EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 2: HEALTH BENEFITS EXCHANGE

OVERVIEW

In 2011 one in five non-elderly North Carolinians lacked health insurance coverage. In some counties in North Carolina more than 25% of adults lack health insurance coverage (See Appendix B.) Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Health Benefits Exchange (Exchange). The ACA requires that each state have an Exchange 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 Exchange, the federal government will create one to offer coverage to individuals and small groups in the state.

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

The Exchange was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The Exchange may also 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 Exchange may 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 Exchange 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 Exchange, must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[5] Each state had the opportunity to define its own essential health benefits package (using benchmarks defined by the US Department of Health and Human Services (US DHHS)) that includes coverage of these services. States were given until December 26, 2012 to make their selection.[6] The proposed regulations specified a default plan for states that did not selected their own essential health benefits plan which will be the benchmark for 2014 and 2015. North Carolina did not select its own plan so it will rely on the default plan. The default plan is the largest Blue Cross and Blue Shield of North Carolina

small group product, which is a Blue Options PPO plan.[7] In addition, the plan must be supplemented with pediatric oral and vision coverage, as well as habilitative services. The default plan for pediatric oral and vision services is coverage offered through the Federal Employees Dental and Vision Program. In addition, all insurance plans that are not grandfathered[8] 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.[9] Insurers must also provide additional preventive services for infants, children, adolescents, and women.[10]

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).[11] 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 Exchange 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 as well as to individuals exempt from the mandate to purchase coverage.[12]

The ACA includes subsidies to make health insurance coverage more affordable through the Exchange. The subsidies are available to single individuals or families with modified adjusted gross income (MAGI) of between 100 - 400% of FPL, if they do not have access to affordable employer-sponsored insurance (ESI) and do not qualify for public coverage such as Medicaid.[13,14] (Table 2.1) In North Carolina, almost 900,000 of the 1.6 million uninsured North Carolinians had family incomes between 100-400% FPL. (See Appendix B.) 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 essential health benefits portion of the premium for the second lowest cost silver plan offered in the Exchange. As long as the family purchases the second lowest cost silver plan then the maximum that the family generally would have to pay is based on a percentage of their income (ranging from 2% for lower income families to 9.5% for those whose incomes are between 300-400% FPL).[a] 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.

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) for the essential health benefits if they enroll in a silver plan. American Indians

[a] Individuals or families may have to pay a higher percentage of their income in premiums if they purchase a more expensive policy (e.g., one that costs more than the second lowest cost silver plan); they purchase coverage that includes additional services beyond the essential health benefits; or the individual or any family members smoke. The subsidies do not apply to covered services that are not part of the essential health benefits or to the tobacco surcharge (if any).

with incomes below 300% FPL pay no cost sharing.[15] 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 Exchange in order to receive the premium tax credit and cost-sharing subsidies.

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[€]	Out-of-pocket cost-sharing limits (Proportion of the Health Savings Accounts (HSA) out-of-pocket cost-sharing limits)[¥] [β]
Families eligible for subsidy			
100-133% FPL[χ]	2%	6%	$2,250 (individual)/ $4,500 (more than one person) (1/3 HSA limits)
133-150% FPL	3-4%	6%	$2,250/$4,500
150-200% FPL	4-6.3%	13%	$2,250/$5,500
200-250% FPL	6.3%-8.05%	27%	$5,200/$10,400 (4/5 HSA limit)
250-300% FPL	8.05-9.5%	30%	$6,400/$12,800
300-400% FPL	9.5%	30%	$6,400/$12,800
Families not eligible for subsidies			
400%+ FPL	No limit	30%	$6,400/$12,800 (HSA limit)

[χ] Immigrants who are lawfully present in the United States for less than five years can qualify for a subsidy if their income is less than 100% FPL. Citizens and immigrants who are lawfully present in the United States for five years or more are not eligible for subsidies unless their income is at least 100% FPL. Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1401(c)(1), enacting Sec. 36B of the Internal Revenue Code of 1986.

[€] Out-of-pocket cost sharing includes deductibles, coinsurance, and copays.

[¥] Out-of-pocket limits do not include premiums, costs associated with non-covered services, or costs incurred from out of network providers. Annual cost sharing limited to $6,400 per individual or $12,800 per family in 2014 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. United States Department of Health and Human Services. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014. Proposed Rule. *Fed Regist* 2012;77(236):73117-73218. December 7, 2012. http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf. Accessed January 23, 2013.

[β] 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.

In addition to the subsidies available to individuals, the ACA also includes tax credits to help small businesses purchase health insurance coverage.[16] 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 Exchange.

The North Carolina Department of Insurance (NCDOI) contracted with Milliman, Inc., an actuarial consulting firm, to develop estimates of the number of people who might gain coverage in the Exchange and examine other Exchange operational and design issues. According to Milliman, approximately 715,000 North Carolinians are expected to obtain their health insurance coverage through the Exchange beginning in 2014.[17] (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 Exchange; 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 Exchange in the first year are expected to have been uninsured in 2013. The remaining 360,000 estimated Exchange enrollees will have had health insurance coverage in the past, and the majority of these are expected to qualify for subsidies to purchase coverage through the Exchange.

