Market Reform and Policy Issues for Implementation of Health Reform in North Carolina

In-Person TAG Meeting #10

November 19, 2012

MANATT HEALTH SOLUTIONS

MERCER

OLIVER WYMAN

Agenda

9:30 – 9:35	**Welcome and Introductions**
9:35 – 9:45	Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG
9:45 – 10:15	Items for Discussion in TAG Meeting #10 • NC DOI Update
10:15 – 11:15	Items for Discussion in TAG Meeting #10, continued • ECP Report Back
11:15 – 11:30	*Break*
11:30 – 12:20	Items for Discussion in TAG Meeting #10, continued • Rating Implementation Report Back
12:20 – 12:30	Wrap Up and Next Steps

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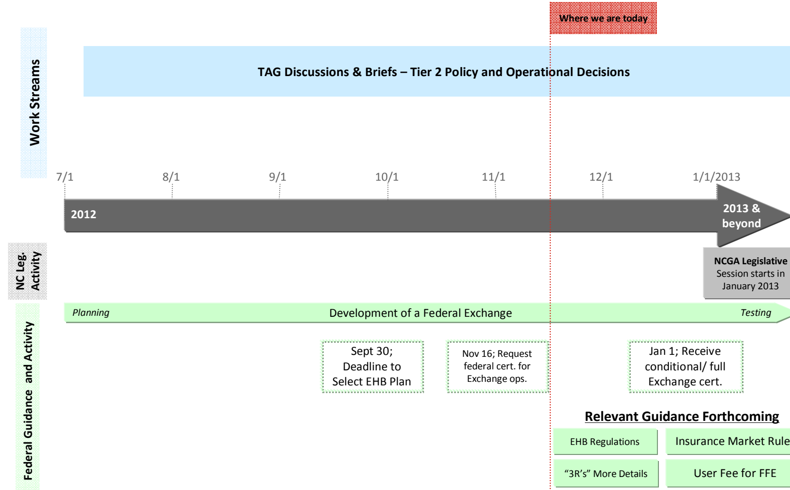
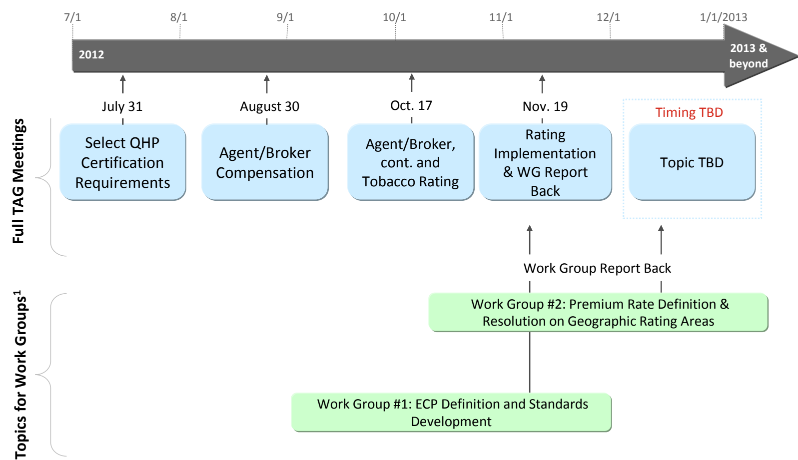
Current Project and Regulatory Timeline



TAG Meeting and Work Groups Planning for 2012



[1]Work Groups will be held as needed to address technical issues and to arrive at options to set before the TAG.

Project Goal and Meeting Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI actions and recommendations for Exchange-related market reform policies.*

(pursuant to North Carolina Session Law 2011-391)

"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study 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. The Commissioner shall submit a report to the...General Assembly containing recommendations resulting from the study."

-- Session Law 2011-391

Objectives for Today's Meeting

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

Statement of Values to Guide TAG Deliberations

The TAG will seek to evaluate the market reform policy options under consideration by assessing the extent to which they:

- Expand coverage;
- Improve affordability of coverage;
- Provide high-value coverage options in the HBE;
- Empower consumers to make informed choices;
- Support predictability for market stakeholders, competition among plans and long-term sustainability of the HBE;
- Support innovations in benefit design, payment, and care delivery that can control costs and improve the quality of care; and
- Facilitate improved health outcomes for North Carolinians.

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NC DOI Update

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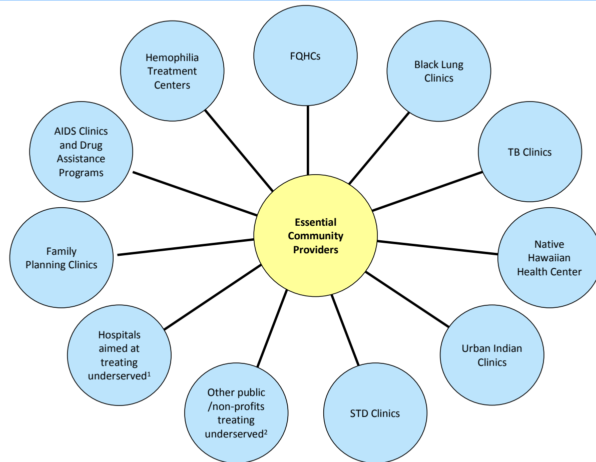
ECP Questions Contemplated by the Work Group

1. ***Are there providers, while not specified in federal statute, who should fall within the definition of ECPs in North Carolina?***
2. *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"?*

Relevant Federal Laws and Regulations – Defining ECPs

- ECPs are defined as providers that serve predominately low-income, medically underserved individuals. *(45 CFR §156.235(c)(1))*
  - ECPs includes providers meeting the criteria defined in section 340B(a)(4) of the PHS act or section 1927(c)(1)(D)(i)(IV) of the Act (e.g.- non-profit providers)
- 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. *(§156.235(a)(1))*
- QHPs are not obligated to provide coverage for any specific medical procedure provided by an ECP. *(45 CFR §156.235(a)(3))*
- QHP insurers are not required to contract with ECPs that refuse to accept "generally applicable payment rates." *(45 CFR §156.235(d))*

