North Carolina Department of Insurance
Market Reform Technical Advisory Group In-Person Meeting #10
Monday, November 19, 2012
Final Notes

NOTE: THIS MEETING WAS HELD PRIOR TO THE RELEASE OF THE PROPOSED REGULATIONS ON HEALTH INSURANCE MARKET RULES WHICH MAY HAVE A BEARING ON CONSENSUS POINTS

Meeting Attendees	Organization
TAG Members and NC DOI Project Team	
George Teague	Aetna Health Inc./Cigna
Barbara Morales Burke	Blue Cross Blue Shield of North Carolina
Tracy Baker	Coventry Health Care of the Carolinas, Inc.
Ken Lewis	FirstCarolinaCare Ins. Co. Inc.
Craig Humphrey *(by phone)*	FirstCarolinaCare Ins. Co. Inc.
David Contorno	Independent Insurance Agents of NC
Joel Ario	Manatt
Sharon Woda	Manatt
Christine Chang	Manatt
Teresa Gutierrez	NC Assoc. of Health Underwriters
Fred Joyner	NC Assoc. of Insurance and Financial Advisors
Mike Kelly	NC Business Group on Health
Vinny Longobardo	NC Business Group on Health
Rebecca Whitaker	NC Community Health Center Association
Allen Freezor	NC Department of Health and Human Services
Jean Holliday	NC Department of Insurance
Julia Lerche	NC Department of Insurance
Lauren Short	NC Department of Insurance
Louis Belo	NC Department of Insurance
Mike Wells *(by phone)*	NC Department of Insurance
Rosemary Gillespie *(by phone)*	NC Department of Insurance
Ted Hamby	NC Department of Insurance
Walter James *(by phone)*	NC Department of Insurance
Michael Keough	NC Health Insurance Risk Pool, Inc./dba Inclusive Health
Pam Silberman	NC Institute of Medicine
Adam Linker	NC Justice Center
Mark Hall	Wake Forest University
Peter Chauncey	Coventry Health Care of the Carolinas, Inc.
Charles Pitts	Cigna HealthCare Carolinas
Interested Parties	
Andy Landes	H-PACT
Amy Jo Johnson *(by phone)*	NC General Assembly
Ryan Blackledge *(by phone)*	NC General Assembly
Ann Lore	Duke University

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Agenda

• Welcome and Introductions
• Project Timeline, Goals/Objectives of Today's Discussion, Statement of Values for TAG
• Items for Discussion in TAG Meeting #10
  o *Essential Community Providers ("ECPs")*
  o *Age and Geographic Rating Areas*
• Wrap Up and Next Steps

Please refer to the November 19 "TAG In-Person Meeting #10" Slide Deck.

Welcome and Introductions

Ted Hamby of the North Carolina Department of Insurance ("DOI" or "the Department") convened the meeting at 9:30 AM and welcomed meeting attendees. Mr. Hamby asked attendees, including those participating by phone, to introduce themselves to the group. Mr. Hamby then turned the floor over to Sharon Woda of Manatt for a review of the objectives of the day's meeting discussion.

Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG

Ms. Woda reviewed the past and future project and regulatory timelines for the TAG's ongoing work (*see slide deck for additional details*) and objectives for the day's meeting which included:

- Define Essential Community Providers in North Carolina
- Define Processes/Procedures to Evaluate Network Adequacy Standards for ECPs
- Recommend Options and Approaches for Definition of Age and Geographic Rating Areas

Ms. Woda briefly reviewed the TAG Statement of Values, developed by the TAG during its first phase of work, and reminded the group that the statement is meant to guide their deliberations and serve as a lens through which to assess the policy options under consideration. Ms. Woda then asked Julia Lerche of the North Carolina Department of Insurance to provide an update on the Department's activities.

Issues for Discussion in TAG Meeting #10

Please note that the "Consensus Points" listed in this section are in DRAFT form only and will be reviewed by the TAG at its next meeting or through email; any modifications to these draft consensus points by the TAG prior to TAG approval will be detailed in the TAG #10 final meeting notes.