Table 2.2
Changes in Insurance Coverage (2013-2014)

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

[χ] Milliman prepared the estimates of the number of people who may gain coverage through the Medicaid expansion before the US Supreme Court decision in *National Federation of Independent Business vs. Sebelius*. As is discussed more fully in Chapter 3, the US Supreme Court held that the Medicaid expansion is voluntary to the states. Thus, the number of people who may potentially become eligible for Medicaid will be largely dependent on whether, and if so, when North Carolina chooses to expand Medicaid to cover low-income people with incomes up to 138% FPL.

Three quarters of the people who purchase coverage directly through the Exchange are expected to be eligible for the premium tax credit and cost-sharing subsidies. Of all the individual market enrollees in the Exchange, 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.[18] Only 25% are estimated to have incomes above 400% FPL.

The number of people expected to obtain coverage through the Exchange 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.

EXCHANGE REQUIREMENTS

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

- Certify, recertify, and decertify qualified health plans, Co-op plans, and federally approved multi-state plans as specified by the Secretary.[19, 20]
- 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.[21, 22]
- Develop and maintain a website that provides standardized comparative information on plan options including costs, quality, and provider networks.[23, 24]
- Assign a quality rating to each qualified health plan offered through the Exchange using criteria developed by the Secretary.[25 , 26]
- Determine eligibility for the premium tax credit and cost-sharing subsidies.[27, 28]
- 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.[29, 30]
- Establish and make available an electronic calculator for determining the costs of coverage after applicable premium tax credits and cost-sharing reductions.[31, 32]
- Certify individuals who are exempt from the requirement to purchase health insurance.[33,34]
- 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.[35]
- 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.[36]
- Provide information to employers of any employee who ceases coverage under a qualified health plan.[37]
- Establish a navigator program to provide information to the public about health plan choices and to help them enroll.[38,39]
- Consult with relevant stakeholders to carry out required activities.[40 , 41]

- Publish average costs of licensing, regulatory fees, and other payments to the Exchange and administrative costs.[42, 43]
- Report on activities, receipts, and expenditures annually to the Secretary of the USDHHS.[44]
- Consider information from employers that contest the imposition of penalties.[45]

States can create one Exchange that covers both individuals (nongroup) and small businesses, or can create two Exchanges. In general, the requirements for the Exchange 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 "metal" level of coverage (e.g., bronze, silver, gold, platinum) so that their qualified employees could choose any plan within a specific tier.[46] The SHOP can offer other employee choice options to employers (e.g., single option, defined set of options within or across metal levels, or full choice). The SHOP must also provide an option for premium aggregation services for small businesses that choose to offer their employees a choice of plans.[47] 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 for state-based Exchanges established for plan year 2014 operations (with the exception of Navigator grants, discussed more fully below). However, the Exchange must be financially self-sufficient beginning January 1, 2015, or after the first year of operation if established later than the 2014 plan year.[48,49] The ACA envisions that the Exchange 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.[50]

States that choose to operate their own Exchange in 2014 must have submitted a letter of intent and their blueprint to 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 by December 14, 2012.[51,52] States must then have a conditionally approved plan by January 1, 2013, and then be able to demonstrate operational readiness sometime before October 1, 2013 (at a date to be specified by the federal government).[53] CCIIO provided states guidance as to what will be required to show operational readiness.[54] To be certified, Exchanges must show their ability to perform the following core functions:

- *Consumer Assistance*, including education and outreach, navigator management, call center operations, website management, consumer support assistors, and written correspondence with consumers to support eligibility and enrollment.
- *Plan Management*, including plan selection, 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.

States that have decided not to operate the full Exchange in 2014 have other options. They can choose to assume responsibility for some consumer assistance functions, plan management functions, or both on behalf of the federally-facilitated Exchange.[55,56] These states must notify the federal government of their decision to operate a partnership plan by February 15, 2013.[57] States that decide not to operate their own Exchange in 2014 may also choose to operate a state-based Exchange at a later date, as long as they submit a blueprint by November two years prior to the first plan year and receive approval from DHHS one year prior to the assumption of the Exchange. However, the last application date for federal funding to help create a state-based Exchange is in October 2014.

STATE DESIGN ISSUES

The state has many options in implementing the Exchange provisions of the ACA. **First and foremost, the state must decide whether it wants to create its own Exchange or leave it to the federal government to implement.** The effective and efficient operation of the Exchange 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 Exchange. The Health Benefits Exchange (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 Exchange within an existing state agency.[58]

The North Carolina House of Representatives passed legislation in 2011 (HB 115), which would have created a state-based Exchange. This bill did not pass the Senate in the 2011 or 2012 Sessions. Although the legislature did not pass legislation creating a Exchange, it did pass legislation stating its intent to create a Exchange within the state, and directing 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 in June 2011. North Carolina was successful in obtaining a $12.4 million dollar grant. Level I grants provide funding for one year (with an opportunity for extension) to begin the process of creating a state-based Exchange. North Carolina's Level I grant period was extended by a year and now runs from August 15, 2011 through August 13, 2013. NCDOI submitted an application in November 2012 for a second Level I establishment grant to continue to prepare for an Exchange. The grant has not yet been awarded.

Since the NCGA did not implement legislation creating a state-based Exchange in the 2012 session, the state will not be able to meet the requirements to show operational readiness by January 1, 2013. Thus, the federal government will operate a federally-facilitated Exchange for North Carolina beginning in January 2014. However, North Carolina has chosen to move forward with a partnership plan assuming some consumer assistance and plan management functions on behalf of the federally-facilitated Exchange (discussed more fully below).[59] This leaves the option for the state to pursue a full state-based Exchange sometime in the future.