Essential Community Providers Called Out in Federal Regulations



1. Includes disproportionate share hospitals, critical access hospitals, children's hospital excluded from the Medicare PPS, free-standing cancer hospital excluded from PPS, and sole community hospitals.
2. Defined in 1927(c)(1)(D)(i)(IV) of the Social Security Act

Source: PHSA section 340B(a)(4)

What other states are doing re: ECPs

State	Approach to Essential Community Providers
Hawaii	Legislation dictates that "the director of health, with the concurrence of the director of human services, shall have the authority to designate other Hawaii health centers not yet federally designated but deserving of support to meet short term public health needs based on the department of health's criteria, as Hawaii Qualified Health Centers." (L 1994, c 238, §2)
Washington	Requires QHPs to include tribal clinics and urban Indian clinics as ECPs. Also allows integrated delivery systems to be exempt from the requirement to include ECPs, if permitted. *(HB 2319)*
Vermont	Intends to emphasize the importance of family planning clinics as ECPs and encourages federal lawmakers to follow by including all family planning clinics as opposed to a "sufficient number."[1]
California	Defines ECPs to include FQHCs, FQHC look-alikes, federally designated 638 Tribal Health Programs, Title V Urban Indian Health Programs, all 1204(a) licensed community clinics, and any providers with approved applications for the HI-TECH Medi-Cal electronic health record incentive program. QHPs must demonstrate sufficient geographic distribution of a broad range of providers reasonably distributed throughout the region with a balance of hospital and non-hospital providers by: 1.) Demonstrating contracts with at least 15% of 340B entities per geographic region proposed by a QHP bidder; 2.) Include at least one ECP hospital per region; and 3.) Demonstrate a minimum proportion of QHP network overlap among QHP networks and ECP network.
Minnesota	Current law is "stronger than federal requirements and requires health plans that contract with providers to offer contracts to all state-designated essential community providers in its service area." *(§ 62Q.19)*

1. Vermont comment on the proposed HHS Exchange Establishment Standards (Part 155) and (Part 156)
2. http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20HBEX%20-%20QHP%20Options%20Webinar.pdf

Considerations for Further Refinement of the Definition of ECPs

Federal statute allows any provider who serves predominantly low-income & medically underserved populations to be considered an ECP. Attempts to enumerate additional categories of ECP providers could ensure there is no ambiguity around providers for inclusion, but may also create a false sense of an exhaustive list- which may be premature at this time.

Pros from enumerating definition in State Statute	Cons from enumerating definition in State Statute
▪ Could ensure that there is no ambiguity around additional groups for inclusion ▪ Could raise profile of lesser-known groups for inclusion in QHP network contracting	▪ May create a false sense of providers being "in" versus "out" during a time when not all providers are known ▪ May be of limited value, since ECP designation does not mean insurers must contract with a specific ECP

ECP List – Initial Fields & Work Completed to Date

- Counties served
- Type of agency (e.g., FQHC, hospital outpatient, rural health clinic, etc.)
- Percent of unduplicated patients seen in January 2012 who
  - Were Medicaid/NC Health Choice patients
  - Were uninsured
  - Had incomes below 200% FPG
- Organization's FY 2011 total unduplicated patients seen
- Whether the organization provides the following services and how many hours a week if offers such services
  - Comprehensive primary care services (e.g., preventive, primary acute)
    - Does the organization limit these services to specific populations (e.g., children, adults)?
  - Prenatal care and delivery services
  - Dental services
  - Behavioral health services (e.g., mental health, substance abuse)
  - Specialty services (e.g., endocrinology, gastroenterology, neurology, cardiology)
- Capacity to accept new patients
- Health insurers or provider networks for which the provider is considered in-network

Work Group Statement for TAG Review: Defining ECPs

The below statement is a draft for the TAG's consideration.

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.	• Keeps existing broad definition
Per Federal regulations, ECPs are providers meeting the criteria defined in Section 340(b) of the PHS Act or any provider that serves predominantly low-income, medically underserved individuals.	• "Plain English" language for ACA
North Carolina should define "serve predominantly low income, medically underserved individuals" in the following way: • *provider organization whose combined client mix is greater than 50% of Medicaid/CHP, uninsured and/or low-income individuals with incomes at or below 250% of the FPL*	• Further defines thresholds for ECP inclusion that any provider could evaluate

Development of an ECP Registry for North Carolina

The initial list could serve as the foundation for a broader effort to identify ECPs in North Carolina

- Opportunity to continue effort to identify ECPs- particularly those who are not identified in the 340(b) statute
- Any provider who meets the definition of an ECP could be added to the list
- A registry could help insurers identify where ECPs are located and the types of services they provide
- Insurers may also have insight into ECP providers they are contracting with, and could encourage providers to be added to the registry
- The North Carolina Department of Insurance could leverage the ECP list when performing network adequacy reviews for inclusion of ECPs *(as applicable as part of the QHP certification process)*

Work Group Statement for TAG Review: Proposal for ECP Registry Process

The below statement is a draft for the TAG's consideration.

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.	• Centralizes list of ECP providers • Allows providers to be added to the list
The registry will be made publicly available and is not proprietary.	• Insurers can use the list for ECP contracting • NC DOI can access the list for QHP certification, etc.
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.	• Establishes process by which providers could be added for inclusion

ECP Questions Contemplated by the Work Group

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

2. ***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"?***

Relevant Federal Laws and Regulations - Network Adequacy

Final rules set out specified network adequacy criteria that an insurer must satisfy in order for each plan to qualify as a QHP.

- Insurers must ensure that the provider network for each QHP:
  - Includes essential community providers (ECPs) *(45 CFR §156.230(a))*
  - Maintains a network that "is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." *(45 CFR §156.230(a))* [1]
  - Is consistent with network adequacy provisions in Section 2702(c) of the PHS Act. *(45 CFR §156.230(a))*
  - A QHP Insurer must also make its provider directory available to the Exchange. *(45 CFR §156.230(b))*
    - The directory must identify which providers are not accepting new patients

Relevant Federal Laws and Regulations – ECPs

The threshold for ECPs is separate, and more stringent, than the general provider network requirements.

