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

In-Person TAG Meeting #11

December 12, 2012

MANATT HEALTH SOLUTIONS

MERCER

OLIVER WYMAN

Agenda

2:00 – 2:10	Welcome and Agenda Review
2:10 – 2:20	Goals/Objectives of Work Group and Today's Discussion
2:20 – 3:30	EHB Items for Discussion in Work Group • **Habilitative Benefits** – *Should the state define habilitative benefits or leave it to insurers to define?* • **Benefit Substitution** -- *Should North Carolina allow benefit substitutions?*
3:30 –3:40	*Break*
3:40 – 4:50	Report Out/Consideration of Draft Guidance and Workgroup Recommendations: • **Draft Guidance: Employee Choice in SHOP; Insurer Participation in SHOP; Employer Size Calculation; Minimum Participation Rates Agent/Broker Compensation** • **Work Group Recommendations: Age Curve; Tobacco Rating; Geographic Rating Areas**
4:50– 5:00	Wrap Up and Next Steps

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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)

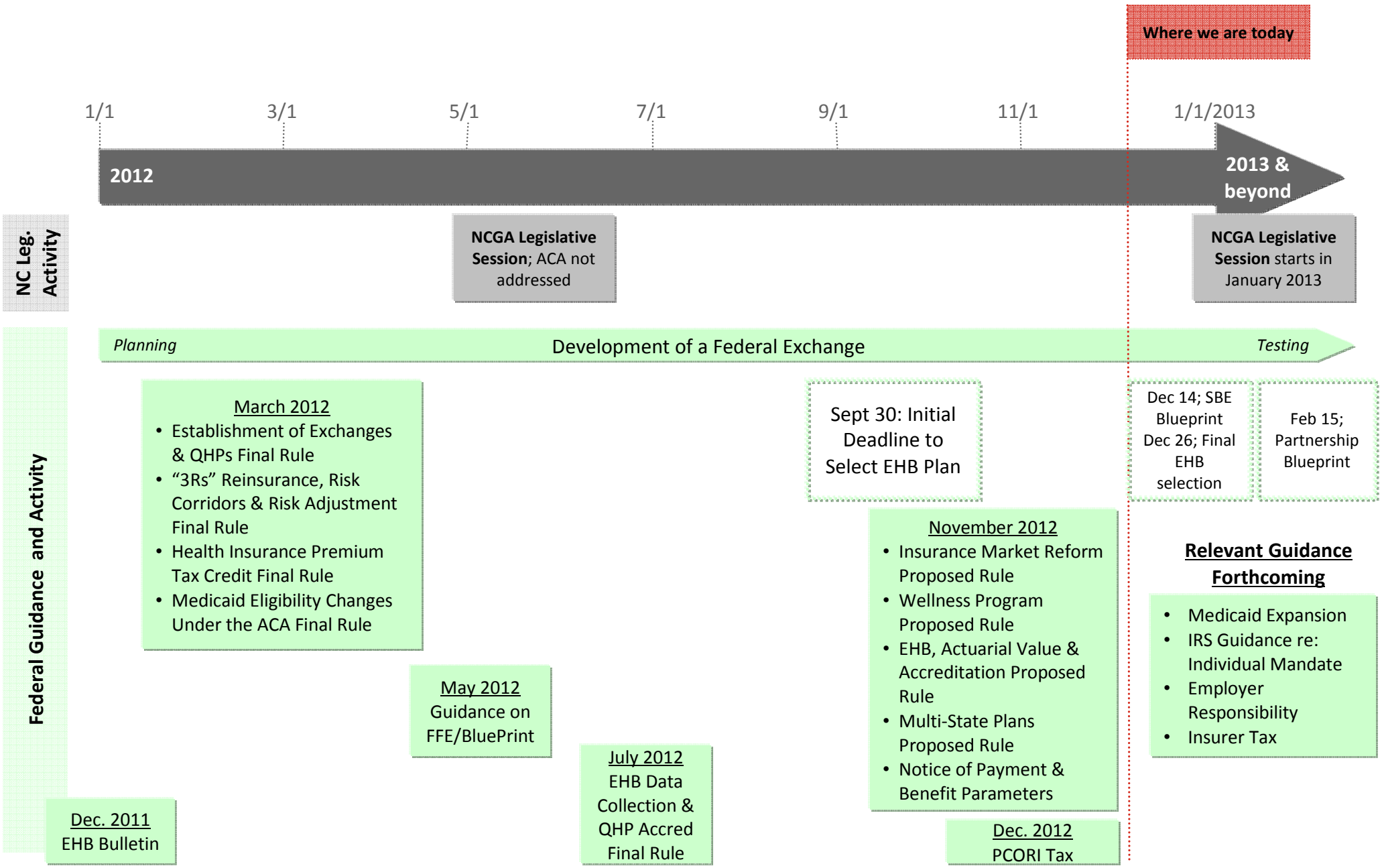
"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related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

- Review recent federal guidance related to Essential Health Benefits and make recommendations for state action, if any, on habilitative benefits and benefit substitution
- Review where new guidance intersects with previous TAG recommendations and address what action, if any, is needed to reconcile recommendations