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). CMS extended the deadlines for Level I and Level II grant applications through 2014.[60] In order to apply for a Level II grant, the state must have authorized the creation of the Exchange with an appropriate governance structure. In addition, the Exchange 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.[61]

When NCDOI received the first Level I establishment grant, it was still operating under the assumption, based on Sec. 49 of Session Law 2011-391, that North Carolina would be creating its own state-operated Exchange beginning 2014. Thus, the Level I establishment grant was used to develop plans to build some of the key components needed to show operational readiness, including developing requirements for the necessary information technology (IT) systems, and strengthening the existing consumer assistance program. The North Carolina Level I establishment grant has been used to do the following, among other activities:

- Engage stakeholders and perform policy analysis on policy issues.
- Develop requirements to expand NCDHHS eligibility IT system to include needed Exchange functionality and expanded user base.
- Develop requirements to build or procure non-eligibility IT systems.
- Establish capacity to provide assistance to individuals and small businesses seeking health insurance.
- Develop comprehensive work plan and budget through 2015 to support anticipated future Level II grant application.

NCDOI contracted with the NCIOM to continue the work of the HBE workgroup and solicit stakeholder input into some of the Exchange 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 Exchange. The two groups were charged with examining different implementation and design issues. (Table 2.3) In general, the HBE workgroup considered those issues unique to the Exchange, and the NCDOI TAG considered those issues which affect health plans both inside and outside the Exchange. The NCIOM HBE workgroup completed its work in April 2012; the work of the NCDOI TAG is ongoing. The first phase NCDOI TAG work was provided to the NCGA in a report in May 2012.[62]

Table 2.3
Design Issues Considered by NCIOM HBE Workgroup and NCDOI Technical Advisory Group

NCIOM HBE Workgroup Issues	NCDOI TAG Issues
• Whether to operate a state-based Exchange or create a partnership Exchange • High level QHP certification options • Exchange sustainability options • Preliminary evaluation planning necessary for a Level II implementation grant • The roles, training, and certification requirements for agents, brokers, navigators, volunteer counselors and other community based organizations • Preliminary discussion of the essential community providers requirements	• Whether to merge the individual and small group market risk pools • Whether to allow groups of more than 50 to purchase QHPs in the Exchange in 2014 • Whether to change the North Carolina laws regarding self-funding and stop-loss coverage for small group plans • Whether to modify North Carolina small group insurance laws to comply with federal definitions for small group (e.g., whether to include groups of one, definition of employee) • The role of the state, if any, in administering the risk adjustment and reinsurance programs, and preliminary plans for program development if applicable • Mechanisms for assuring a level playing field inside and outside the Exchange (i.e., to mitigate adverse selection) • Geographic rating areas and other rating factors • Analysis of essential health benefits options for North Carolina • Operationalizing the essential community provider requirements

RECOMMENDATIONS

The HBE workgroup met 16 times from August 2010 to April 2012. In addition, a subcommittee met on four occasions to examine options for the navigator program. The information in this chapter will be most relevant to the state if the NCGA chooses to create a state-operated Exchange sometime in the future. Even absent this determination, much of this information will be useful to the state if it chooses to move forward with a partnership option. This information will also be presented to the Exchange Board (if created).

State-Based or Partnership Exchange

As noted earlier, the ACA gives states the authority to create its own Exchange or leave it to the federal government to operate an Exchange on the state's behalf. However, in subsequent regulations and policy guidance, the USDHHS set forth a proposed hybrid approach—called a "partnership" Exchange option.[63] 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 Exchange operational options: state operated, federally facilitated, or partnership. More detailed information is provided below.

Table 2.4
Overview of Different Exchange Operational Arrangements

	State Operated Exchange	Federally Facilitated Exchange	State-Federal Partnership
Consumer Assistance	State	Federal, with some harmonization to state laws	State option to develop and operate in person assistance program and help manage federal Navigator program
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

Although workgroup members recommended that North Carolina create and operate its own Exchange, it did consider the partnership option. At the point that the workgroup considered this option, it was unclear which operational functions could be assumed by the state under the partnership option. Therefore, the workgroup examined all of the Exchange core functions to determine which functions would best be handled by a state agency or state-based Exchange, and those that would best left to 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 NCDHHS and local social services agencies. In addition, NCDOI already operates a successful consumer assistance program—Health Insurance Smart NC (Smart NC) —which helps consumers with insurance related questions, complaints, appeals, and external review. 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 Exchange 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 Exchange website, but they also recognized that the federal government would need to get a lot of the underlying data from the NCDOI. Thus, there was more of a consensus that the state-based Exchange 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 Exchange plan management functions will be similar to traditional regulatory oversight functions, and are integral to the oversight of health plans offered through the Exchange. Further, the NCDOI will continue to regulate insurers outside the Exchange. Thus the state should also regulate and oversee plans operating within the Exchange. To minimize the possibility of conflicting rules operating inside and outside the Exchange, the workgroup recommended that a state-based Exchange (if created), along with NCDOI, assume responsibility for plan management. In addition, the workgroup recommended that the Exchange rely on the NCDOI for several of the Exchange functions, including, but not limited to, rate approval, evaluation of plans against the QHP certification standards (e.g., accreditation, quality, etc.), analysis of data submitted to identify discriminatory benefit design, and market regulation, as NCDOI regularly performs these functions as part of it regulatory oversight of plans. This will help streamline the certification process, and reduce duplicative regulatory oversight of insurers.