- QHPs must have a "**sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access for low- income, medically underserved individuals**." *(45 CFR §156.235(a)(1))*
- ECPs are defined as providers that serve predominately low-income, medically underserved individuals. *(45 CFR §156.235(c)(1))*
  - ECPs include providers meeting the criteria defined in section 340B(a)(4) of the PHS act or section 1927(c)(1)(D)(i)(IV) of the Act
- QHPs are not obligated to provide coverage for any specific medical procedure provided by an ECP. *(45 CFR §156.235(a)(3))*
- QHP insurers are not required to contract with ECPs that refuse to accept "generally applicable payment rates." *(45 CFR §156.235(d))*
- A QHP insurer must pay a FQHC no less than the relevant Medicaid prospective payment system (PPS) rate, or, alternatively, may pay a mutually agreed upon rate to the FQHC provided that such rate is at least equal to the QHP issuer's generally applicable rate. *(45 CFR §156.235(e))*

Common Measures Used to Assess Network Adequacy

There are common measures used to assess adequacy, but not a set of metrics which are agreed upon to set network adequacy standards.

Measures	Rationale and Sample Metrics
Provider Type	Ensures that networks are broad to meet potential range of enrollee needs (E.g. PCP vs. emergency care vs. family planning)
Provider Ratios	Assesses the number of enrollees served by a provider type (E.g. 2 providers: 1,500 enrollees)
Number and Type of Covered Lives	Encourages adequate number and mix of providers accessible to targeted population (E.g. 5,000 enrollees, 100 of which have diabetes)
Appointment Availability Standards	Standards for appointment availability take into account the urgency of the need for services (E.g. Within 4 weeks of request)
Appointment Waiting Time Standards	Includes requirements for in-office waiting times to ensure beneficiary has timely access to care (E.g. No longer than 1 hour)
Travel Time/Distance standards	Limits distance enrollee must travel to receive care. This can vary based on whether enrollee resides in an urban or rural area or provider type. (E.g. 30 minutes/30 miles)
Geographic Designation	Ensures that geographic barriers and concentration of membership are taken into consideration (E.g. Urban vs. rural)

Note: Not all measures are used within a particular state or insurer

North Carolina Network Adequacy Reporting- Standards Reporting

North Carolina currently requires insurers to set their own adequacy standards in an uniform format

Geographic Provider Accessibility Standards (HMO)

HMO	Area	PCP	Pediatric	OB/Gyn	Specialist	Non-MD	Acute Facility	Out patient Facility	Mental Health	Mental Health non-MD	Mental Health Facility
Plan 1	Rural	2:30 miles	2:30 miles	2:30 miles	2:25 miles	2:25 miles	1:20 miles	1:20 miles	1:15 miles	1:15 miles	1:20 miles
Plan 2	Urban	1:10 miles	1:10 miles	1:10 miles	1:10 miles	1:15 miles	1:10 miles	1:15 miles	1:15 miles	1:20 miles	1:25 miles
Plan 3	Suburban	1:20 miles	1:20 miles	1:15 miles	1:25 miles	1:30 miles	2:30 miles	2:30 miles	1:20 miles	1:20 miles	1:30 miles

- North Carolina HMOs/PPOs report across the same provider types
- Most HMOs/PPOs also distinguish against geographic designation (rural/urban/suburban) but it is not required

= Insurer-set network adequacy standards

Source: North Carolina Department of Insurance Annual Report and Analysis of 2010 Activity; Requirements apply to PPOs as well

North Carolina Network Adequacy Reporting- Provider Counts

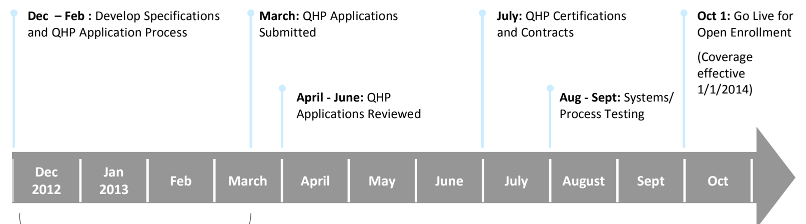
In addition to network adequacy standards, insurers are also required to report on the number of provider types by county

Insurer	County	PCPs	Pediatricians	Ob/Gyn	Specialist Physicians	Non-MD Providers	Inpatient Facilities	Outpatient Facilities	MH/CD Providers	MH/CD Non-MD Providers	MH/CD Facility Services
1	Alamance	57	19	16	92	43	1	21	3	10	1
	Alexander	15	0	0	12	7	0	1	0	0	0
	Alleghany	7	0	0	1	1	1	1	1	1	0
2	Alamance	51	18	10	126	71	1	2	4	30	2
	Alexander	12	0	0	0	12	0	0	0	3	0
	Alleghany	7	0	0	14	7	1	1	0	4	0
3	Alamance	99	20	13	223	28	6	27	5	16	1
	Alexander	17	0	0	15	8	1	1	0	1	0
	Alleghany	8	0	0	5	2	2	2	2	2	0

- North Carolina HMOs/PPOs report across the same provider types
- North Carolina does not set specific enrollee to provider ratios, but requires reporting of those ratios

Source: North Carolina Department of Insurance; Requirements apply to PPOs as well

Key Dates for State in Year One Timeline



Limited timeframe for insurers to contract with ECPs, in addition to other QHP requirements

Considerations for Setting ECP Network Adequacy Standards

Existing process of requiring insurers to define their own standards, as opposed to a state-defined standard across all insurers, appears to be a viable in light of challenges. Additional parameters could be considered for ECP network adequacy reporting and evaluation.

Pros of requiring that insurers set ECP standards	Cons of requiring that insurers set ECP standards
▪ Allows time for further evaluation of ECP providers/services and target population ▪ Possible under existing timelines & aligned with current state regulation	▪ May not adequately address network adequacy concerns for ECP population

The TAG will next consider what those parameters will be.