Market and Exchange Rules/Regulations



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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Proposed Rule Summary: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Areas for Further Consideration

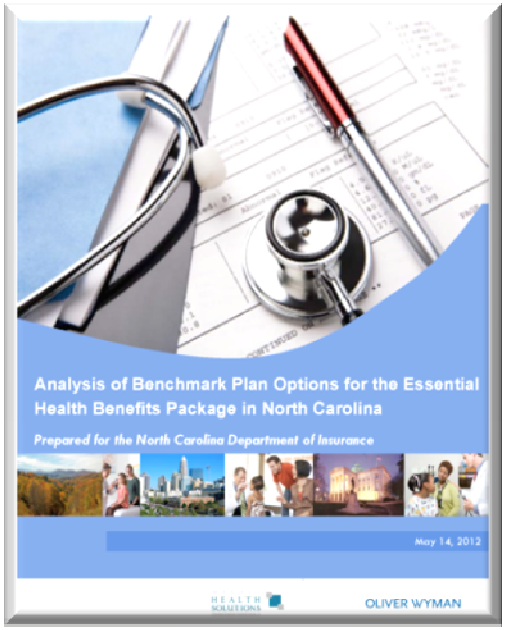
- Allows states until December 26th to select a benchmark plan from one of ten options in the state or change selection already made.
  - States that do not make a selection will default to the largest plan by enrollment in the small group market.
  - Proposes a standard process for selection of benefits not covered in the benchmark package, such as pediatric dental and vision, and a minimum standard for coverage of prescription drugs
- Proposes flexibility for habilitative services regardless of if a state defaults
- Proposes to allow states the option of permitting insurer substitution of EHB benefits, within certain parameters

Report Out

- Adopts AV standard for allowable variation of plans from the metal levels of +/-2 %
- Implements Section 1311 of the ACA, requiring that QHPs be accredited on the basis of performance by an accrediting entity recognized by HHS
- Provides guidance on determining prescription drug benefit and payment for state-required benefits beyond EHBs, and broadens non-discrimination testing to outside of the Exchange

Previous NC DOI & TAG Analysis of Benchmark Plan Options

- The TAG discussed the EHB selection process on April 9th, and reached consensus that North Carolina should further investigate the relative advantages of defining the benchmark package at the state-level.
- On May 14th, the NC DOI issued a report to inform North Carolina's potential selection of a benchmark plan. The report stated that "there appear to be few clear reasons for North Carolina to choose one benchmark option over another, although certain factors suggest eliminating the FEBHPs as preferred options."



- On May 14th, the NC DOI issued it's Study Report to the NCGA and stated that:
  - the benchmark plan options available to the State from which to choose the benchmark plan do not differ significantly in either the benefits covered or the overall impact on premiums.
  - the plan option that would be selected by default (should the state not make an active choice) does not appear to be detrimental to the citizens of North Carolina in either the range of benefits offered or cost of coverage.
  - the default option may result in the least amount of disruption to current policyholders.

The report of the benchmark plan options and the NC DOI Study Report can be found at:
http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/NC%20DOI%20Session%20Law%202011-391%20Study%20Report.pdf

Benchmark Plan Options in North Carolina

Plans Eligible for Benchmark Status	North Carolina Plans
State Employees Health Plan	▪ Option: State Employees Health Plan ▪ State only has two plans; difference in cost-sharing, only ▪ Analyzed as 1 plan
Federal Employees Health Benefit Plans (FEHBP)	▪ Option 1: BCBS Standard Option ▪ Option 2: BCBS Basic Option ▪ Option 3: GEHABP Standard Option
Small Group Insurance Plans	▪ Option 1: BCBSNC Blue Options ← Default Plan ▪ Option 2: UHC Choice Plus ▪ Option 3: BCBSNC UW Small HAS
Largest Non-Medicaid HMO	▪ Option: WellPath Select, Inc.

North Carolina defaulted to the largest small group option plan, BCBSNC Blue Option in September 2012 and the proposed rules offer no compelling reason to alter the default plan.

A complete listing of the benefits offered under BCBS Blue Options can be found at: http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf ; The report of the benefit plan options can be found at: http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/NC%20DOI%20Session%20Law%202011-391%20Study%20Report.pdf

Relevant Proposed Regulations - Habilitative Benefits

The proposed rule gives states the authority to select and define habilitative benefits if the benchmark plan does not include coverage for habilitative services. If the state does not define habilitative benefits, the rule proposes that insurers will select the habilitiative benefits for inclusion in the EHB and report to HHS.

- "If the base-benchmark plan does not include coverage for habilitative services, the state may determine which services are included in that category." *(§156.110(f) Proposed Rule)*
- If the EHB-benchmark plan does not include coverage for habilitative services, and the state does not determine which services are included, "a plan must include habilitative services that meet one of the following— (i) Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (ii) Are determined by the issuer and reported to HHS." *(§156.115(a)(4) Proposed Rule)*

Definition of Habilitative vs. Rehabilitative Benefits

- **Habilitation** – "Health care services that help a person *keep*, *learn* or *improve* skills and functioning for daily living.
  - Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."
- **Rehabilitation** – "Health care services that help a person *keep*, *get back* or *improve* skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.
  - These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings."

