the basis of relative quality and price.<sup>yy</sup> The Secretary of USDHHS will establish standards for the quality rating system, and will also collect enrollee satisfaction information on all health plans.<sup>zz</sup> In addition, the ACA directs the Secretary to develop strategies to further reward quality of care through market based incentives.<sup>aaa</sup>

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 Carolinians 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. 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 lower quality plans because they may not be able to afford a higher quality 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<sup>bbb</sup> on this point. Some members of the group argued that the federal standards will greatly enhance current quality standards, and that 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).

*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 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.<sup>ccc</sup> 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.

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<sup>yy</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4).

<sup>zz</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c).

<sup>aaa</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(g).

<sup>bbb</sup> 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.

<sup>ccc</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.1045.

*Network adequacy standards.* The 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.<sup>ddd</sup> Qualified health plans must meet the state established network adequacy standards.<sup>eee</sup> 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 be sufficient to meet the federal network adequacy standard. If not, 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 if needed, 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.

*Essential community providers.* In addition to the network adequacy standards, the ACA requires health plans to contract with essential community provider (ECP) in order to be certified.<sup>fff</sup> ECPS are providers that serve predominantly low-income, medically underserved communities. They include, but are not limited to federally qualified health centers (FQHCs), family planning entities receiving federal funds, Ryan White grantees, black lung clinics, comprehensive hemophilia diagnostic treatment centers, public health entities receiving funding for sexually transmitted diseases or tuberculosis, disproportionate share hospitals, children’s hospitals, critical access hospitals, free standing cancer centers, rural referral centers, sole community hospitals, and other state agencies or nonprofits that provide the same types of services to the same population.<sup>ggg</sup> The intent of this provision is to “strengthen access in medically-underserved areas and for vulnerable populations,”<sup>hhh</sup> and to ensure that there are a sufficient number and types of providers to “assure that all services, including mental health and substance abuse services, will be accessible without unreasonable delay.”<sup>iii</sup> The final HBE regulations state that a “QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.”<sup>jjj</sup> There are also special contracting and payment rules for contracts with Indian health providers.

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<sup>ddd</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 155.1050.

<sup>eee</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.230.

<sup>fff</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031.

<sup>ggg</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031 referencing 42 USC §§256(b)(a)(4), 1927(c)(1)(d)(i)(IV) for definition of essential community provider.

<sup>hhh</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475 at p. 18419.

<sup>iii</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475 at p. 421.

<sup>jjj</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.235.

While the ACA requires QHPs to contract with essential community providers, it also states that QHPs need not contract with ECPs if such provider refuses to accept the generally applicable payment rates.<sup>kkk</sup> However, the ACA includes special payment requirements for FQHCs. If the QHP contracts with FQHCs, it 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,”<sup>lll</sup> or another payment rate if mutually agreed upon by the FQHC and QHP, and at least equal to the generally applicable payment rate of the QHP.<sup>mmm</sup>

The workgroup members agreed that the HBE Board should monitor this provision to ensure that low-income and other vulnerable populations have access to all services without unreasonable delay, and if necessary, further clarify how QHPs can meet this requirement.

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

**RECOMMENDATION 2.2: 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 standardize terminology, definitions, benefit design or array, or 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 in the HBE market. Benefit design limits are not intended to limit simple differences in co-pays or to limit the use of products that use more cost-effective or high performing provider networks.**
  - 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) **The HBE Board should not have the authority to exclude insurers from participating in the HBE if they otherwise meet the certification and other ACA requirements.**
- c) **Aside from allowing the HBE Board to standardize terminology, plan design or limit the number of different plan designs per metal level (Sec. a.i. above), the**

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<sup>kkk</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(2), 42 USC 13031

<sup>lll</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(g), 10104(b)(2).

<sup>mmm</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.235(e).

**HBE Board should not impose any other 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.**

- d) 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.**

**RECOMMENDATION 2.3: NCDOI OBJECTIVE NETWORK ADEQUACY STANDARDS**

**The North Carolina Department of Insurance should study and if applicable, 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.**

**RECOMMENDATION 2.4: HBE MONITORING OF ESSENTIAL COMMUNITY PROVIDER PROVISIONS**

**The HBE Board, in collaboration with the North Carolina Department of Insurance, should monitor insurers' contracts with essential community providers to ensure that low-income and other vulnerable populations have reasonable and timely access to a broad range of providers. If necessary, the HBE Board should provide additional guidance to insurers about what constitutes a sufficient number or reasonable geographic distribution necessary to meet this requirement for qualified health plans offered in the HBE, and/or provide incentives to encourage insurers to contract with a greater number of essential community providers.**

***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 identifies 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.<sup>nnn</sup> The 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

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<sup>nnn</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(5).

funding for Exchange operations.<sup>000</sup> HHS guidance suggests that HHS will charge insurers users fees if the federal government establishes the HBE in a state.<sup>7</sup>

Milliman Inc. prepared a preliminary estimate of the HBE’s ongoing operational costs beginning in 2014. Milliman estimated that the North Carolina HBE operations would cost approximately \$23.8 million in 2014, \$25 million in 2015, and \$26.7 million in 2016.<sup>2</sup> The Milliman estimates were among the first estimates developed across the country, and did not reflect subsequent regulations and guidance or 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).