The Exchange imposes new responsibilities that may not be fully addressed as part of the current NCDOI regulations. For example, the Exchange must establish network adequacy standards to ensure that the QHP offers a sufficient choice of providers.[64] If the state does not have its own network adequacy standards, the federal government will create standards for plans operating in the Exchange.[4] While NCDOI does not have specific network adequacy rules; it requires health plans with networks to develop their own standards and measures the plans against those standards.[65] Additionally, there are protections in place for consumers who are not able to access network providers.[66] Based on the final Exchange 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 Exchange Board (if created) should have the authority to adopt standards for qualified health plans offered in the Exchange. In addition, the workgroup also recommended that the state assign quality ratings to the different plans, within the criteria established by the USDHHS. One of the advantages of having North Carolina 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. The workgroup recommended that a state-based Exchange 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 Exchange 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 MAGI. The IRS has responsibility for reconciling the amount of the premium tax credit that the individual received through the Exchange with the amount they are ultimately eligible to receive based on year-end taxes. As the IRS will be responsible for this reconciliation function, work group members thought it made more sense for the federal government to also make the initial eligibility decision about the premium tax credit and cost-sharing subsidy. Similarly, the workgroup members recommended that the federal government determine whether a person is exempt from the mandate, as for many people, the person's MAGI will be critical to this determination.

In addition, the workgroup recommended that the federal government assume responsibility for determining whether an employer is offering minimum essential coverage. In order to make this determination, the Exchange 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. 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 Exchange 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 Exchanges).

Enrollment. In general, the workgroup members recommended that the state-based Exchange maintain responsibility for enrolling and disenrolling people in QHPs. Workgroup members believed that a state-based Exchange could provide better customer service helping people enroll and disenroll. Further, the Exchange 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 Exchange or NCDOI review.

Financial management. Workgroup members supported having the state-based Exchange have primary responsibility for financial management of the Exchange, specifically setting and collecting any assessments. This option is only available if the state chooses to operate a state-based Exchange. CCIIO recently published guidance on the fees it will charge participating insurers to support the operational costs of the federally-facilitated Exchange.[67] In 2014, the proposed user fee is 3.5% of the premium costs for plans sold through the federally-facilitated Exchange; however, the final user fee may be changed to closer align with fees charged by other state-based Exchanges.[68] If the state operates the Exchange, it has greater control over the costs

of the Exchange and how the Exchange 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 were discussed with NCDOI's TAG.[69]

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

RECOMMENDATION 2.1: STATE AND FEDERAL EXCHANGE OPERATIONAL RESPONSIBILITIES

a) The North Carolina General Assembly should create a state-based Health Benefits Exchange. The state-based Exchange should be responsible for most of the operational aspects of the Exchange, including consumer assistance, plan management, eligibility, enrollment, and financial management. However, after the Exchange 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 Exchange Board should consider the costs of providing these functions through a state-based versus federally facilitated Exchange, 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 Exchange should have any discretion to modify QHP participation requirements if necessary to enhance Exchange operations. Specifically, the workgroup explored the question of whether the Exchange Board should have the authority to: limit the number or type of plan designs, require insurers participating in the Exchange 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 Exchange should have the flexibility to give health plans more time to meet the ACA's accreditation standards, and whether the NCGA, NCDOI, or the Exchange should establish network adequacy standards.

With some caveats, the workgroup members reached consensus about giving the Exchange 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 Exchange, meet the needs of consumers, reduce adverse selection into the Exchange 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 Exchange 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 Exchange 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 Exchange 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 Exchange, participation of health plans in the Exchange, appropriate competition among plans, adverse selection into the Exchange and/or among participating plans in the Exchange, the overall functioning of the Exchange, and the impact of any changes on the non-Exchange health insurance market.

Notwithstanding the above, the workgroup agreed that the Exchange 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 Exchange have the authority to limit the number of plan or benefit designs within each 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. In recommending that the Exchange Board have authority to limit benefit design, the workgroup was not recommending that the Exchange Board have the authority to limit 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 Exchange is providing consumers and small businesses with a choice of health plans—in terms of premium levels, out of pocket costs, and plan design. To facilitate meaningful choice, the Exchange 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 Exchange 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 Exchange. However, if the Exchange 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 Exchange 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 proper functioning or based on consumer or employer feedback. The Exchange 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 Exchange Board may choose to limit the number or types of different health plans offered by any insurers, the group did not recommend that the Exchange exclude any insurer from participating in the Exchange if it otherwise met the certification requirements.

Require insurers participating in the Exchange to offer three or four of the metal plans. The ACA requires all issuers participating in the Exchange 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 Exchange 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 levels of 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 (e.g., 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 Exchange 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 Exchange Board should have the authority to require health plans to offer 3 or 4 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 Exchange 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.[70] Exchanges must assign a quality rating to each plan on the basis of relative quality and price.[71] The Secretary of USDHHS will establish standards for the quality rating system, and will also collect enrollee satisfaction information on all health plans.[72] In addition, the ACA directs the Secretary to develop strategies to further reward quality of care through market based incentives.[73]

The HBE workgroup discussed whether the Exchange should have the authority to impose any 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 Exchange 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 Exchange should have flexibility to require that insurers meet additional quality standards, the group could not reach consensus on this point. [74] 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 Exchange 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 Exchange shop and compare website).