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North Carolina Department of Insurance Update

Ms. Lerche stated that the NC DOI submitted an Exchange Establishment Grant application to CCIIO on November 15, 2012 to support Exchange-related activities, including plan management, consumer assistance and eligibility system development. The timing of the application submission was due to funding needs. The application was submitted under the assumption that the state will pursue a state-federal partnership Exchange; this assumption was later confirmed by Governor Perdue through an announcement in November indicating that the state intends to establish a state-federal partnership Exchange, with the plan to build a state-based Exchange in the future.

Ms. Lerche then reviewed recent federal activity, including the U.S. Department of Health and Human Services ("HHS") extension of Exchange deadlines. Originally due November 16, states planning to establish a state-based Exchange may now submit their declaration letters and blueprints by December 14. States pursing a partnership Exchange may submit their documentation until February 15, 2013.

During October, DOI met with HHS regarding consumer assistance and plan management issues and HHS was receptive to DOI's plans. Ms. Lerche also noted that the state did not select an essential health benefits (EHB) benchmark plan, after noting that potential EHB plan options were relatively similar to one another. The details of the EHB plan will be posted on the DOI website.

DOI's next steps include assessing qualified health plan (QHP) application and review processes, finalizing the state's blueprint, reviewing additional regulations from the federal government as they are released, and working on any necessary legislative changes.

The TAG discussed the possibility of Governor-elect McCrory deciding to pursue a different Exchange option. DOI noted that the partnership model preserves all choices for the state. DOI will allow health insurers to comment on Exchange planning and will distribute information to insurers as it receives it from the federal government. The Exchange grant application is available upon request.

Ms. Lerche then turned the floor over to Ms. Woda to lead the discussion on ECPs.

Essential Community Providers

Definition of ECPs

Ms. Woda provided a brief overview of relevant federal and state law and regulations, other state approaches to ECPs, concerns related to ECPs, and the ECP workgroup's consensus points on the issues *(see slide deck for additional details)*. Pam Silberman of the NC Institute of Medicine reviewed the results of a survey of 340(b) entities in the state; over 155 responses were received within a week of the survey's release. Ms. Silberman will share the list of respondents who meet ECP requirements with TAG members and insurers in the state to help them build their ECP networks. She also noted that the survey was not sent to free clinics, as they do not collect payment. If the free clinics decide to accept payment, then they would likely qualify as ECPs. Ms. Woda then asked the group to discuss the following question and related workgroup statements on the ECP issue:

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Are there providers, while not specified in federal statute, who should fall within the definition of ECPs in North Carolina?

TAG members agreed with the proposed workgroup statements and suggested calculating client mix based on service volume. The group also noted that any Medicaid expansion would not impact this issue.

Consensus Point(s):

The TAG **reached consensus** on endorsing the following statements:

- The State should adopt the expansive federal definition of an ECP provider at this time, as it does not limit the type of provider included for ECP consideration.
- Per Federal regulations, ECPs include providers meeting the criteria defined in Section 340(b) of the PHS Act or any provider that serves predominantly low-income, medically underserved individuals.
- North Carolina should define "serve predominantly low income, medically underserved individuals" in the following way:
    - Provider organizations whose combined client mix is greater than 50% Medicaid/CHIP, uninsured and/or low-income individuals with incomes at or below 250% FPL.
- North Carolina should build on the current efforts to develop a registry of ECP providers in the state. Any provider who meets the definition of an ECP can be added to the list.
- The registry will be made publicly available and is not proprietary.
- Providers can seek to have themselves added to the list. Insurers, through network contracting efforts, could inform providers of the registry and encourage registry participation.

The group then turned to a discussion of network adequacy for ECPs.