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 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 states’ HBE cost estimates. Table 2.5 reflects the information provided to the HBE workgroup from PCG Health.

**Table 2.5  
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).

<sup>000</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR § 155.160.

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 estimate for North Carolina 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 current grant activities.

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. Aggregate health insurance premiums are expected to increase significantly in 2014 as a result of the ACA, resulting in more premium tax revenue than would otherwise be expected. This is the result of several factors. First, Milliman estimated that approximately 350,000 more people will have commercial health insurance coverage in 2014 relative to the number that would have been covered in 2014 absent the ACA. Second, Milliman estimated that average fully-insured health insurance premiums across the individual and group markets would increase by 16.5% from 2013 to 2014. This is about 6% higher than what would have been expected if the ACA were not in place. The increase in average health insurance premiums over and above the usual expected annual increase is primarily a result of changes in the individual market. These changes include the coverage of additional benefits, as well as insurance reforms that will lead to a disproportionate number of higher cost individuals entering the market in 2014. These changes include guaranteed issue requirements, elimination of medical underwriting, and the provision of subsidies to make health insurance more affordable.

The workgroup recommended that the annual increase in premium tax revenue resulting from the expected annual increase in premiums over the baseline year of 2013 that would have occurred in the absence of the ACA would go into the state's General Funds. However, the increase due to implementation of the ACA should be set aside into the HBE Trust Fund starting in 2014. Based on the average premium and enrollment estimates from Milliman, the increase in premium tax revenues in 2014 attributable to the ACA is estimated to be approximately \$62 million.<sup>PPP</sup> Note that Milliman's estimates were not expressly prepared for the purpose of calculating premium tax revenue, and estimates are very sensitive to the assumptions. For example, if there are only 200,000 new entrants to the individual market in 2014 as a result of the ACA, the premium tax revenue increase would be only \$41 million (assuming no change to average premiums in the individual market Exchange).

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<sup>PPP</sup> Lerche, J. Health Actuary, Actuarial Services Division, North Carolina Department of Insurance. Written (email) communication, April 15, 2012.

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.<sup>qqq</sup> 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 receive only the new health insurance premium tax revenues generated as a result in the growth in the number of covered lives and the increase in costs of health insurance premiums due to the ACA over the 2013 baseline year. 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 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.<sup>rrr</sup> 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 the 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 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).

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:

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<sup>qqq</sup> NCGS §105-228.5B.

<sup>rrr</sup> Keough, M. Executive Director, Inclusive Health. Written (email) Communications. February 28, 2012.

- *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 be built into the premium costs, and 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, in order to discourage insurers from offering large numbers of plan designs in each metal level. The additional fees would also help offset the additional administrative costs in certifying and overseeing all of the new plans offered within the HBE.
- *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, if allowed under federal law. 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 option to charge fees for individuals both inside and outside the HBE.
- *Foundation funding.* The HBE should have the authority to seek foundation or other funding, particularly in the first few years, to support navigator grants (see discussion of navigators below). However, the workgroup members did not believe the HBE should rely on foundation funding to support ongoing operational expenses, as foundation funding is typically time limited.

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 that may remain in the Inclusive Health Trust Fund after it closes down operations for HBE operational costs.

Thus, the workgroup recommended:

#### **RECOMMENDATION 2.5: 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. **Fees on insurers who offer more than a specified number of health plans per metal level.**
  - iii. **Advertising revenues**
  - iv. **Grants from foundations or other philanthropic sources**

#### ***Education, Outreach, Navigators, and Enrollment Assistance***

The ACA includes different mechanisms to inform and educate the public about new insurance options, and to help facilitate their enrollment into coverage. There are separate, but similar, requirements for the HBE and Medicaid agency. At the very general level, the HBE and the Medicaid agency must engage in broad outreach efforts to educate the public and targeted populations about the availability of new insurance coverage options, insurance subsidies, and how to enroll. To make it easier for people to apply, the ACA and federal regulations specify that people can apply online, in person, by telephone, or by fax.<sup>sss. ttt</sup> Individuals can always seek informal help from family or friends. However, the ACA also envisions that there will be other sources of trained enrollment assistants, including trained navigators, DSS workers, and agents or brokers (at the state option). Further, the new law creates a “no wrong door” enrollment process. Individuals can apply directly to the HBE, and if eligible for Medicaid or CHIP, enroll directly into those programs, and conversely, people can apply for Medicaid or CHIP, and if ineligible, be screened and, if eligible, enrolled into a QHP in the HBE.