-- *Affordable Care Act Uniform Glossary of Terms [emphasis added]*

- **Habilitative Services** – "Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

-- *Social Security Act, Section 1915(c)(5)(a)*

"The [ACA Uniform Glossary & Medicaid] definitions include the concept of 'keeping' or 'maintaining' function, but this concept is virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation). Private insurance and Medicare may use different definitions in relation to coverage of these services."

-- *EHB Bulletin, December 2011, p.11*

Rehabilitative Benefits in North Carolina

BCBS North Carolina Benchmark Plan Rehabilitation Benefit:

Benefit Description	Visit Limit Quantity	Other Details
Cardiac Rehab	30	• More allocated if deemed necessary
Pulmonary Rehab	1	• One course of treatment per year; excludes group classes
Speech Therapy	30	• Stuttering not covered
Physical/ Occupational/Chiropractic Therapy	30	• Combined 30 visits per year

Responses from Other States

Other States' Approaches to Habilitative Benefits

- California passed legislation in September 2012 designating its EHB benchmark plan. The bill defines habilitative benefits as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy."[1]
- Oregon's EHB Workgroup recommended (and in September 2012 its Governor endorsed) adopting the parity approach to habilitative services, noting the need for continued "work on defining 'parity' for developing a habilitative services package similar to that of rehabilitative services packages."[2]
- Maryland requires coverage of "habilitative services" for children under age 19 in its small business standards for health insurance, defining these as "services, including occupational therapy, physical therapy and speech therapy, for the treatment of a child with a congenital or birth defect to enhance the child's ability to function."[3] The state also passed legislation in July 2012 requiring the establishment of a workgroup on access to habilitative service benefits for children with autism or ASD.[4]
- Habilitation services and devices are covered in a number of instances under states' autism benefit provisions. For example, Illinois defines habilitative services in the context of autism as "any professional, counseling and guidance service and treatment program, including applied behavior analysis, that is necessary to develop, maintain and restore to the maximum extent possible the function of an individual."[5]

[1] California Senate Bill 951
[2] Final Oregon EHB Workgroup Summary Presentation, September 2012. Available at: http://www.oregon.gov/OHA/OHPR/Pages/EHB/index.aspx
[3] Md. Code Ins.§ 150835(a)(3)
[4] Maryland Senate Bill 744
[5] 215 ILCS 5/256z.14(i)(3)

Considerations for Habilitative Benefits

Since North Carolina's benchmark plan option does not include habilitative services, the state has the option to select the habilitative benefit for the EHB package.

Pros from State-Selection of habilitative benefits	Cons from State-Selection of habilitiative benefits
▪ Benefit would be standard across plans, which would streamline certification and discrimination testing ▪ Consumers/advocates would have an opportunity to weigh in on benefit design at a macro level	▪ Relatively short-timeframe with a number of important issues to sort through (e.g. benefits for autism?); reaching resolution might be difficult ▪ Could limit insurer innovation and product design options

Question for Discussion – Habilitative Benefits

Question: *Should the state define habilitative benefits or leave it to insurers to define?*

Options	Additional Details
State Should Define	• State should define and a process should be identified for definition (See next slide)
State Should Define Within Certain Guidelines	• State should define, but recommendation can be made to only define within certain guidelines, such as defining parity to rehabilitative benefit in benchmark plan
Insurers Should Define	• Insurers should define and be subject to the proposed rule requirements (e.g. – at parity with rehabilitative benefit in benchmark plan or determined by the insurer and reported too HHS)
Insurers Should Define Within Certain Guidelines	• Insurers should define and be subject to additional guidelines, such as only be allowing to provide parity with rehabilitative benefit in benchmark plan
Other	• ?

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Relevant Proposed Regulations- Actuarial Substitutions

The proposed rule gives insurers the flexibility to substitute benefits, subject to certain conditions, if a state allows for benefit substitutions.

Benefit substitution is federally allowed if the insurer meets the following conditions:

1. The substitution is among (not across) categories and is not the prescription drug benefit
2. Submits evidence of actuarial equivalence of substituted benefits to the state, certified by a member of the American Academy of Actuaries, based on analysis using generally accepted actuarial principles and uses a standardized population
3. Actuarial equivalence of benefits is determined regardless of cost-sharing *(§156.11b(b) Proposed Rule)*

"Resulting plan benefits are still subject to the requirements of non-discrimination" *(Preamble)*

- A plan is not an EHB if its benefit design, or the implementation of its benefit design, discriminated based on an individual's age, expected length of life, present/predicted disability, degree of medical dependency, quality of life, or other health conditions *(§156.125 Proposed Rule)*

States have the option to enforce a stricter standard on benefit substitution or prohibit it completely *(Preamble)*

Considerations for Substitution of Benefits

Permitting substitution of benefits provides insurers flexibility and offers consumers different options. However it creates administrative and oversight challenges for states that would be tasked with determining the appropriateness of such substitutions and their impact across the market.