<u>Network Adequacy for ECPs</u>

Ms. Woda reviewed federal and state laws and regulations related to network adequacy measures, noting that there currently is no industry standard in North Carolina as the state currently allows insurers to set their own standards and requires them to report related metrics to the NC DOI. Ms. Woda then reviewed the short timeline for insurers to contract with ECPs; unlike other types of providers, insurers may not have current contracts in place with ECPs. TAG members should consider balancing the strictness of potential network adequacy measures with the limited timeframe available. Ms. Woda then laid out the pros and cons of allowing insurers to define their own standards and additional parameters that could be considered for reporting and evaluation.

Ms. Woda then asked the group to discuss the following question and related workgroup statements on the ECP network adequacy issue:

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How should North Carolina define a "sufficient number and geographic distribution" of ECPs to ensure "reasonable and timely access" for "low income, medically underserved individuals"?

The TAG agreed with the proposed workgroup statements and discussed the need for additional data on the numbers of uninsured, Medicaid, and CHIP individuals by county. Ms. Silberman agreed to provide this information to DOI to share with the TAG. Regarding the ECP process in 2016, the TAG noted that one year would not provide enough experience, and thus, two years after implementation would be the more appropriate time to re-visit the process.

Consensus Point(s):

The TAG **reached consensus** on the following statements:

- The State should require insurers to set network adequacy standards for ECP providers. The State should initially require insurers to set network adequacy standards for ECP primary care providers (PCPs, pediatric, and OB/GYN) that are at least equal to what is required for the non-ECP population.
- Such standards shall be ECP-specific, and be based on the anticipated or actual enrollment of the target population and the number of contracted ECP providers.
- Insurers should be required to meet their self-defined ECP standards for primary care and report ECP standards for other types of care using the existing state-mandated network adequacy reporting process.
- To the extent exceptions are permitted under federal law, they should be granted to insurers looking to become QHPs in the North Carolina market.
- The NC DOI should re-evaluate the ECP network adequacy standards and reporting process within two years of implementation in 2014 to assess whether it has resulted in a sufficient number of ECPs to provide reasonable and timely access for low-income medically underserved individuals in North Carolina.

Ms. Woda then turned the floor over to Joel Ario from Manatt to discuss implementation of rating requirements.

Rating Implementation

<u>Geographic Rating Areas</u>

Mr. Ario introduced the discussion by reviewing relevant federal and state laws and regulations, current rating areas in NC, and describing the results of prior workgroup deliberations on the subject (*see slide deck for additional details*). Mr. Ario reviewed the options for setting new rating areas, such as Metropolitan Statistical Areas, hospital referral clusters, or California's proposed approach. The TAG reviewed the following question and related workgroup statements on the geographic rating areas issue:

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If Federal Guidance/Regulations allow states to set geographic rating areas by county, should North Carolina exercise that option in 2014 and 2015?

The TAG agreed that North Carolina could elect to use counties in 2014 and 2015 if permitted by forthcoming federal regulations, with the intent of evaluating another strategy in the long term. Other discussion included:

- Some TAG members questioned if the issue of setting geographic rating factors (or an allowable range for factors to vary, such as 1.5 to 1) had been considered. This issue was discussed and most members were not in favor of this approach.
- TAG members noted that the base factors should be the same, though members recognized that differences would be based on provider contracts, claims experience, and utilization differences in counties which are specific to each insurer.
- Insurer TAG members noted that while setting standard regions would reduce costs for some areas, it could also result in an overall reduction of coverage options as this cross-subsidization could push marginally profitable counties into unprofitability and result in insurers exiting those counties.
- TAG members reminded each other that the goal is for consumers to enter their zip code into the Exchange web portal and be led to an insurance premium rate. It was clarified that process would happen irrespective of how geographic rating areas were set, but that more segmented areas (such as current county designation) would lead to rates being different across those geographic areas (e.g. potentially a different rate by county, for example).
- NC DOI noted that it has regulatory oversight of rates and insurers will need to show that their rates are actuarially justified and do not include morbidity or other factors not related to geography.
- TAG members discussed if the geographic rating factor should be the same for the individual and small group markets, but did not reach consensus on this point.
- TAG members noted that different emerging, innovative care delivery models, such as Accountable Care Organizations, may want to operate through the exchange. If so, the discussion of geographic rating areas should take into account that these care delivery models may need flexibility to operate in small, geographic regions.