The HBE workgroup created a subcommittee to consider education and outreach efforts; training for nonprofits and other groups who can refer individuals to appropriate assistance; navigator

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<sup>sss</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.405.

<sup>ttt</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.907.

training, certification, compensation and accountability; the role of agents and brokers; and how to create the “no wrong door” eligibility and enrollment process. The subcommittee reported its recommendations to the full committee.

*Education and Outreach.* The HBE is required to conduct education and outreach to inform the public about the HBE.<sup>uuu</sup> In addition, the HBE must provide for the operation of a toll-free hotline to answer questions and help people enroll.<sup>vvv</sup> The ACA also imposes new outreach requirements on state Medicaid agencies. The agency is required to conduct outreach to vulnerable populations “including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.”<sup>www</sup>

The HBE workgroup recognized that the HBE might need to enlist the support of different groups to provide education and outreach to the nongroup market other than those who will be effective in targeting the small group market. For example, while nonprofits, human services agencies, community-based organizations, and faith groups may be enlisted to provide education and outreach to individuals, the HBE may need to enlist the support of Chambers of Commerce, professional associations, small business resource centers, community banks, or other organizations to reach small businesses.

Regardless of what organization or entity provides the education and outreach, the HBE workgroup recommended that these organizations receive similar information so that there is a consistent message about new potential insurance opportunities. The HBE workgroup recognized that these materials may need to be tailored somewhat to a specific target audience, but the underlying information should be similar regardless of the audience. Therefore, the HBE workgroup recommended that the HBE work with the North Carolina Department of Insurance (NCDOI), North Carolina Division of Medical Assistance (DMA), and other appropriate organizations to develop a standardized community outreach and education toolkit so that interested organizations and individuals can disseminate similar outreach and education materials. The toolkit should provide basic information about public insurance options (including Medicaid and North Carolina Health Choice), nongroup coverage available through the HBE, eligibility for the premium tax credit and cost-sharing subsidies, different insurance options for small businesses, the small business tax credit, the eligibility and enrollment website, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.

*Informal assistance.* As noted earlier, individuals can seek help in the enrollment process from many different sources. Individuals can obtain help from certified navigators, agents, or brokers (discussed more fully below). However, an individual can seek help from other sources as well.

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<sup>uuu</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205(e).

<sup>vvv</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

<sup>www</sup> PPACA Sec. 2201, amending Sec. XIX of the Social Security Act, 42 USC 1396w-3(b)(1)(F).

The new federal regulations state that the HBE must accept applications from the applicant, an authorized representative, or someone acting responsibly on behalf of the applicant.<sup>xxx</sup>

The HBE workgroup recognized that some individuals will first learn of the new insurance options through their health care providers or through other nonprofit or community-based organizations. It is important to offer basic training to these organizations so that they understand the new insurance options and can make appropriate referrals. Thus, the HBE workgroup recommended that the HBE, in conjunction with the North Carolina Department of Insurance and North Carolina Division of Medical Assistance, offer workshops or other training opportunities to provide basic information about public and private insurance options, the HBE website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.

To implement the information, outreach, and assistance provisions of the ACA, the HBE workgroup recommended:

#### **RECOMMENDATION 2.6. OUTREACH AND EDUCATION**

- a) The Health Benefits Exchange (HBE), in conjunction with the North Carolina Department of Insurance (NCDOI), and North Carolina Division of Medical Assistance (DMA), and other appropriate organizations, should develop a standardized community outreach and education toolkit so that interested organizations and individuals can disseminate similar outreach and education materials. The toolkit should provide basic information about public insurance options (including Medicaid and North Carolina Health Choice), nongroup coverage available through the Health Benefit Exchange, eligibility for the premium tax credit and cost-sharing subsidies, different insurance options for small businesses, the small business tax credit, the computerized eligibility and enrollment system, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.**
- b) The HBE, in conjunction with the NCDOI and DMA, should offer workshops and other training opportunities to provide basic information about public and private insurance options, the HBE website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.**

*Navigators.* The ACA requires the HBE to provide grants to navigator *entities* to help people understand their insurance options and enroll into coverage in the HBE. To be eligible to receive a grant, the HBE entity must have existing relationships or show that they can establish relationships with individuals or small businesses likely to enroll in a QHP.<sup>yyy</sup> The regulations clarify that the HBE must contract with at least two of the following categories of eligible *navigator entities* to receive the navigator grants, including: consumer and consumer-focused nonprofit groups; trade, industry, and professional associations; commercial fishing industry organizations, ranching and farming organizations; chambers of commerce; unions; resource

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<sup>xxx</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.20.