Require insurers participating in the Exchange 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 Exchange 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 Exchanges the authority to establish the length of time in which an insurer must receive outside accreditation following initial certification in the Exchange.[75] 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 Exchange Board, in exceptional circumstances, have the flexibility to provide plans with additional time beyond two years to obtain initial accreditation.

Network adequacy standards. The federal regulations require that Exchanges 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.[76] Qualified health plans must meet the state established network adequacy standards.[77] 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 Exchange should establish standards for plans offered in the Exchange, or whether 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 Exchange. The workgroup also recommended that NCDOI include some flexibility in the network adequacy standards, if needed to test innovative or quality-driven delivery models. This issue of creating minimum network adequacy standards both inside and outside the Exchange was referred to the NCDOI TAG for further consideration.

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.[78] 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.[79] The intent of this provision is to "strengthen access in medically-underserved areas and for vulnerable populations,"[80] and link to the general network adequacy standards, which are intended 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."[81] The final Exchange 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."[82] There are also special contracting and payment rules for contracts with Indian health providers.

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.[83] 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,"[84] 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.[85]

The workgroup members agreed that the Exchange 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 Exchange Board is broadly constituted with diverse membership, the NCIOM recommended:

RECOMMENDATION 2.2: HEALTH BENEFIT EXCHANGE BOARD AUTHORITY FOR EXCHANGE CERTIFICATION

a) **The North Carolina General Assembly should give the Health Benefits Exchange (Exchange) Board the authority to:**
   i. **Require insurers offering qualified health plans in the Exchange 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 Exchange determines that there is a reasonable level of choice in the Exchange market. Any restrictions in benefit design should not limit simple differences in co-pays or 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 Exchange Board should not have the authority to exclude insurers from participating in the Exchange if they otherwise meet the certification and other ACA requirements.**

c) **Aside from allowing the Exchange Board to standardize terminology, plan design, or limit the number of different plan designs per level (Sec. a.i. above), the Exchange Board should not impose any other new requirements earlier than 2016. Thereafter, before imposing new requirements on health plans, the Exchange Board should consider the likely impact of those requirements on the overall functioning of the Exchange, the needs of consumers and/or employers purchasing in the Exchange, 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 Exchange, participation of health plans in the Exchange, adverse selection into the Exchange and/or among participating plans in the Exchange, and, in consultation with the North Carolina Department of Insurance, the impact of any changes on the health insurance market operating outside the Exchange.**

d) **The Exchange Board should give insurers applying to become qualified health plans 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 Exchange 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: DEVELOP 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 Exchange. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.

RECOMMENDATION 2.4: MONITOR ESSENTIAL COMMUNITY PROVIDER PROVISIONS
The Health Benefit Exchange 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 Exchange 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 Exchange, and/or provide incentives to encourage insurers to contract with a greater number of essential community providers.

After the work of the NCIOM HBE workgroup was completed, the NCDOI TAG considered and made recommendations to the NCDOI about how to operationalize the essential community provider provisions. Summaries of the NCDOI TAG recommendations and deliberations are available on the NCDOI website: http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx.

Exchange Sustainability Options
Federal funding necessary to create and operate a state-based Exchange is only available through the first year of operations (2014 if the Exchange is state-based in the first year). Thereafter, the Exchange 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.[86] 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 funding for Exchange operations.[87] As noted earlier, HHS proposed rules state that HHS will charge a user fee of 3.5% of premium costs for plans sold in the federally-facilitated Exchange in 2014.[88]

Milliman Inc. prepared a preliminary estimate of the ongoing operational costs beginning in 2014 of a North Carolina state-based Exchange. Milliman estimated that the North Carolina Exchange operations would cost approximately $23.8 million in 2014, $25 million in 2015, and $26.7 million in 2016.[17] This equates to roughly 0.5% of Exchange premiums in 2014. 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 Exchange providing bare minimum services, including functions related to Exchange 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 change depending on the Exchange's design and operational features. Because Milliman prepared its estimate before the preliminary regulations were issued, it did not include all of the Exchange operational requirements specified in the federal regulations. For example, the Milliman estimate does not include the costs of premium aggregation for small businesses (an Exchange 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 and duration 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' Exchange cost estimates. Table 2.5 reflects the information provided to the HBE workgroup from PCG.

Table 2.5
Comparison of North Carolina Estimated Exchange Costs with Other States

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

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

PCG cautioned that it was difficult to compare the Exchange 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 Exchange 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 is 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 Exchange operations. The group recommended that any new premium tax revenues generated as a result of the implementation of the ACA be put into a trust fund and designated for the Exchange 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 Exchange 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.[89] 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).

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 NCGA 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.[90] 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 Exchange 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 Exchange's budget requirements, the HBE workgroup also recommended that the NCGA pass through the revenues it uses to support Inclusive Health. After the workgroup finished its work, staff at Inclusive Health reported that they did not receive any premium payment support in SFY 2012

because premium collections for all types of insurance products collected that year were less than the base fiscal year amount from 2006-2007.[91] First quarter SFY 2013 projections are comparable to SFY 2012 projections, which means that it is unclear there will be any payment in SFY 2013. Beginning in 2014, individuals who were receiving coverage through the state or federal high risk pool will gain coverage through the Exchange. Inclusive Health will no longer be needed to provide coverage to these high risk individuals. Thus, any remaining funds should be transferred to the Exchange to support operations, net the reserves needed to pay outstanding health bills.