Pros of Permitting Insurer Substitution

- Provides insurers flexibility in meeting EHB plan requirements and in product innovation
- Different benefit designs could appeal to different consumers

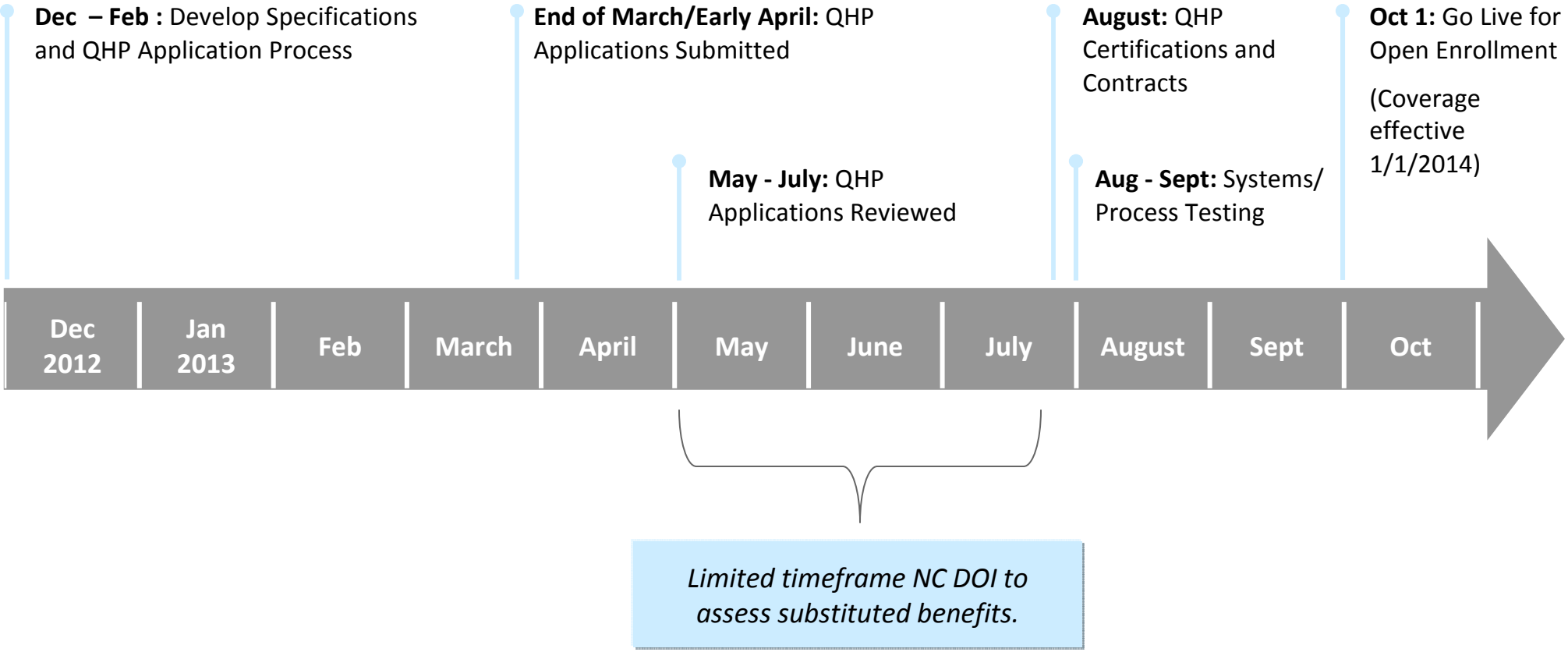
Example Benefit Substituted	Example Benefit Added
Routine adult vision exams	Routine hearing exams
Dental implants associated with injury, congenital defect or tumor removal	Wigs for chemotherapy patients*

Cons of Permitting Insurer Substitution

- Insurers would be required to perform actuarial equivalence testing, which will increase costs
- State would need to develop a new testing process to check for both discrimination as well as adverse selection/favorability
  - E.g. State may need to develop a process that tests for clinical appropriateness
- Time frame for certification will be longer if many plans submit substitutions
- Ability of consumers to compare plans might be limited/compromised

*Unclear which category wigs might be included

Key Dates for State in Year One Timeline



Responses from Other States & Stakeholders

Other States' Approaches to Benefit Substitution

- California passed legislation in September 2012 designates its EHB benchmark plan and prohibits insurers from making benefit substitutions for the EHB package, regardless of whether those substitutions are actuarially equivalent, except that they may substitute their prescription drug formularies for the formulary provided under the benchmark as long as certain specified conditions are met. [1]
- The Maryland Insurance Department held a public hearing in mid-November 2012 to receive testimony on substitution rules for benefit design under the state's EHB benchmark plan. Participants were asked to "provide arguments for and against instituting a "no substitutions" policy regarding EHBs for the 2014 plan year (which would be re-evaluated at a later date for 2015) for all benefits other than in vitro fertilization. The restriction would not include creative plan designs that provide additional benefits (for example through step therapy) or changes in provider networks." As the MD Health Care Reform Coordinating Council "mandated that their be 'liberal substitution of the IVF benefit'," the Department also sought comment at the hearing on four specific substitution options for the IVF benefit.[2]