<sup>yyy</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(2)(A).

partners of the Small Business Administration; licensed agents and brokers (if they do not receive compensation directly or indirectly from insurers); and other public or private entities which may include Indian tribes, tribal organizations, and state or local human service agencies.<sup>zzz</sup>

The HBE workgroup recognized that there is a difference between “navigator entities” and individual navigators. Navigator entities are organizations that can serve as local coordinating bodies—working with and overseeing the work of individually trained navigators. For example, a community-based organization may serve as the navigator entity and receive a small navigator grant to help pay for operational expenses (see navigator compensation discussion, below). This entity would serve as the coordinating body for individuals who are trained and certified as navigators. The individual navigators may or may not work for the navigator entities. Navigators are best suited to work with individuals in the nongroup market. As discussed more fully below, the HBE workgroup recommended that small groups that seek information or enrollment assistance be channeled to licensed agents or brokers.

The state or HBE can establish licensure or certification requirements for individual navigators. Navigators must be able to provide impartial information about different health plans, and, therefore, cannot have a conflict of interest.

Navigators must be able to perform specific responsibilities:

- Conduct public education activities to educate the public about coverage offered through the HBE.
- Distribute fair and impartial information about enrollment into QHPs, and the subsidies available through the HBE.
- Help people with enrollment into qualified health plans.
- Provide referrals to applicable health insurance consumer assistance, ombudsman programs, or other appropriate state agency or agencies that can address consumer questions or complaints.
- Provide information in a manner that is culturally and linguistically accessible.<sup>aaaa</sup>

The HBE workgroup used NCDOT’s Seniors’ Health Insurance Information Program (SHIIP) as a successful example of a navigator program. SHIIP counselors help provide information to older adults and people with disabilities about Medicare, Medicare Advantage plans, Medicare supplement plans, Medicare Prescription Drug Plans, and long-term care insurance. NCDOT contracts with 109 SHIIP coordinating organizations across the state. These organizations help coordinate the work of more than 800 volunteer SHIIP counselors. To serve as SHIIP counselor, individuals must complete required training and pass a competency exam. Currently, the training is provided online, includes 13 different modules, and takes approximately 24 hours to complete. SHIIP counselors must also meet continuing education requirements, and be recertified annually. Individual SHIIP counselors must also report certain information to NCDOT and must meet

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<sup>zzz</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.210(b)(2).

<sup>aaaa</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(3).

minimum activity thresholds (such as providing a minimum number of one-on-one counseling sessions) to be recertified. SHIIP also has a complaint system so that people can provide feedback to NCDOI about specific SHIIP counselors, and individual volunteers can be terminated for cause. SHIIP counselors may not provide advice to individuals about plan selection, they only provide information so that individuals can make their own choice of Medicare Advantage, Medicare Prescription Drug Plans, Medicare supplement, or long-term care insurance plans.

Individual HBE navigators will play a similar role to SHIIP counselors. They will help individuals and families understand plan options, insurance concepts, and how to access and navigate the website (including sorting plans on the basis of premiums, cost sharing, providers, quality, or other factors important to the individual consumers). However, navigators—like SHIIP counselors—are not licensed to provide advice on plan selection. Thus, navigators can help individuals understand their plan choices, but should not offer advice or steer the individual or family to a particular health plan. If an individual or family needs help selecting a health plan, then that person should be referred to a licensed agent or broker.

In order to ensure that individual HBE navigators have the training and competency to assist individuals in understanding their plan choice, the HBE workgroup recommended that the HBE contract with NCDOI to develop a process for training and certifying navigators, including the requirement to pass a competency exam. Navigators should be required to complete continuing education requirements and meet minimum activity thresholds. In addition, navigators should be required to provide certain information to the state, including, but not limited to, information on the number of people served and types of services provided. Navigators should be required to meet these requirements—including continuing education, minimum activity thresholds, and reporting, to obtain their annual recertification. Navigator entities should have a designated person who serves as the navigator coordinator. These coordinators must also be certified as navigators, but will have additional responsibilities and training to serve as the coordinator and oversee the work of individual navigators.

As noted earlier, the ACA requires navigators to give impartial information and advice. To ensure that navigators can provide impartial information, the ACA directs the HBE to have procedures to avoid “conflicts of interest.” Neither the ACA nor the draft regulations give additional detail about how to avoid conflicts of interest, except that individuals may not directly or indirectly receive compensation from health plans. Further, there are very specific rules about potential conflicts of interest for agents and brokers (discussed more fully below). Thus the HBE workgroup discussed mechanisms to prevent navigator conflicts of interest that could inappropriately steer people towards a specific health plan.