Further Defining Parameters Specific to ECPs

Parameter 1:

Illustrative ECP Standards Example

1 ECP PCP per 1,500 members of target population	2 ECP Providers within 10 miles of the target population
Provider Ratio	*Time/Distance*

- Require that ECP standards set by insurers take into consideration:
  - The specific numbers of the low income, medically underserved individuals either projected to be covered by the insurer, or actually covered by the insurer
  - Only ECP providers- as designated on the registry or added to the registry

Further Defining Parameters Specific to ECPs

Parameter 2:

Current Network Reporting, by Specialty

PCP	Pediatric	OB/Gyn	Specialist	Non-MD	Acute Facility	Out patient Facility	Mental Health	Mental Health non-MD	Mental Health Facility
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

- Require insurers to report ECP standards and provider counts across specific specialty areas already used for reporting of network adequacy
- Establishes a threshold for PCPs, Pediatricians and OB/GYNs that is at least equal to the non-ECP standards

✓ = Included for ECP-specific reporting

■ = Indicates standard must at least be equal to what is required for the non-ECP population

Further Defining Parameters Specific to ECPs

Parameter 3:

- Allow insurers to have exceptions to ECP coverage, as permitted under federal law
- Examples of viable exceptions include:
  - ECP provider availability
    - *"A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timeliness access…"* *(45 CFR 156.235(a))*
  - ECP refuses to contract and rates were generally applicable payment rates
    - *"Nothing….shall required a QHP to contract with an ECP if such provider refuses to accept the generally applicable payment rates of such issuer."* *(45 CFR 156.235(d))*
  - Issuer uses an employed model, or is through a single contracted medical group
    - *Issuers must have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for the target population. (45 CFR 156.235(b))*

Work Group Statement for TAG Review: Interim Establishment of Insurer ECP Standards

The below statement is a draft for the TAG's consideration.

Statement	Rationale
The State will require insurers to set network adequacy standards for ECP providers. The State will 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.	• Keeps existing methodology • Sets thresholds for primary care providers
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.	• Allows for ECP-specific standards establishment
Insurers will be required to meet ECP standards for primary care and report ECP standards for other types of care using the existing state-mandated network adequacy reporting process.	• Relies on existing process, and informs comparisons between ECP and non-ECP standards
To the extent Exceptions are permitted under federal law, they will be granted to insurers looking to become QHPs in the North Carolina market.	• Establishes exceptions criteria which would not preclude insurers with valid exceptions from becoming a QHP

Options and Action Steps

Question: Should the NC DOI, in conjunction with ECP providers and insurers, re-evaluate the process by 2016?

Options	Action Steps
Yes	• Flag for follow up by 2016 • Conduct a broader study to assess additional options available for establishment of an ECP network adequacy process based on experience in first 2 years
No	• Do nothing

The Work Group Recommends: 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.

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Market Reform Questions Contemplated by the Work Group

Geographic Rating Areas

- ***If federal guidance/regulations allow states to set geographic rating areas by county, should north Carolina exercise that option in 2014 and 2015?***
- ***If federal guidance/regulations indicate that geographic ratings areas by county are too narrow, or if North Carolina does not prefer the county-level, how should regions be defined for 2013 and 2015?***

Age Bands & Factors

1. *Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015? If so, what additional factors should be considered? ?*

Relevant Laws and Regulations- Geographic Rating Areas

ACA and Federal Guidance:

- Each State shall establish 1 or more rating areas within that State. The Secretary shall review the rating areas to ensure the adequacy of such areas. *(PPACA Section 2701(a)(2))*
  - The Secretary will address the process for States requesting approval of rating areas in future rulemaking. *(Exchange Establishment NPRM §156.255(b)(2))*
  - Rating areas apply to the non-grandfathered fully-insured small group and individual plans. Fully insured large group plans are only subject to rating areas, and other rating requirements, in states that allow large groups to purchase through the exchange. *(PPACA Section 2701(a)(1) and (a)(5))*
- Rating areas will be applied consistently inside and outside of the Exchange *(Exchange Establishment NPRM §155.140(b)(2))*

North Carolina Statute: *(applicable to small group, only)*

- A carrier shall define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas, and shall be revenue neutral to the small employer carrier. *(NCGS: 58-50-130(b)(7))*

How Rating Areas Are Currently Defined in NC

- Most insurers use counties to group the state into broader regions
- Many insurers offer separate regions by market type (e.g. small group has a separate rating region than the individual or large group market)
- Few insurers offer separate regions by product type (e.g. HMO small group has separate rating areas than non-HMO small group)
- Most insurers group counties into regions in the individual market, with the number of regions ranging between 4 and 8
- Most insurers do not group counties into rating regions for the small group market
- Factors range from 1.4 to 1 in the individual market and from 1.5 to 1 in the small group market

The rate development process usually begins 6 to 12 months out from the time the product goes to market, making timing of the essence to determine rates for October 2013 open enrollment.

Initial TAG Recommendations & NC DOI Response

The TAG discussed geographic rating areas and requested that they be set by the NCDOI after a study. NC DOI supported this recommendation in their report to the NCGA.

The TAG recommends that the NC DOI, in consultation with insurers, be responsible for the establishment of geographic rating areas for the North Carolina individual and small group markets pursuant to the ACA. The NC DOI should commission a study analyzing the impact of different rating area options on premiums and risk distribution in the individual and small group markets. At the conclusion of the study, the NC DOI should establish rating areas. Rating areas should be set by December 31, 2012 and reassessed by the NC DOI on an as-needed basis.

In general, the TAG prefers more segmented geographic rating areas, as is the current practice of most major insurers in the State, but it also believes that additional analysis on the impact of different rating regions on premium costs and access is needed before rating areas are configured.