Excerpts of National Dialogue

- **Community Catalyst:** "Flexibility [in benefit substitution] could allow for tremendous variation in EHB plans and in some cases, adverse selection. Too much variation is confusing for consumers and raises concerns about transparency in consumer plan choice"[3]
- **American College of Physicians:** "ACP chapters can contact their State Insurance Commissioner or related entity and urge them to require coverage of comprehensive evidence-based primary and preventive care services; provide strong oversight of insurer benefit substitution activities; and encourage use of high-value, cost conscious interventions."[4] (*Emphasis added*)
- **United Healthcare (NE):** "The State should allow maximum flexibility regarding actuarially equivalent substitutions within statutory benefit categories […] and provide clarity indicating how and under what circumstances such substitutions may be made."[5]

[1] California Senate Bill 951
[2] http://www.mdinsurance.state.md.us/sa/consumer/substitution-of-essential-health-benefits.html-benefits.html
[3] http://www.communitycatalyst.org/doc_store/publications/Transparency_EHB_final_July_2012.pdf
[4] http://www.acponline.org/advocacy/state_policy/hottopics/essential_health_benefits.pdf
[5] http://www.doi.ne.gov/healthcarereform/exchange/EHB/United_Health_Care.pdf

Question for Discussion – Substitution of Benefits

Question: *Should North Carolina allow for benefit substitutions?*

Options	Additional Details
No	• North Carolina should not allow for substitutions in 2014
Yes, Subject to Insurer Burden of Proof	• North Carolina could allow substitutions if insurer submits actuarial equivalence testing by an external actuary and insurer provides proof that such a substitution is non-discriminatory • Substitution would still be subject to approval, however, resources and clinical expertise for review by DOI may be limited
Other	• ?

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Report Out: Employee Choice in SHOP

Proposed guidance seek to allow employees choice of all plans within a metal level in the SHOP exchange, while TAG recommendations proposed allowing employers the option to select 1 QHP.

Benefit Notice

- HHS proposes to limit the federal SHOP to a purchasing model through which an employer selects a metal level and employees are permitted to enroll in any QHP offered by any insurer in that metal level
- Comment is sought on whether employers should be allowed to direct employers to a single QHP for all employees (as is common practice today)
- Comment is also sought on whether employees should be allowed to purchase certain plans at the next highest levels ("buy up"), recognizing that this would increase choice and adverse selection

Original TAG Recommendation

- The TAG recommends that employers should not be prohibited from restricting employee choice of plans to one or more specific plan(s) within a single metal level in the SHOP Exchange. The TAG also recommends further consideration of the extent to which the employer should be allowed to offer expanded choice.

Source: Issue Brief #1

Report Out: Insurer Participation in SHOP

Proposed guidance requires insurers that participate in the individual exchange to participate in the SHOP, but does not expand metal level participation requirements.

Benefit Notice

- Requires insurers applying to participate in a federal exchange in the individual market to also participate in the SHOP, except where neither the insurer nor any other insurer in the same "issuer group" is participating in the small group market in that state
  - Issuer Group is defined as insurers linked by common ownership or by a common nationally licensed service mark
  - Participation is defined as offering at least silver and gold level QHPs

Original TAG Recommendation

- The TAG did not specifically weigh in on insurer participation in the individual exchange being linked to insurer participation in the SHOP.
- The TAG recommends that insurers should not be required to participate in additional metal levels [beyond silver and gold] as a condition of Exchange participation in 2014 and 2015.

Source: Issue Brief #2

Further Consideration: Employer Size Calculation in SHOP

Proposed guidance uses full time equivalents to determine SHOP eligibility while North Carolina uses actual number of number of employees.

Benefit Notice & State Statute

- To determine eligibility for the SHOPs, employees will be counted based on full-time equivalents effective October 1, 2013
- Notice recognizes that this could create inconsistent definitions for how a small group is defined in versus out of the exchange
  - In North Carolina, employee is defined as a non-seasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. *(NCGS § 58-51-80(c))*

Original TAG Recommendation

- The current methodology for counting employees for the purpose of determining employer group size (small or large) under North Carolina law differs from the methodology in the ACA. The TAG recommends that North Carolina align the methodology for determining employer group size with the ACA effective January 1, 2014.

Question: Should the TAG make any changes to its prior recommendation based on the new guidance?

Source: Issue Brief #1

Note: NC Statute definition of employee is for purposes of counting group size

Further Consideration: Minimum Participation Rate in SHOP

Proposed guidance requires a minimum participation rate of 70%, which could be increased by the state and/or extended to the non-SHOP market.