Both the safety net workgroup (see Recommendation 4.4 in Chapter 4) and members of the HBE workgroup recognized the important role that safety net organizations could play in helping the uninsured enroll in appropriate health plans. Thus, the workgroup was concerned about creating too strict a definition of conflict of interest that could preclude staff from safety net organizations from serving as certified navigators. The workgroup recommended that the HBE create conflict of interest rules that would preclude an *entity* from serving as a coordinating navigator entity if they would derive financial benefit from steering an individual to a particular health plan or

health insurer. Under this definition, any health care provider that receives differential reimbursement from different insurers would not be eligible to serve as a certified navigator entity or receive navigator funding. However, it was acknowledged that there may be certain situations where the employees of these provider organizations could appropriately serve as certified patient navigators, such as those who work for: (1) safety net providers such as free clinics, FQHCs, rural health clinics, and health departments that provide primary care services to the uninsured and other vulnerable populations; and (2) hospitals or other types of health care organizations in rural or other underserved communities if the HBE or NCDOI certifies that there are insufficient navigators in those communities to meet the need for navigator services and that additional capacity is needed. Employees of these organizations or other individuals can serve as individual navigators as long as the individual, and his or her immediate family members do not receive compensation directly or indirectly from an insurer, and as long as their wages, salary, or job performance is not based on the health plans which individuals select. The HBE should adopt rules, guidance, education, and conflict of interest disclosure requirements, and should specifically monitor these provider-linked navigators to ensure that they comply with the ACA's prohibitions against steering patients to particular plans.

While the HBE is required to provide grants to navigator entities, the HBE may not use federal funds that the state received to establish the HBE for that purpose.<sup>bbbb</sup> The prohibition on the use of federal funds will cause difficulties in the first few years of HBE operations. The HBE will begin to accept applications in October 2013, for initial enrollment on January 1, 2014. The federal regulations specified that the initial enrollment period will run from October 1, 2013 to March 31, 2014.<sup>cccc</sup> The Level II federal HBE grant will be used to pay for all of the initial HBE set up and operational costs through 2014. Depending on the funding source, the HBE may not have separate operational funds until 2014 (at the earliest) or 2015. Thus, while the ACA and accompanying regulations require the HBE to provide grants to navigator entities, it restricts the use of federal funds for this purpose.

The HBE workgroup discussed possible funding sources for the first two years, as well as ways of structuring grants to navigator entities. Although the HBE cannot use federal funds to pay for navigator services, it can use Level II federal funds to develop the navigator training and certification. In addition, outreach and educational expenses are legitimate uses of HBE funding. Thus the workgroup recommended that the HBE use federal funds to pay for training, continuing education, and certification. In addition, the HBE should provide small grants to community-based organizations, social services agencies, professional associations, navigator entities, and other appropriate organizations to provide education and outreach about new insurance options to targeted individuals and small employers. The HBE Board should also seek funding from state philanthropic organizations or other sources to help pay small grants to navigator entities to help offset the administrative costs to coordinate and oversee the work of local navigators. Initially, the HBE should pay each navigator coordinating entity a flat rate, based on size of the targeted population. After the first year, however, the navigator grants should be based, in part, on outcomes so that navigator entities are rewarded for doing a good job with education, outreach,

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<sup>bbbb</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(6).

<sup>cccc</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.410.

and enrollment facilitation. The workgroup suggested that the HBE Board explore the question about whether individual navigators should receive any compensation for their services.

Thus, to ensure that the state operate an effective navigator system, the workgroup recommended:

**RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS**

- a) **The Health Benefit Exchange (HBE) should contract with the North Carolina Department of Insurance (NCDI) to develop and oversee the navigator program.**
  - i. **The NCDI, in conjunction with the HBE, should create a standardized training curriculum along with a competency exam to certify individual navigators.**
  - ii. **Individual navigators should be recertified annually. To be recertified, the navigator must:**
    - A. **Complete continuing education requirements and meet minimum activity thresholds, as specified by the NCDI in conjunction with the HBE.**
    - B. **Provide data to the state to ensure the overall functioning of the navigator system. Such data may include, but not be limited to, information on the number of people served and types of services provided.**
    - C. **Be connected to a specific navigator entity.**
  - iii. **Individual navigators can be terminated for cause.**
  - iv. **Navigator entities should have a designated person who serves as the navigator coordinator. These coordinators must also be certified as navigators, but will have additional responsibilities and training to serve as a coordinator and oversee the work of individual navigators in their community.**
- b) **The HBE Board shall create strong conflict of interest rules for individual navigators and navigator entities. The conflict of interest rules should:**
  - i. **Preclude navigator entities from serving as a coordinating entity if they would derive financial benefit from steering an individual to a particular health plan or health insurer.**
  - ii. **Allow employees of primary care safety net organizations (eg, FQHCs, free clinics, rural health clinics, or health departments) or other individuals to serve as individual navigators as long as the individuals, and their immediate families, do not receive compensation directly or indirectly from an insurer, and as long as their wages, salary, or job performance is not directly or indirectly based on the health plans which the individual selects. The HBE Board can allow employees of hospitals or other health care organizations to serve as navigators in rural or other underserved communities, but only if the HBE Board certifies that there is insufficient navigator capacity in those communities to meet the needs of individuals seeking navigator assistance. The HBE should adopt rules, guidance, education, and conflict of interest disclosure requirements, and should specifically monitor these provider-linked navigators to ensure that they comply with the ACA’s prohibitions against steering patients to particular plans.**
- c) **If allowed by the federal government, the HBE should use federal funds to help pay for training, continuing education, and certification of individual navigator and navigator entities. In addition, the HBE should provide small grants to community-based organizations, social services agencies, professional associations, navigator entities and other appropriate organizations to provide education and outreach about new insurance options to targeted individuals and small employers.**

- d) The HBE Board should seek funding from state philanthropic organizations or other sources to help pay small grants to navigator entities to help offset the administrative costs to coordinate and oversee the work of local navigators.**
- i. In 2013, the HBE should pay each navigator coordinating entity a flat rate based on size of the targeted population.**
  - ii. Thereafter, the navigator grants should be based, in part, on outcomes so that navigator entities are rewarded for doing a good job with education, outreach, and enrollment facilitation.**
  - iii. The HBE Board may explore the option of compensating individual navigators for their services.**

*Agents and brokers.* Agents, brokers, or other people who receive compensation directly or indirectly from insurers may not serve as navigators, although the state or HBE can allow agents or brokers to enroll individuals, small businesses, or eligible employees into QHPs offered through the HBE.<sup>dddd</sup> However, agents and brokers also need training to help enroll individuals, small businesses, or their employees into a qualified health plan offered through the HBE. Agents and brokers need to understand the different insurance affordability programs (including Medicaid, CHIP, and the insurance subsidies offered through the HBE). In addition, agents and brokers need to understand the small business tax credit available through the HBE. Thus, the workgroup recommended that agents and brokers receive training, be certified, and subject to continuing education requirements in order to be allowed to enroll individuals or small businesses into coverage offered through the HBE.

Agents and brokers are in the best position to provide information and advice to small employers as employers need to weigh many factors in deciding whether to offer health insurance coverage and what type of coverage to offer. For example, businesses need to understand the financial implications of offering group health insurance coverage in terms of tax deductibility. Businesses also need to consider whether to offer health insurance through a Section 125 plan, and whether it is more advantageous to purchase health insurance inside or outside the HBE. And businesses need to understand the implications of whether to offer their employees one plan or a choice of plans in a particular metal level. Agents are licensed to sell health insurance coverage outside the HBE, and many will also receive the training and certification to sell coverage inside the HBE. Navigators will not be trained to provide this level of information. Thus, the workgroup recommended that small employers who need more information or advice should be funneled to an agent or broker rather than a navigator.

While HBE workgroup members recommended that small businesses generally be referred to agents for assistance, the workgroup did recognize that there are some concerns in relying primarily on agents and brokers to service small employer groups. The ACA is very specific on reducing conflicts of interest among navigators, but the law does not specifically prohibit conflicts of interest if the agent/broker is not compensated as a navigator. Currently, there are many different ways in which agents and brokers are either directly, or indirectly, encouraged to steer clients to specific insurers. For example, carriers often limit the number of agents or brokers they appoint to represent them. As a result, agents can be “captive” to a particular insurer or group of insurers. Agents who are captive can only sell products for those specific insurers.

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<sup>dddd</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.220.

Other agents are independent, but may still have a financial incentive to steer clients to a specific insurer. For example, some insurers pay higher commissions after an agent or broker places a certain level of business in that company.

Further, typical compensation arrangements make it financially prohibitive for agents and brokers to service the smallest employer groups (ie, those with <10 employees). It often costs more to agents and brokers and insurers on a per person basis to provide services to small groups, as there are certain fixed costs that are spread among a smaller group of covered lives. In addition, small groups generally lack human resource staff, so look to agents and brokers to handle many of the functions that larger organizations handle internally. If agents or brokers are paid a flat commission per covered life, the aggregate fee may be insufficient to cover the costs of servicing these small groups. To make it more difficult, some insurers pay agents or brokers progressively higher commissions, depending on the size of the group. The workgroup discussed the possibility of paying agents and brokers more for smaller groups, recognizing the higher costs in providing services to small employers. However, if insurers pay higher commissions for some groups over others, the additional commission rate will be spread over all of the insurers' small group business as insurers must essentially charge the same premium for different small businesses. (Insurers can only vary rates based on age and family composition of the covered individuals and geography. Insurers may not charge differential premiums based on differences in administrative expenses of covering different small employer groups).