One of the primary advantages of financing the Exchange 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. The workgroup believed that another potential advantage would be that the federal government could 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 (e.g., 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 Exchange. Thus, workgroup members also recommended that the Exchange be given other mechanisms to raise needed funding if the Exchange trust fund does not generate sufficient revenues to cover the Exchange's operational expenses from the premium taxes.

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

- *Advertising fees*. These fees may not generate significant revenues. Further, the administrative costs of collecting and selling advertising would reduce the revenues that could be used for Exchange operations. In addition, advertising health plans that were offered through the Exchange could reduce the effectiveness of the Exchange 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 Exchange board should establish criteria for the types and placement display of potential advertising.
- *User fees on insurers operating within the Exchange*. Workgroup members discussed the imposition of additional user fees on insurers operating within the Exchange. Some members were concerned that adding additional user fees on insurers offering coverage within the Exchange might discourage health plans from participating in the Exchange (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 Exchange, an additional user fee charged to health plans operating in the Exchange might result in

higher premiums outside the Exchange. 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 level, in order to discourage insurers from offering large numbers of plan designs in each level. The additional fees would also help offset the additional administrative costs in certifying and overseeing all of the new plans offered within the Exchange.

- *User fees on individuals purchasing within the Exchange*. Workgroup members also discussed the possibility of charging a user fee to individuals who purchased coverage within the Exchange, if allowed under federal law. However, workgroup members were concerned that imposing a fee on users in the Exchange would discourage people from purchasing coverage in the Exchange. Further, many individuals could be gaining the benefits of the Exchange (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 Exchange. Thus, workgroup members also discussed the option to charge fees for individuals both inside and outside the Exchange.
- *Foundation funding*. The Exchange 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 Exchange 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 Exchange 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 Exchange 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 Exchange operational costs.

Thus, the NCIOM recommended:

RECOMMENDATION 2.5: ENSURE HEALTH BENEFITS EXCHANGE FINANCIAL SUSTAINABILITY

a) The North Carolina General Assembly (NCGA) should establish an Exchange 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 Exchange Trust Fund to pay for reasonable Exchange 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 Exchange from a base year of 2013.

ii. The trust fund should include the premium tax revenues generated as a result of the increase in the costs of the premium due to the implementation of the ACA.

b) The NCGA should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the Exchange Trust Fund.

c) **The NCGA should give the Exchange 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 Exchange 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 Exchange, up to a maximum threshold established by the NCGA.**
   ii. **Fees on insurers who offer more than a specified number of health plans per 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 Exchange and Medicaid agency. At the very general level, the Exchange 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.[92,93] Individuals can always seek informal help from family or friends. However, the ACA also envisions that there will be other sources of trained enrollment counselors such as In-Person Assisters, Navigators, DSS workers, agents and/or brokers. Subsequent to the work of the HBE workgroup, the federal government also gave states that will be providing consumer assistance under a partnership option the authority to train and pay in-person assisters. This is discussed in more detail below. Further, the new law creates a "no wrong door" enrollment process. Individuals can apply directly to the Exchange, 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 Exchange.

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 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 Exchange is required to conduct education and outreach to inform the public about the Exchange.[94] In addition, the Exchange must provide for the operation of a toll-free hotline to answer questions and help people enroll.[95] 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."[96]

The HBE workgroup recognized that the Exchange might need to enlist the support of different groups to provide education and outreach to the nongroup market and 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 Exchange 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 Exchange work with the 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 Exchange, 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, enrollment, and other insurance issues.

General training. As noted earlier, individuals can seek help in the enrollment process from many different sources. Individuals can obtain help from certified navigators, in-person assisters, agents, or brokers (discussed more fully below). However, an individual can seek help from other sources as well. The new federal regulations state that the Exchange must accept applications from the applicant, an authorized representative, or someone acting responsibly on behalf of the applicant.[97]

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 Exchange, in conjunction with NCDOI and DMA, offer workshops or other training opportunities to provide basic information about public and private insurance options, the Exchange 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. HEALTH BENEFITS EXCHANGE OUTREACH AND EDUCATION

a) The Health Benefits Exchange (Exchange), in conjunction with the North Carolina Department of Insurance (NCDOI), 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

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, enrollment, and other insurance issues.

b) **The Exchange, in conjunction with the NCDOI and DMA, should offer workshops and other training opportunities to other groups, including providers, nonprofits and community-based organizations to provide basic information about public and private insurance options, the Exchange 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 Exchange to provide grants to navigator *entities* to help people understand their insurance options and enroll into coverage in the Exchange. To be eligible to receive a grant, the navigator entity must have existing relationships or show that they can establish relationships with individuals or small businesses likely to enroll in a QHP.[98] The regulations clarify that the Exchange 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 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.[99]

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 Exchange 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 Exchange.
- Distribute fair and impartial information about enrollment into QHPs, and the subsidies available through the Exchange.
- 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.[100]

The HBE workgroup used NCDOI'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. NCDOI contracts with 109 SHIIP coordinating organizations across the state. These organizations help coordinate the work of more than 900 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 NCDOI and must meet 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 Exchange 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 Exchange navigators have the training and competency to assist individuals in understanding their plan choice, the HBE workgroup recommended that the Exchange 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 Exchange 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 Exchange 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 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 Exchange 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 Exchange 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 Exchange is required to provide grants to navigator entities, the Exchange may not use federal funds that the state received to establish the Exchange for that purpose.[101] The prohibition on the use of federal funds will cause difficulties in the first few years of Exchange operations. The Exchange 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.[102] The Level II federal Exchange grant can only be used to pay for all of the initial Exchange set up and operational costs through the first year of operation. Depending on the funding source, the Exchange may not have separate operational funds until 2014 (at the earliest) or 2015. Thus, while the ACA and accompanying regulations require the Exchange 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 Exchange 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 Exchange funding. Thus the workgroup recommended that the Exchange use federal funds to pay for training, continuing education, and certification. In addition, the Exchange 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 Exchange 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 Exchange 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, and enrollment facilitation. The workgroup suggested that the Exchange Board explore the question about whether individual navigators should receive any compensation for their services.