Benefit Notice & State Statute

- Established a minimum participate rate of 70% for federal SHOPs
- Proposes for federal SHOPs to apply a different minimum participation rate in states where a state law sets the rate, or there is evidence that a higher or lower rate is used by the majority of QHP issuers in the small group market outside of the SHOP
- Current North Carolina statute allows insurers to impose "reasonable employer participation" requirements on small employers *(NCGS 58-50-130(a)(4a))*

Original TAG Recommendation

- The TAG **recommends the establishment of a minimum participation requirement in the SHOP to mitigate adverse selection, and that the Exchange board, in consultation with the North Carolina Department of Insurance, be granted the authority to determine the SHOP participation requirement.**

Question: Should the TAG make any changes to its prior recommendation based on the new guidance?

Source: Issue Brief #1

Further Consideration: Agent/Broker Compensation

Proposed guidance requires that agent/broker compensation be standardized in and outside of the exchange for similar plans.

Benefit Notice

- Requires insurers participating in federal exchanges and SHOPs to pay the same broker compensation inside and outside the exchange for similar health plans

Original TAG Recommendation

- There was strong support among many TAG members for standardization of agent compensation both within and across insurers, applicable to all forms of agent compensation, however consensus was not reach on this.
- There was also strong support for standardizing agent/broker compensation across products in and out of the exchange (only), but consensus was not reached as some members felt that did not go far enough.

Question: Should the TAG make any changes to its prior recommendation based on the new guidance?

Source: Final TAG 9 Notes

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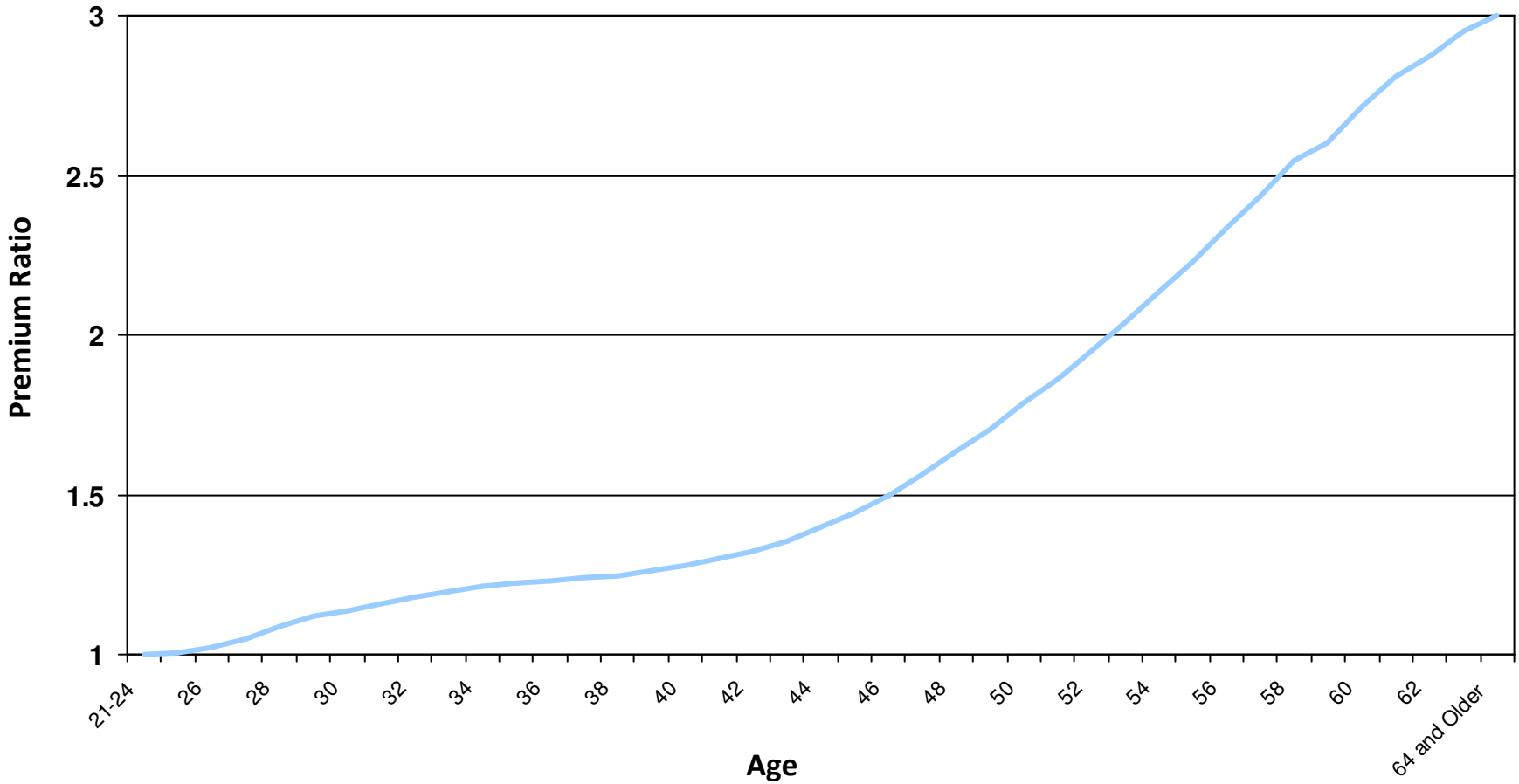
Relevant Laws and Regulations – Federal Age Bands and Factors

The proposed rules prescribe uniform age bands that all states and insurers must follow and offer a federal default age curve to implement the 3:1 ratio. States have the flexibility to submit their own rating curves.