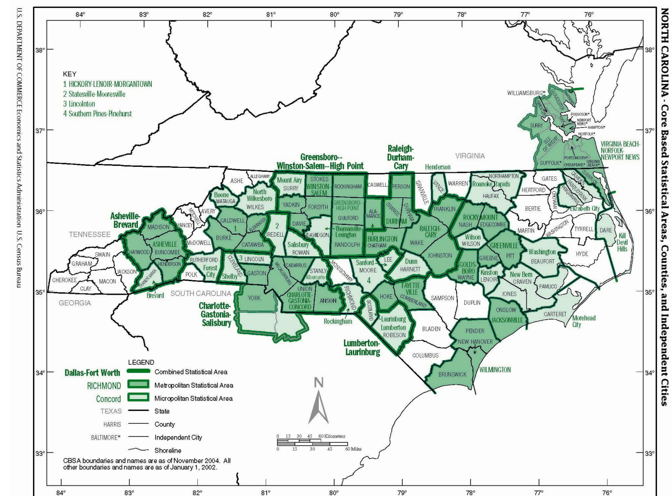
TAG Statement pulled from Issue Brief #2, available at: http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/Issue%20Brief%202%20-%20Rating%20Areas%20and%20Leveling%20the%20Playing%20Field%20Issues.pdf
NCDOI Report to the NCGA, available at: http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/NC%20DOI%20Session%20Law%202011-391%20Study%20Report.pdf

Considerations for Setting Areas

Rating Area Considerations	
County Level Designations	▪ Unclear if county-level designations will be permitted
Zip Code	▪ Unlikely that zip code delineation will be allowed
Maximum Regions	▪ CCIIO may consider up to a maximum number of regions in a state
Contiguous Areas	▪ Unclear if rating areas are required to be contiguous, although non-contiguous groupings could have the potential for rating to be based on health status rather than costs of care.
Morbidity	▪ Morbidity should not be considered in rating areas
Service Area vs. Rating Area	▪ In the preamble of the Exchange final rule, CCIIO recommends that Exchanges consider aligning QHP service areas with rating areas established by the State, but it is not a regulatory requirement to do so
Individual vs. Small Groups	▪ Unclear if geographic rating areas will be required to be the same, by market

Federal market reform rules will inform rating areas considerations.

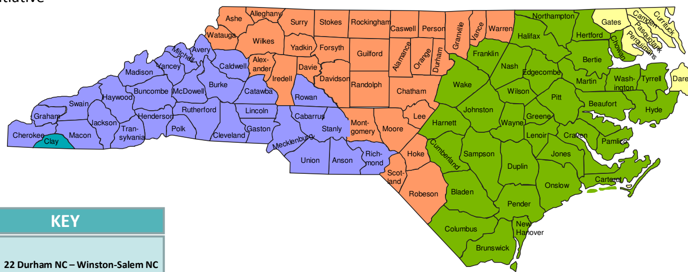
Metropolitan Statistical Areas (MSAs) could be considered as a baseline for states that do not currently use a regional approach



Source: http://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Nov2004/cbsa2004_NC.pdf

CMS has Hospital Referral Clusters that Categorize Counties Which Could be Used as a Basis for Regional Groupings

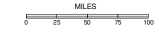
- CMS has divided the country into 92 Hospital Referral Clusters (HRCs)
- HRCs are defined by beneficiary county of residence and were recently used in the bundled payment initiative



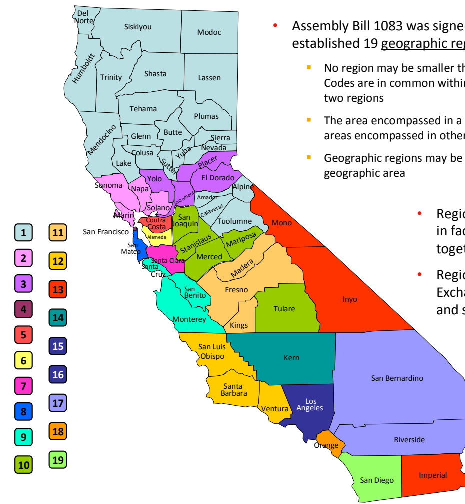
KEY

- 22 Durham NC – Winston-Salem NC
- 23 Raleigh NC – Greenville NC
- 24 Norfolk VA – Richmond VA
- 25 Charlotte NC – Greenville SC
- 29 Atlanta GA

- Could use designation as a geographic rating areas
- Could also use in conjunction with MSAs to identify regions outside of MSAs



North Carolina could Consider a Similar Process Used by California To Establish Their Rating Areas



- Assembly Bill 1083 was signed by Governor Brown on September 30th and established 19 geographic regions
  - No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions
  - The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions
  - Geographic regions may be noncontiguous. No plan shall have less than one geographic area
- Regions were established based on the variances in factors, whereby similar factors were grouped together as a proxy for similar medical costs
- Regions are applied both in and out of the Exchange and are the same in both the individual and small group markets

How Should North Carolina Establish Geographic Rating Areas?

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

	Options	Description
	Yes	• North Carolina should set rates at the county level
Work Group Consensus	Yes, for 2014 & 2015	• North Carolina could elect to use counties in 2014 & 2015 only, with plans for developing another strategy for the long term *(see next question)*
	No	• North Carolina should not set rates by county, but should define broader regions (see next question)
	Other	• Other?

The workgroup also discussed prohibiting insurers from further segmenting geographic rating areas in 2014 and 2015; though several members expressed support for this approach, the group had concerns over potential unintended consequences and ultimately did not reach consensus on this point.

How Should North Carolina Establish Geographic Rating Areas?

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?

Options	Considerations for Implementation
Establish New Grouping Methodology for North Carolina based on Studies/Analysis	• North Carolina could consider an economic impact analysis, which could set market regions for where prices are the same/similar and/or be based on hospital/provider locations and cost of care
Rely on Existing Groupings/Definitions	• North Carolina could consider using MSAs, CCNC Regions, CMS Network Adequacy designations, or CMS Hospital Clusters as a baseline for grouping • North Carolina could consider using the regions set by the largest statewide insurer in the individual and small group market
Consider California Approach	• North Carolina's DOI could establish geographic rating areas in the same manner as California, up to the maximum number permitted under federal rules (once released)
Rely on Federal Minimums	• North Carolina could defer to the federal minimums (if applicable) to set rating areas for 2014 and 2015 and target another approach for a later year (e.g. 2016 & beyond)
Other?	• Other?