The federal government will contract with navigators under a federally-facilitated Exchange or a partnership plan. However, states that run their own Exchange or choose to assume the consumer assistance functions, under a partnership plan, can train and contract with "in-person assisters." For all ostensible purposes, "in-person assisters" will play a similar role as navigators. However, the states can use federal grant funds to help pay for in-person assisters as part of the general outreach and education function. NCDOI plans on developing a training and certification program for in-person assisters under the federal partnership model. This training and certification program will be modeled on the NCDOI successful NC SHIIP program, and will follow the recommendations set out in this chapter. NCDOI plans to contract with intermediary assister organizations or administrative entities, which will have the responsibility for identifying and monitoring the work of in-person assisters across the state.

Thus, to ensure that the state operate an effective navigator and/or in-person assister program, the NCIOM recommended:

RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS/IN-PERSON ASSISTERS

a) **The Health Benefit Exchange (Exchange) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator/in-person assister program. In the absence of a state-based Exchange, NCDOI should develop and oversee an in-person assister program that meets the same functions.**
   i. **The NCDOI, in conjunction with the Exchange, should create a standardized training curriculum along with a competency exam to certify individual navigators or in-person assisters.**
   ii. **Individual navigators/in-person assisters should be recertified annually. To be recertified, the navigator/in-person assister should be required to:**
      A. **Complete continuing education requirements and meet minimum activity thresholds, as specified by the NCDOI, in conjunction with the Exchange.**

B. **Provide data to the state to ensure the overall functioning of the navigator/in-person assister 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/in-person assister administrative entity.**

iii. Individual navigators/in-person assisters can be terminated for cause.

iv. Navigator or in-person assister administrative entities should have a designated person who serves as the navigator/in-person assister coordinator. These coordinators must also be certified as navigators/in-person assisters, but will have additional responsibilities and training to serve as a coordinator and oversee the work of individual navigators/in-person assisters in their community.

b) The Exchange Board (or NCDOI under a partnership model) shall create strong conflict of interest rules for individual navigators/in-person assisters and navigator/in-person assister administrative entities. The conflict of interest rules should:

i. **Preclude navigator/in-person assister administrative 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 (e.g., FQHCs, free clinics, rural health clinics, or health departments) or other individuals to serve as individual navigators/in-person assisters 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 Exchange Board can allow employees of hospitals or other health care organizations to serve as navigators/in-person assisters in rural or other underserved communities, but only if the Exchange Board certifies that there is insufficient navigator/in-person assister capacity in those communities to meet the needs of individuals seeking navigator/in-person assister assistance. The Exchange should adopt rules, guidance, education, and conflict of interest disclosure requirements, as well as reporting requirements, and should specifically monitor these provider-linked navigators/in-person assisters to ensure that they comply with the ACA's prohibitions against steering patients to particular plans.

c) If allowed by the federal government, the Exchange Board/NCDOI should use federal funds to help pay for training, continuing education, and certification of individual navigator/in-person assister and navigator/in-person assister administrative entities. In addition, the Exchange should provide small grants to community-based organizations, social services agencies, professional associations, navigator/in-person assister administrative entities and other appropriate organizations to provide education and outreach about new insurance options to targeted individuals and small employers.

d) The Exchange Board/NCDOI should seek funding from state philanthropic organizations or other sources to help pay small grants to navigator/in-person assister administrative entities to help offset the administrative costs to coordinate and oversee the work of local navigators/in-person assisters.

i. In 2013, the Exchange/NCDOI should pay each navigator/in-person assister administrative entity a flat rate based on size of the targeted population.

ii. Thereafter, the navigator/in-person assister grants should be based, in part, on outcomes so that navigator/in-person assister administrative entities are rewarded for doing a good job with education, outreach, and enrollment facilitation.

iii. The Exchange Board/NCDOI may explore the option of compensating individual navigators/in person asssiter for their services.

Agents and brokers. Agents, brokers, or other people who receive compensation directly or indirectly from insurers may not serve as navigators/in-person assisters, although the state or Exchange can allow agents or brokers to enroll individuals, small businesses, or eligible employees into QHPs offered through the Exchange.[103] However, agents and brokers also need training to help enroll individuals, small businesses, or their employees into a qualified health plan offered through the Exchange. Agents and brokers need to understand the different insurance affordability programs (including Medicaid, CHIP, and the insurance subsidies offered through the Exchange). In addition, agents and brokers need to understand the small business tax credit available through the Exchange. 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 Exchange.

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 Exchange. And businesses need to understand the implications of whether to offer their employees one plan or a choice of plans in a particular level. Agents are licensed to sell health insurance coverage outside the Exchange, and many will also receive the training and certification to sell coverage inside the Exchange. Navigators/in-person assisters 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/in-person assister.