- States must use the following standard age bands in the individual and small group markets for the purposes of age rating, subject to the rating rules of PHS Act Section 2701:
  - Children: A single age band covering children 0 to 20 years of age, where all premium rates are the same (rates must be actuarially justified and based on a standard population)
  - Adults: One year age bands starting at age 21 and ending at age 63
  - Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same *(Insurance Market Rules NPRM §147.102)*
- Health insurance issuers within any market in a state must use a uniform age rating curve; the same rating curve applies to both the individual and small group market *(Insurance Market Rules NPRM §147.102).*
  - A state may apply the default age rating curve developed by CMS *(see next slide)*, or may develop its own standard age rating curve
  - A state planning to use its own standard rating curve must submit the proposed curve to CMS no later than 30 days after publication of the Final Rule
- Age bands and age factors should be determined based on an enrollee's age on the first day of a plan or policy year *(Insurance Market Rules NPRM §147.102).*

Federal Age Curve



Work Group Questions & Initial Response: North Carolina-Specific Age Curve

Questions: Should North Carolina submit a North Carolina-based age curve? If the state chooses to submit a North Carolina-based age curve, how should it be calculated?

Relevant Laws and Regulations – Tobacco Rating

The proposed rule gives flexibility to states to establish a narrower ratio across the market and/or for states to give insurers flexibility with respect to tobacco rating.

- A state may prescribe a narrower ratio for the tobacco rating factor (e.g., 1.25:1 vs 1.5:1) or prohibit varying rates for tobacco use *(Insurance Market Rules NPRM §147.102)*.
  - If a state plans to adopt a narrower ratio for tobacco use, the state must submit relevant information to CMS within 30 days of publication of the Final Rule *(Preamble)*
- States can be prescriptive with insurers or allow insurers to vary the tobacco use factor overall or by age band (e.g., use a lower tobacco use factor for a younger person than an older person) as long as the factor does not exceed 1.5:1 for any age group *(Insurance Market Rules NPRM §147.102)*
- In the small group market, the surcharge would be tied to a wellness program; insurers can impose the surcharge only if they give enrollees the option of participating in a tobacco cessation program and waive the surcharge for those who participate *(Preamble)*
- In the individual market, HHS does not propose that tobacco surcharges be linked to smoking cessation programs; the ACA does not permit discounts for wellness programs in the individual market *(Preamble)*

Previous TAG Considerations & Work Group Questions and Initial Response: Tobacco Rating Issue

The TAG discussed considerations related to the tobacco rating factor at its October 2012 meeting and reached consensus that the factor should be limited to less than 1.5 (though the TAG did not reach consensus regarding what the appropriate rating factor would be).

Questions on tobacco rating: *Should the state impose a standard tobacco rating factor? If so, how should a factor of less than 1.5 be determined? If the state does not implement a standardized a factor, how should insurers limit the tobacco rating factor to something lower than 1.5?*

Implementation Question: *How should tobacco use be measured?**

*Unclear how much, if any, flexibility will be given to determine this within a partnership model.

Relevant Laws and Regulations – Geographic Rating Areas

The proposed rules set minimum requirements for geographic rating areas, while still permitting states to request flexibility on rating areas.

- In establishing geographic rating areas, a state may use one of three approved standards for geographic rating areas, or submit its own standard, subject to CMS approval. The three approved geographic rating area standards are:
  1. one rating area for the entire state;
  2. no more than seven rating areas based on counties or 3-digit zip codes (i.e., areas in which all zip codes share the first three digits); or
  3. no more than seven rating areas based on metropolitan statistical areas (MSAs) and non-MSAs
- A state may also propose to CMS for approval other existing geographic rating divisions on which to base rating areas, or a number of rating areas greater than seven *(Insurance Market Rules NPRM §147.102(b))*
- All sections of a geographic rating area do not need to be geographically adjacent *(Insurance Market Rules NPRM, Fed Reg 70592)*
- If a state does not establish adequate rating areas or submit information to CMS on those rating areas, CMS will either impose one rating area or establish multiple rating areas within the state in accordance with the standards described above *(Insurance Market Rules NPRM §147.102(b))*

NC Statute for small group market 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))*

Geographic Rating Areas

The Rating Work Group and TAG previously discussed geographic rating areas and developed statements on related policy options, which were presented to the TAG at its November 2012 meeting prior to the market rules coming out.

Prior Draft Consensus Points from TAG Meeting:

- North Carolina should elect to use counties in 2014 & 2015 only, if allowed, with plans for evaluating another strategy for the long term.
- If the feds require a cap on the number of areas, NC 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).