The TAG then reviewed the following question:

If Federal Guidance/Regulations indicate that geographic rating areas by county are too narrow, or if North Carolina does not prefer the county-level, how should regions be defined for 2014 and 2015?

The TAG agreed that North Carolina's DOI could establish geographic rating areas to group counties in a way that minimizes market disruption, in a similar manner as California, up to the maximum number permitted under federal rules (once released). The TAG also discussed the following points:

- This issue will depend on additional federal regulations.
- The TAG favored the California approach, at least as a starting point, and then layering on North Carolina-specific requirements. TAG members noted that while North Carolina would set the

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geographic areas, insurers could set the factors within each area. A con to this regional approach would be that an insurer may cherry-pick which regions to stay in and which to exit.
- TAG members questioned if insurers would have to be active in a whole geographic area or if they could pick parts within an area.

Consensus Points:

The TAG **reached consensus** on the following revised statements :

- North Carolina should elect to use counties in 2014 & 2015 only, with plans for evaluating another strategy for the long term.
- If the federal government requires a cap on the number of areas, North Carolina's DOI could establish geographic rating areas to group counties in a way that minimizes market disruption, in a similar manner as California, up to the maximum number permitted under federal rules (once released).

Age Bands & Factors

Mr. Ario reviewed the relevant federal and state laws and regulations regarding age bands and factors, how they are currently defined in NC, and how other states are approaching this issue. Mr. Ario reviewed the considerations for implementation and options for changing age band and factors. Then the TAG reviewed the following question and related workgroup statements on the issue:

Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015? What additional options should be considered in North Carolina?

The TAG agreed that North Carolina should refrain from imposing rating factor parameters in the individual and small group market, but could consider additional limited parameters on age bands in the individual market. The TAG also agreed with potentially determining a process to set single year age bands in the individual market and would like to revisit this issue in the future, after the federal regulations on age bands are released.

Should standardized age bands for children be established in the individual market?

The TAG agreed that age bands should not be standardized for 2014 and 2015 and that insurers should continue with today's practice, which are generally one year increments with some clustering around ages 0 to 2. The TAG would also like to revisit this issue in the future, after the federal regulations on age bands are released. Other items of discussion included:

- The TAG discussed that insurers prefer one year increments for children because children's healthcare needs and costs vary by age (e.g. higher costs in infants/young children).
- TAG members also discussed whether the small group market should move to single year bands if single year age bands are used in the individual market, particularly in the context of employee

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choice. TAG members noted that this should be considered in the future after federal regulations are released.

Consensus Points:

The TAG **reached consensus** on the following statements:

- North Carolina should refrain from imposing rating factor parameters in the individual and small group market, but could consider additional limited parameters on age bands in the individual market for 2014 and 2015.
    - North Carolina should determine a process to consider the feasibility of implementing single year age bands in the individual market**.**
    - Age bands for children should not be standardized for 2014 and 2015.

Mr. Ario then turned the floor back to Ms. Woda to wrap up the meeting, including a review of next steps.

Wrap Up and Next Steps

Ms. Woda reviewed next steps as follows:

- TAG review of meeting minutes. The group was also asked to review the TAG Meeting # 10 minutes once made available via email in advance of the next meeting.
- Attend webinar on December 7th, assuming the regulations have been released.
- Attend next in person meeting on December 12th.

TAG members are encouraged to send any additional feedback or suggestions to Allison Garcimonde (agarcimonde@manatt.com) or Lauren Short (lauren.short@ncdoi.gov) of the NC DOI.

The meeting was adjourned at 12:33 pm.

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