The Work Group reached consensus that if federal guidance indicates that geographic rating areas by county are too narrow, North Carolina should attempt to minimize disruption by maintaining as much of its current approach as possible. The group agreed the California approach could be considered as a process by which this could occur.

Market Reform Questions Contemplated by the Work Group

Geographic Rating Areas

- *If federal guidance/regulations allow states to set geographic rating areas by county, should north Carolina exercise that option in 2014 and 2015?*
- *If federal guidance/regulations indicate that geographic ratings areas by county are too narrow, or if North Carolina does not prefer the county-level, how should regions be defined for 2013 and 2015?*

Age Bands & Factors

1. ***Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015? If so, what additional factors should be considered?***

Relevant Laws and Regulations- Age Bands and Factors

ACA and Federal Guidance on Age, only:

- Premiums offered by non-grandfathered plans in the individual and small group markets can vary by age, except that such rate shall not vary by more than 3 to 1 for adults *--(ACA Section 2701(a)(1)(A))*

North Carolina Statute: *applicable to small group, only)*

Unless the small employer carrier uses composite rating, the small employer carrier shall use the following age brackets:

a. Younger than 15 years;
b. 15 to 19 years;
c. 20 to 24 years;
d. 25 to 29 years;
e. 30 to 34 years;
f. 35 to 39 years;
g. 40 to 44 years;
h. 45 to 49 years;
i. 50 to 54 years;
j. 55 to 59 years;
k. 60 to 64 years;
l. 65 years

Carriers may combine, but shall not split, complete age brackets for the purposes of determining rates under this subsection. Small employer carriers shall be permitted to develop separate rates for individuals aged 65 years and older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor. *NCGS 58-50-130(b)(6)*

How Age Bands and Factors Are Currently Defined in NC

Almost all insurers will need to compress adult age factors to stay within the 3:1 ACA-mandated requirement.

- All insurers conform to required age bands under NC §58-50-130 for small group products
- Most insurers use single year age bands starting at or before age 21 for individual products
- Individual Product Spread
  - The average factor spread ranges from 3.77 to 5.58 – indicating that all insurers will need to also make adjustments to stay within the ACA requirement of 3:1
- Small Group Product Spread
  - The average factor spread ranges from 2.54 to 4.48 – indicating that almost all insurers will need to make adjustments to stay within the ACA requirement of 3:1

Average factor: Average of male and female

Responses from Other States

Other States' Approaches to Age Bands/Factors Implementation:

- CA- No more than the following age categories may be used in determining premium rates: Under 30; 30–39; 40–49; 50–54; 55–59; 60–64; 65 and over. However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).[1]
- DC- The law includes early adoption of the 3:1 requirements that are present in the ACA. They also include a restriction that the age factors for any age may not be more than 4% greater than the prior age. "a plan of individual or small group health insurance rates shall not include a standard rate for any age that is more than 300% of the standard rate for the age with the lowest rate in the same plan and the standard rate for any age shall not be more than 104% of the standard rate for the previous age." (DC ST § 31-3311.02)[2]
- NJ- insurers currently offering standard plans in New Jersey's individual market may consider age in establishing different premiums, with classifications set at minimum in five-year increments... eleven age factor categories: 19 and under; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; and 65 and over... Premiums may differ from the lowest to the highest based on age by no more than 350 percent. (note: considering changes needed under ACA).[3]

[1] http://info.sen.ca.gov/pub/11-12/bill/asm/ab_1051-1100/ab_1083_bill_20120911_enrolled.pdf
[2] http://weblinks.westlaw.com/result/default.aspx?cite=UUID%28N46AFA25075%2D6F11E0A026D%2DCE73F53D307%29&db=1000869&findtype=VQ&fn=%5Ftop&pbc=DA010192&rlt=CLID%5FFQRLT5775649419410&rp=%2FSearch%2Fdefault%2Ewl&rs=WEBL12%2E07&service=Find&spa=DCC%2D1000&sr=TC&vr=2%2E0
[3] http://www.cshp.rutgers.edu/Downloads/9490.pdf

Considerations for Establishing Age Factors/Bands

The 3:1 statutory requirement will raise premiums for younger populations and lower them for older populations.

Considerations for Implementation	
Age Bands	▪ Unclear if feds will set default age bands, nationally, or what flexibility will be given to states ▪ Setting parameters around age bands, or standardization of age bands across insurers, may be a part of federal requirements (assumes age bands could be separate in the individual market versus the small group market) ▪ In North Carolina, currently regulated in the small group market only
Age Factors	▪ Unclear if feds will set default age factors, nationally, or what flexibility will be given to states ▪ Setting parameters around age factors may be a part of federal requirements ▪ Unclear if standardization of age factors across insurers will be required as part of federal regulations, or if individual insurers will be responsible for setting own factors within 3:1 requirement (assumes age factors could be separate in the individual market versus the small group market) ▪ In North Carolina, not currently regulated

Federal market reform rules will inform accuracy of considerations.

Options for Changing Age Bands/Factors In North Carolina

Options	Additional Details
Establish standardized age bands in the individual market	• Consider standardizing age bands in the individual market
Set age band parameters in the individual market	• North Carolina could consider establishing parameters around how ages could be grouped for pricing in the individual market (e.g. no more than 3 years factored together)
Establish standardized age factors in both markets	• Standardize age factors for the individual and small group markets (separately by market) to apply across all insurers
Set maximum allowable increases between ages across both markets	• Similar to DC, set a maximum amount that premiums can increase based solely on age between distinct ages or age bands (e.g. 4%)
Other?	• ?

Considerations for Additional Requirements on Age

Implementing additional parameters on age factors could help smooth premium increases due solely to age for consumers over time, but also creates additional market disruption in the short term and reflects change from current business practices.

Pros from setting parameters around age?	Cons from setting parameters around age?
▪ Minimizes rating differences to consumers ▪ Over long term, could stabilize market	▪ Reflects a shift from the way the market currently operates ▪ In short term, could cause market disruption

Question for Discussion- Age

Question: Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015?