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. 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 (i.e., 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. (Beginning in 2014, 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 interest of individual navigators/in-person assisters or navigator/in-person assister administrative entities, the group wanted to also minimize the potential conflict of interest among agents who place business in the Exchange. 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 Exchange. The workgroup made a number of recommendations to address these potential problems. First, the Exchange 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 Exchange. Thus, the HBE workgroup recommended that NCDOI require insurers to pay agents and brokers the same commission, whether placing business inside or outside the Exchange. The workgroup also recommended that the NCDOI, in conjunction with the Exchange, 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 Exchange 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 Exchange 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. Many of the above issues related to agents and brokers have been addressed by NCDOI's TAG, and information about the discussion and recommendations is available on the NCDOI website.[104]

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.[105] 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 Exchange, the workgroup recommended that the NCDOI TAG consider whether the state should eliminate minimum participation requirements.

To address these concerns, the NCIOM recommended:

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

a) The Health Benefits Exchange (Exchange)Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the Exchange.
   - **i. The Exchange 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 Exchange), how to use the Exchange website, and the small business tax credit.**
   - **ii. Small businesses that contact the Exchange or call center needing additional information and advice should be directed to an agent or broker rather than an individual navigator. However, the Exchange should only refer small businesses to independent agents or brokers who are able to sell any of the qualified health plans offered in the Exchange.**

b) The NCDOI, in conjunction with the Exchange, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the Exchange, 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 the Exchange 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 Exchange 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 Exchange.**
   - **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 Exchange 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 (e.g., 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 NCDOI, in conjunction with the Exchange, 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 Exchange, then agents or brokers who place business in the Exchange 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 (i.e., Medicaid, CHIP, or subsidized insurance coverage offered through the Exchange). For example, the Exchange and Medicaid must both use the same streamlined application form.[106,107] 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.[108,109] In North Carolina, NC FAST is expected to serve as the eligibility system for Medicaid, North Carolina Health Choice, and subsidized coverage through the Exchange (should the state operate its own Exchange).

In addition to the specific role of navigators/in-person assisters, both the Exchange and Medicaid have a responsibility to assist people in applying for and enrolling into appropriate public or private health insurance coverage. The Exchange 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 Exchange. If the Exchange identifies people who are potentially eligible for Medicaid or CHIP, the Exchange must share information with the Medicaid agency so that an eligibility decision can be made without undue delay.[110,111]

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). DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[112] In addition, if the person is determined to be ineligible for Medicaid, he or she must be screened to enroll into a QHP, and, if eligible, must be able to enroll "without delay."[113,114] Thus, the workgroup recommended that DSS workers be trained and certified as navigators/in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a QHP offered through the Exchange. To make it easier for DSS offices to serve as navigator/in-person assister administrative 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 Exchange 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 Exchange 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 DSS 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 Exchange 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/in-person assister or other trained staff outside of the local social services office.

To address these concerns, the NCIOM recommended:

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 (CHIP) eligibility workers are cross-trained and certified as navigators /in-person assister 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 (Exchange).

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 Exchange 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/in-person assisters or other trained staff outside of the local DSS offices.

c) The Exchange 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.

REFERENCES AND NOTES

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[1] The penalty is $95/year or 1% of income (whichever is greater) in 2014. The penalty amount increases to $695/year or 2.5% of income by 2016. The maximum penalty that any individual or family would incur is the amount they would have had to pay if they had purchased the lowest cost bronze plan available in the nongroup market, or the cost they would have incurred to purchase an employer-sponsored plan. Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1501(b), enacting Sec. 5000A(c),(e)(1)(B) of the Internal Revenue Code of 1986, 26 USC 5000A.

[2] The constitutionality of the individual mandate along with the Medicaid expansion was challenged in the United States Supreme Court, in *National Federation of Independent Business v. Sebelius*, 567 US ___ (2012).. The Supreme Court held that the mandate that people purchase health insurance coverage or pay a penalty was a constitutional exercise of Congress' taxing authority. Available at: http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. Accessed November 7, 2012.

[3] 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.

[4] 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).

[5] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(a).

[6] United States Department of Health and Human Services. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Proposed Rule. *Fed Regist*.

2012;77(227):70644-70676. http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf. Accessed November 29, 2012.

[7] The Center for Consumer Information and Insurance Oversight prepared a summary of the proposed North Carolina essential health benefit benchmark plan. The summary is available at: http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf. Accessed December 10, 2012.

[8] 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. United States Department of Health and Human Services. Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act; United States Department of Health and Human Services. Interim Final Rule and Proposed Rule. 75 *Fed Reg*ist. 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.

[9] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC 300gg.

[10] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC 300gg.

[11] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(d), 42 USC 18022.

[12] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(e), 42 USC 18022.

[13] 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.

[14] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1401(c)(1), enacting Sec. 36B of the Internal Revenue Code of 1986.

[15] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1402(d)(1)(2), 2901.

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

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[19] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1301, 1311, 1321, 1322, 1334, 10104.

[20] 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.

[21] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).

[22] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

[23] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).

[24] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

[25] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(D).

[26] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.200.

[27] 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.
[28] 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.
[29] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(F), 1411, 1413.
[30] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.
[31] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(G).
[32] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.
[33] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(H).
[34] 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.
[35] 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).
[36] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(I).
[37] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(J).
[38] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(K), 1311(i).
[39] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.210-220.
[40] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(6).
[41] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.130.
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[44] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1313.
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[46] 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).
[47] 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).
[48] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(a),(d)(5).
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