Just as the HBE workgroup wanted to minimize the potential conflict of individual navigators or navigator entities, the group wanted to also minimize the potential conflict of interest among agents who place business in the HBE. In addition, the workgroup wanted to ensure that agents and brokers are adequately compensated for working with the smallest employers, as these groups are the least likely to currently offer coverage and often need more help in understanding their different insurance options operating inside and outside the HBE. The workgroup made a number of recommendations to address these potential problems. First, the HBE should not refer small businesses to agents or brokers who are “captive” agents, or who are restricted to selling certain limited number of plans. In addition, the HBE workgroup recommended that agents disclose if they receive differential commissions from different insurers.

In addition, the workgroup wanted to ensure that agents and brokers have no disincentive to place business in the HBE. Thus, the HBE workgroup recommended that the NCDOI require insurers to pay agents and brokers the same commission, whether placing business inside or outside the HBE. The workgroup also recommended that the NCDOI, in conjunction with the HBE, examine other options to reduce potential conflicts of interest—such as paying agents or brokers a standard amount per enrollee regardless of the insurer, and paying the same rate for individuals enrolled in nongroup coverage as for employees enrolled in a group health plan.

To encourage agents and brokers to educate and enroll small businesses that had not previously offered insurance coverage, the workgroup recommended that NCDOI and the HBE examine whether agents should be paid differentially for enrolling small businesses that have not offered health insurance coverage within the last six months. The workgroup also recommended that the NCDOI and HBE examine whether agents and brokers should be paid a higher rate per person for the smallest groups, and a lower rate per person as the size of the employer increases.

The HBE workgroup also discussed barriers which discourage small businesses from offering coverage to their employees. The cost of health insurance coverage is typically cited as the primary barrier to offering coverage. However, some small businesses have difficulty meeting insurers' minimum participation rates. Under current law, insurers set minimum participation rates—for example, that 75% of eligible employees must enroll in the insurance coverage—to prevent adverse selection into the plan. The ACA allows the SHOP to set minimum participation requirements for group coverage.<sup>cccc</sup> Some of the HBE workgroup members argued that there was less need to set minimum participation rates after the ACA is fully implemented, as more people will have insurance coverage and, therefore, there will be less possibility of adverse selection. Others argued that the mandatory insurance coverage provisions apply in the nongroup market, but do not change the dynamics in the small group market as small employers with fewer than 50 full time equivalent employees are not required to offer coverage. Thus, there is still a need for minimum participation rates to prevent adverse selection. Because this was an issue that affected small groups both inside and outside the HBE, the workgroup recommended that the NCDOI Technical Advisory Group consider whether the state should eliminate minimum participation requirements.

To address these concerns, the HBE workgroup recommended:

**RECOMMENDATION 2.8. REQUIREMENTS FOR AGENTS AND BROKERS SELLING COVERAGE IN THE HBE**

- a) **The Health Benefits Exchange Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the HBE.**
  - i. **The HBE should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The training and certification should include, but not be limited to, information about the different insurance affordability programs (including Medicaid, CHIP, and insurance subsidies offered through the HBE), how to use the HBE website, and the small business tax credit.**
  - ii. **Small businesses that contact the HBE or call center, that need additional information and advice, should be directed to an agent or broker rather than an individual navigator. However, the HBE should only refer small businesses to independent agents or brokers who are able to sell any of the qualified health plans offered in the HBE.**
- b) **The North Carolina Department of Insurance, in conjunction with the HBE, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the HBE, encourage agents and brokers to work with the smallest employers (with 10 or fewer employees), and encourage agents and brokers to reach out to small businesses that had not recently provided employer sponsored insurance coverage. As part of this analysis, NCDOI and NCHBE should consider the impact of any changes in agent and broker compensation on overall agent/broker compensation, insurers' medical loss ratio, and on premium prices in the nongroup and small group market. As part of this analysis, NCDOI and the HBE should consider whether to:**
  - i. **Pay agents and brokers a standard commission per enrollee regardless of the insurer.**
  - ii. **Require insurers to pay agents and brokers the same standard commission, whether placing business inside or outside the HBE.**

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<sup>cccc</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.705(b)(10).