Options	
No	• No additional parameters should be placed on age factors for 2014 and 2015
Yes	• North Carolina should consider a broad range of additional parameters to be placed on age factors *(see next slide)*
Yes, if limited	• 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 *(see next slide)*
Yes, in long term only	• North Carolina should consider additional parameters on age factors in the long term, starting in 2016 *(see next slide)*
Other	• ?

Workgroup members generally agreed that complying with new 3:1 ACA-mandated requirements in 2014 will already result in significant market disruption, such that the state should refrain from imposing additional parameters on age bands in the small group and rating factors in both the individual and small group market until the impact of reforms is better understood.

Options for Discussion- Age Factors

Question: What additional options should be considered in North Carolina?*

Options	Next Steps
Establish standardized age bands in the individual market	• Determine a process by which the standardized age bands would be considered
Set age band parameters in the individual market	• Determine a process to set single year age bands in the individual market
Establish standardized age factors in both markets	• Determine a process to identify/set factors
Set maximum allowable increases between ages across both markets	• Set maximum allowable increase between ages
Other?	• ?

Members expressed an interest in further considering the use of single-year age bands in the individual market to mitigate the potential for rate cliffs across bands, since many insurers in the individual market already use highly segmented age bands. Members did not want to consider a change to standardized age bands in the small group market or standardized age factors in either the individual or small group markets at this time.

Age Bands in the Individual Market- Children

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E
Use of Bands under Age 21	No	Yes	Yes	Yes	Yes
If so, how many	NA	5	5	6	8
Age Bands	NA	0-01, 02-12, 13-16, 17-18, 19-20	Primary 0-17, 18, 19, 20 Dependent 0-26,	0-1, 2-16, 17, 18, 19, 20	<1, 1-4, 5-15, 16, 17, 18, 19, 20

Question for Discussion- Age Factors

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

Options	
No	• No age bands should not be standardized for 2014 and 2015
Yes	• North Carolina should consider standard age bands in the short term for 2014 and 2015
Yes, in Long Term only	• North Carolina should consider standard age bands in the long term, starting in 2016
Other	• ?

Agenda

9:30 – 9:35	Welcome and Introductions
9:35 – 9:45	Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG
9:45 – 10:15	Items for Discussion in TAG Meeting #10 • NC DOI Update
10:15 – 11:15	Items for Discussion in TAG Meeting #10, continued • ECP Report Back
11:15 – 11:30	*Break*
11:30 – 12:20	Items for Discussion in TAG Meeting #10, continued • Rating Implementation Report Back
12:20 – 12:30	**Wrap Up and Next Steps**

Next Steps

- **Review meeting minutes once released**
  - Minutes reflect points of consensus and considerations discussed during today's meeting, which will be used to develop issue briefs
- **Attend next webinar & in person meeting**
  - Timing is dependent on the release of additional guidance from the federal government
  - In Person meeting tentatively scheduled for December 12th. Webinar TBD.

Questions?

ECP: Statute *(ACA 1311(c)(1)(C))* & Providers Defined in SSA 1927(C)(1)(D)(i)(IV)

Statute:

GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure

SSA:

An entity that—

(aa) is described in section 501(c)(3) of the Internal Revenue Code of 1986[476] and exempt from tax under section 501(a) of such Act or is State-owned or operated; and

(bb) would be a covered entity described in section 340B(a)(4) of the Public Health Service Act insofar as the entity described in such section provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section

ECP: Regulations *(45 CFR §156.235)*

"(a) *General requirement.* (1) 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. (2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section. (3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) *Alternate standard.* A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) *Definition.* Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law: (1) Health care providers defined in section 340B(a)(4) of the PHS Act; and (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111– 8.

(d) *Payment rates.* Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) *Payment of federally-qualified health centers.* If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section."

Providers Defined in Section 340B(a)(4) of the PHS Act

(4) ''Covered entity'' defined

In this section, the term ''covered entity'' means an entity that meets the requirements described in paragraph (5) and is one of the following:

(A) A Federally-qualified health center (as defined in section 1905(*l*)(2)(B) of the Social Security Act [42 U.S.C. 1396d(*l*)(2)(B)]).

(B) An entity receiving a grant under section 256a 1 of this title.

(C) A family planning project receiving a grant or contract under section 300 of this title.

(D) An entity receiving a grant under subpart II 1 of part C of subchapter XXIV of this chapter (relating to categorical grants for outpatient early intervention services for HIV disease).

(E) A State-operated AIDS drug purchasing assistance program receiving financial assistance under subchapter XXIV of this chapter.

(F) A black lung clinic receiving funds under section 937(a) of title 30.

(G) A comprehensive hemophilia diagnostic treatment center receiving a grant under section 501(a)(2) of the Social Security Act [42 U.S.C. 701(a)(2)].

(H) A Native Hawaiian Health Center receiving funds under the Native Hawaiian Health Care Act of 1988.

(I) An urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(J) Any entity receiving assistance under subchapter XXIV of this chapter (other than a State or unit of local government or an entity described in subparagraph (D)), but only if the entity is certified by the Secretary pursuant to paragraph (7).

(K) An entity receiving funds under section 247c of this title (relating to treatment of sexually transmitted diseases) or section 247b(j)(2) 1 of this title (relating to treatment of tuberculosis) through a State or unit of local government, but only if the entity is certified by the Secretary pursuant to paragraph (7).

Providers Defined in Section 340B(a)(4) of the PHS Act - Continued

(L) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]) that— (i) is owned or operated by a unit of State or local government, is a public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government, or is a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals who are not entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or eligible for assistance under the State plan under this subchapter; (ii) for the most recent cost reporting period that ended before the calendar quarter involved, had a disproportionate share adjustment percentage (as determined under section 1886(d)(5)(F) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(F)]) greater than 11.75 percent or was described in section 1886(d)(5)(F)(i)(II) of such Act [42 .S.C. 1395ww(d)(5)(F)(i)(II)]; and (iii) does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)(iii)], or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act [42 U.S.C. 1395i–4(c)(2)]), and that meets the requirements of subparagraph (L)(i).

(O) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)(i)], or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.