Work Group Questions & Initial Response: Geographic Rating Areas

Questions: *Should the state submit an exception to permit North Carolina to use counties as geographic rating area? (e.g. 100 rating areas?) f 100 counties is not approved or not desired, how should geographic rating areas be calculated? Does this process change if the state is allowed more than 7 areas?*

Agenda

2:00 – 2:10	Welcome and Agenda Review
2:10 – 2:20	Goals/Objectives of Work Group and Today's Discussion
2:20 – 3:30	EHB Items for Discussion in Work Group • **Habilitative Benefits** – *Should the state define habilitative benefits or leave it to insurers to define?* • **Benefit Substitution** -- *Should North Carolina allow benefit substitutions?*
3:30 –3:40	*Break*
3:40 – 4:50	Report Out/Consideration of Draft Guidance and Workgroup Recommendations: • **Draft Guidance: Employee Choice in SHOP; Insurer Participation in SHOP; Employer Size Calculation; Minimum Participation Rates Agent/Broker Compensation** • **Work Group Recommendations: Age Curve; Tobacco Rating; Geographic Rating Areas**
4:50– 5:00	Wrap Up and Next Steps

Next Steps

- **Review Meeting Notes Once Released**

Questions?

Responses from Stakeholders- Habilitative Benefits

Excerpts of National Dialogue on Habilitative Benefits

- The Institute of Medicine's (IOM) EHB Report recommended that the Secretary look to state Medicaid program as a guide for defining what is covered under the EHB habilitation benefit. The IOM report states:

  "The Committee is guided by the unambiguous direction of Section 1302 to start with a commercial insurance health benefit; however, it suggests that the Secretary compare, in particular, how Medicaid plan benefits for habilitation and mental health and substance abuse services compare with commercial plans that currently include such services."[1]

- The Habilitation Benefits Coalition (HBC) endorsed the IOM approach and the NAIC definition of habilitation (which has since been incorporated into the Universal Glossary of Health Coverage and Medical Terms) and recommended that HHS continually assess habilitation services coverage to ensure adequacy of access. HBC states:

  "The extent of coverage of habilitation services and devices should at least be in parity with rehabilitation coverage. In other words, regardless of the diagnosis that leads to a functional deficit in an individual, the coverage and medical necessity determinations for rehabilitative and habilitative services and devices should be based on clinical judgments of the effectiveness of the therapy, service or device to assess the deficit. Such judgments should be made on a periodic basis to ensure the individual continues to benefit from the rehabilitative or habilitative intervention."[2]

[1] Institute of Medicine Report on Essential Benefits: Balancing Coverage and Cost, September 2011, p.81-2.
[2] The Habilitation Benefits Coalition (HBC) members include the American Academy of Pediatrics, American Assoc. of People with Disabilities, American Heart Association/American Stroke Association, Autism Speaks, March of Dimes, National Association of Children's Hospitals, National Down Syndrome Society, United Cerebral Palsy among other organizations.
3 HBC. "Coverage of Habilitation Services and Devices in the Essential Benefits Package Under the ACA." October 25, 2011.

Post-Election Health Reform Guidance
Released November 20, 2012

Proposed Rule	Link	Comment Due Date
Essential Health Benefits, Actuarial Value, Accreditation		
Proposed rule on essential health benefits, actuarial value, and plan accreditation	http://www.ofr.gov/ofrupload/ofrdata/2012-28362_PI.pdf	December 26 , 2012
Additional information on state essential health benefits benchmark plans	http://www.cciio.cms.gov/resources/data/ehb.html	December 26 , 2012
State Medicaid director letter on essential health benefits and the Medicaid benchmark	http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf	December 26 , 2012
Actuarial value calculator and methodology	http://cciio.cms.gov/resources/regulations/index.html#pm	December 26 , 2012
Final notice recognizing entities for accreditation of qualified health plans	http://www.gpo.gov/fdsys/pkg/FR-2012-11-23/html/2012-28440.htm	NA
Paperwork Reduction Act (PRA) package on accrediting entities	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10449.html	December 26 , 2012

Post-Election Health Reform Guidance
Released November 20, 2012

Proposed Rule	Link	Comment Due Date
Health Insurance Market Reforms and Wellness Rules		
Proposed rule on health insurance market reforms and rate review	http://www.ofr.gov/OFRUpload/OFRData/2012-28428_PI.pdf	December 26, 2012
Proposed rue on incentives for nondiscriminatory wellness programs in group health plans	http://www.ofr.gov/OFRUpload/OFRData/2012-28361_PI.pdf	January 25, 2013
PRA package for rate review	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10379.html	December 26, 2012
Other PRA Packages		
PRA package on certifying qualified health plans	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10433.html	NA
PRA package on insurer compliance with title XXVII of the Public Health Service Act	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10430.html	NA

Post-Election Health Reform Guidance
Released November 30, 2012 and December 5, 2012

Proposed Rule/Notice	Link	Comment Due Date
Proposed Rule & Notices		
Multi-State Plan Program	http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/html/2012-29118.htm	January 4, 2013
Notice of Benefit and Payment Parameters	http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf	December 31, 2011
PCORI Rule	https://www.federalregister.gov/articles/2012/12/06/2012-29325/fees-on-health-insurance-policies-and-self-insured-plans-for-the-patient-centered-outcomes-research	NA