- iii. **Pay agents and brokers a standard commission for each individual whether enrolling in a nongroup plan or group plan.**
- iv. **Require insurers to appoint all licensed agents and brokers in good standing who have been certified to offer insurance inside the HBE as part of the insurers' panel.**
- v. **Pay agents and brokers a higher per person commission or other compensation to encourage agents and brokers to enroll very small groups (eg, groups of under 10 employees).**
- vi. **Pay higher commissions or other compensation to encourage agents and brokers to enroll small businesses that had not offered health insurance in the last six months.**
- c) **If the NCDOL, in conjunction with the NCDOL, does not change agent and navigator compensation structure to prevent conflicts of interest or reduce the incentive to steer individuals or businesses to different insurers or plans inside or outside the HBE, then agents or brokers who place business in the HBE must disclose to their individual and small business clients if they receive differential commissions from different insurers.**

*No wrong door.* The ACA creates a “no wrong door” approach for eligibility and enrollment into any of the insurance affordability programs (ie, Medicaid, CHIP, or subsidized insurance coverage offered through the HBE). For example, the HBE and Medicaid must both use the same streamlined application form.<sup>ffff, gggg</sup> The state must also create an eligibility and enrollment system that allows individuals to apply for any insurance affordability program to which they are entitled without delay.<sup>hhhh, iiiii</sup> In North Carolina, NC FAST is expected to serve as the eligibility system for Medicaid, North Carolina Health Choice, and subsidized coverage through the HBE.

In addition to the specific role of navigators, both the HBE and Medicaid agency have a responsibility to assist people in applying for and enrolling into appropriate public or private health insurance coverage. The HBE must first screen people to assess whether an individual is eligible for Medicaid or CHIP before they can be considered for the insurance subsidies in the HBE. If the HBE identifies people who are potentially eligible for Medicaid or CHIP, the HBE must share information with the Medicaid agency so that an eligibility decision can be made without undue delay.<sup>jjjj, kkkk</sup>

The HBE workgroup recognized that many of the low-income uninsured will first seek information about insurance options through their local department of social services. DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.<sup>llll</sup> In addition, if the person is determined to be ineligible for

<sup>ffff</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.907.

<sup>gggg</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.405

<sup>hhhh</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.345.

<sup>iiii</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.1200(b)(3).

<sup>jjjj</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4).

<sup>kkkk</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.345.

<sup>llll</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.908.

Medicaid, he or she must be screened to enroll into a qualified health plan, and, if eligible, must be able to enroll “without delay.”<sup>mmmm</sup>, <sup>nnnn</sup> Thus, the workgroup recommended that DSS workers be trained and certified as navigators so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the HBE. To make it easier for DSS offices to serve as navigator entities, the HBE workgroup recommended that the state develop data capture mechanisms so that all or most of the data needed for reporting and accountability to the state would be captured through the NCFAST system. Further, the HBE Board should examine options to help offset some of the administrative costs for DSS workers in providing enrollment assistance to individuals who have been determined to be ineligible for Medicaid or North Carolina Health Choice.

The workgroup recognized that not every DSS office would want, or have the resources, to take on the additional workload that could be created by providing advice to people about HBE insurance options. Thus, the workgroup wanted further clarification on what the federal government meant by ensuring that a person was eligible to enroll “without delay.” The workgroup members were concerned that absent immediate assistance, many of the people who seek services from the local social services office might fall through the cracks if they were directed to another agency for care. Assuming that there is some flexibility, the workgroup recommended that the HBE Board create other mechanisms to ensure a “warm hand-off” so that people who are determined to be ineligible for Medicaid or CHIP, can receive immediate assistance from a trained navigator or other trained staff outside of the local social services office.

**RECOMMENDATION 2.9: “NO WRONG DOOR” ELIGIBILITY AND ENROLLMENT**

- a) **Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice eligibility workers are cross-trained and certified as navigators so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the Health Benefits Exchange (HBE).**
  - i. **NCFAST should design the eligibility and enrollment system to electronically capture data needed for oversight of navigators.**
- b) **If allowed under federal law, the HBE Board, working with the North Carolina Division of Social Services, North Carolina Division of Medical Assistance, and Social Services Directors Association should create other mechanisms to ensure that people who seek in-person services from local DSS, who are determined to be ineligible for Medicaid or CHIP, can receive immediate assistance from trained navigators or other trained staff outside of the local DSS offices.**
- c) **The HBE Board should examine options to help offset some of the administrative costs for DSS workers in providing enrollment assistance to individuals who have been determined to be ineligible for Medicaid or North Carolina Health Choice.**

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<sup>mmmm</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §2201, enacting §1943(b)(1)(C) of the Social Security Act, 42 USC 1396w-3(b)(1)(C).

<sup>nnnn</sup> United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.1200(e).

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