Metropolitan Statistical Areas (MSAs) could be considered as a baseline for states that do not currently use a regional approach

- In the 1940's Federal agencies began to develop a single set of geographic guidelines to enhance data production for the largest population centers in the United States.
- The term "metropolitan areas" is used to generally describe an area containing a large population center and adjacent communities that have a high degree of integration with that population center.
- OMB's metropolitan area standards establish consistent definitions for collecting, tabulating and publishing Federal data for metro areas.
- An MSA is a metropolitan area made up of central counties, that include the MSAs central cities, and outlying counties that meet OBM requirements
  - Population size requirements - A city of 50,000 or more population *or* a U.S. Census Bureau defined urbanized areas of 50,000 or more population and smaller urban clusters of 10,000 to 49,999 population.
  - Central cities - City with the largest population in the MSA.
  - Central counties - Those counties that include a central city of the MSA, or at least 50 percent of the population of such a city, provided the city is located in a qualifier area; and those counties in which at least 50 percent of the population lives in the qualifier urbanized area.

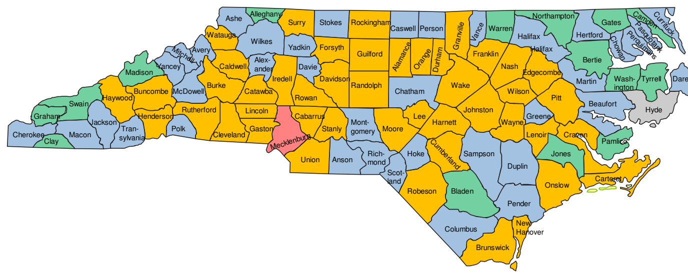
North Carolina Metropolitan Areas

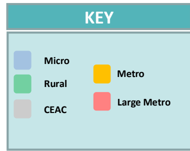
1. Asheville
2. Burlington
3. Charlotte-Gastonia-Concord (NC-SC)
4. Durham-Chapel Hill
5. Fayetteville
6. Goldsboro
7. Greensboro-High Point
8. Greenville
9. Hickory-Lenoir-Morganton
10. Jacksonville
11. Raleigh-Cary
12. Rocky Mount
13. Wilmington
14. Winston

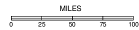
Source: http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/msa.shtm

Metropolitan Aras Source: http://proximityone.com/metro_healthinsurance.htm

CMS has Network Adequacy Standards that Categorize Counties Which Could be Used as a Basis for Regional Groupings

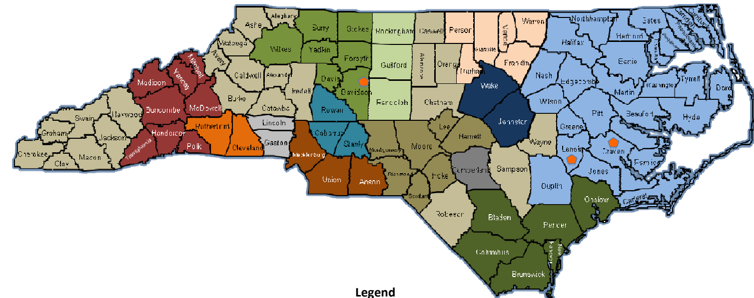






- Could use designation as a non-contiguous grouping
- Could also use in conjunction with MSAs to identify regions outside of MSAs

Community Care of North Carolina also has Areas Which Could Be Used as a Basis for Regional Groupings



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Community Care
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Source: CCNC September 2012

Rating Variances in the Individual Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E	Insurer F
Product(s)	All	All	All	All	All	All
Use of County or Zip Code	County	County	County	County	3-Level Zip Code	Unknown
Use of Regions	Yes	Yes	Yes	Yes	No	Yes
If so, how many	7	7	4	8	N/A (2 different rate factors)	8
Lowest Factor Used	0.93	0.93	0.90	0.84	0.99	0.90
Highest Factor Used	1.20	1.09	1.15	1.16	1.08	1.04
Ratio between Highest and Lowest	1.3:1	1.2:1	1.3:1	1.4:1	1.1:1	1.2:1

Sample of most insurers having greater than 5000 lives; Carrier "A" in the individual market is not the same as Carrier "A" in the small group market

Rating Variances in the Small Group Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E	Insurer F
Product(s)	All	All	All	All	All	All
Use of County or Zip Code	County	County	County	County	County	County
Use of Regions	No	No	Yes	Yes	No	Yes
If so, how many	N/A (23 different rate factors)	N/A (14 different rate factors)	13	13 (9 different rate factors)	N/A (22 different rate factors)	10 (9 different rate factors)
Lowest Factor Used	0.84	0.80	0.90	0.90	0.83	0.90
Highest Factor Used	1.25	1.15	1.04	1.15	1.25	1.15
Ratio between Highest and Lowest	1.5:1	1.4:1	1.2:1	1.3:1	1.5:1	1.3:1

Sample of most insurers having greater than 5000 lives; Carrier "A" in the individual market is not the same as Carrier "A" in the small group market

Age Band and Factor Variances in the Adult Individual Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E
Use of Bands over Age 21	No	Yes	No	No	No
If so, how many	NA	10	NA	NA	NA
Oldest Age Used	65+	66+	65	70	64
Male Spread: 21 – Oldest Age	4.9	5.19	6.09	5.03	4.57
Female Spread: 21 – Oldest Age	2.92	3.38	3.68	3.86	3.21
Average Spread: 21 – Oldest Age	3.84	4.11	5.58	4.39	3.77

Age Band and Factor Variances in the Small Group Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E
Uses Age Bands Consistent with NC Age Bands (§ 58-50-130)	Yes	Yes	Yes	Yes	Yes
Provides Medicare Primary & Secondary Factors	Yes	Yes	No	No	Yes*
Male Medicare Secondary: Spread 25 – 65+	6.05	6.82	7.35*	8.44*	8.18
Female Medicare Secondary: Spread 25 – 65+	2.66	2.85	2.88*	2.83*	2.56
Medicare Secondary: Average Spread 25 – 65+	3.76	4.06	4.24*	4.48*	2.54

*Carrier did not discern between Medicare Primary and Secondary