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

In-Person TAG Meeting #5

March 30, 2012

MANATT HEALTH SOLUTIONS

MERCER

OLIVER WYMAN

Agenda

9:30 – 9:40	**Welcome and Introductions**
9:40 – 9:45	Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG
9:45 – 10:45	Issues for Discussion in TAG Meeting #5 • Risk Adjustment *(30 min)* ▪ Should North Carolina administer the federal risk adjustment model in the state for the first year or monitor the federal risk adjustment process for future administration? ▪ If the state elects to administer, should the NC DOI or another entity take on these administration responsibilities? ▪ If the state elects to administer, should the state use a distributed model in the first year? • Reinsurance *(30 min)* ▪ Should North Carolina administer reinsurance in the state or defer administration to the federal government? ▪ If the state elects to administer, should the NC DOI or another entity be tasked with establishing the reinsurance entity?
10:45 – 11:05	Issues for Discussion in TAG Meeting #5 • Group Participation Requirements *(20 min)* ▪ Should NC have an employer participation rate in the SHOP exchange? ▪ If North Carolina has an employer participation rate in the SHOP, who should determine that rate?
11:05 – 11:15	*Break*
11:15 – 12:00	Review Points of Consensus from Prior TAG Meetings, TAG #4 Meeting Minutes
12:00 – 12:20	Discussion on Most Favored Nation Issue ▪ Should the TAG review the implications of MFN clauses in health care provider/insurer contracts in the North Carolina marketplace in light of the ACA? ▪ If MFN requires TAG review, what items should specifically be addressed by the TAG during that review to assess the impact of MFN on the post-ACA marketplace?
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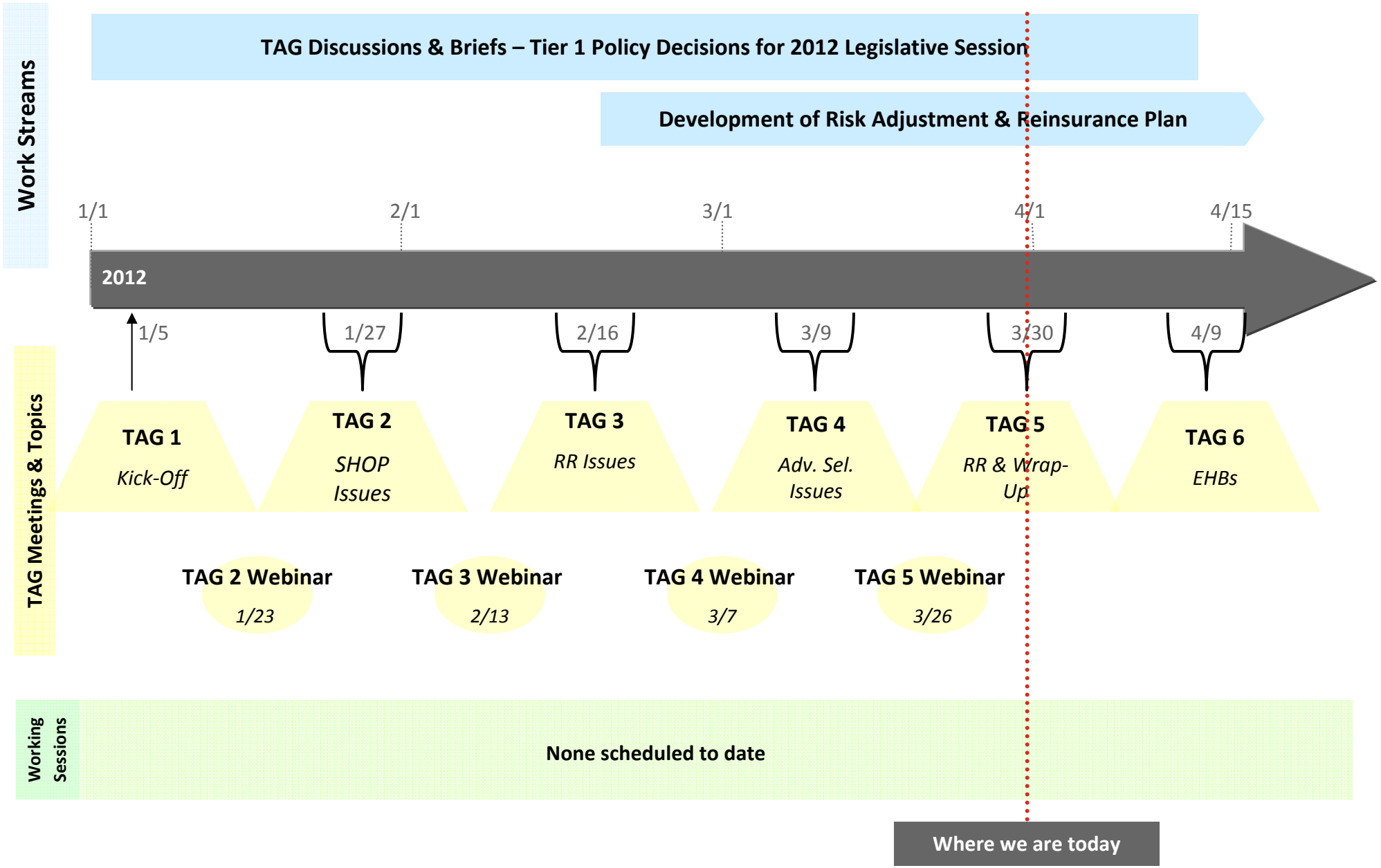
TAG Deliberations – Work Plan for 2012 NCGA Session



Project Goal and Meeting Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI recommendations to the NCGA on 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

Goals for Today's Meeting

- Confirm Options and Decision Points for Each of the Policy Questions Related to Risk Adjustment, Reinsurance and Group Participation
  - Identify Considerations for Each Policy Option
  - Identify Any Points of Consensus Within Each Policy Question
- Review Existing Consensus Points in Light of Final Regulations
- Confirm TAG 4 Meeting Minutes
- Address Most Favored Nation Issue

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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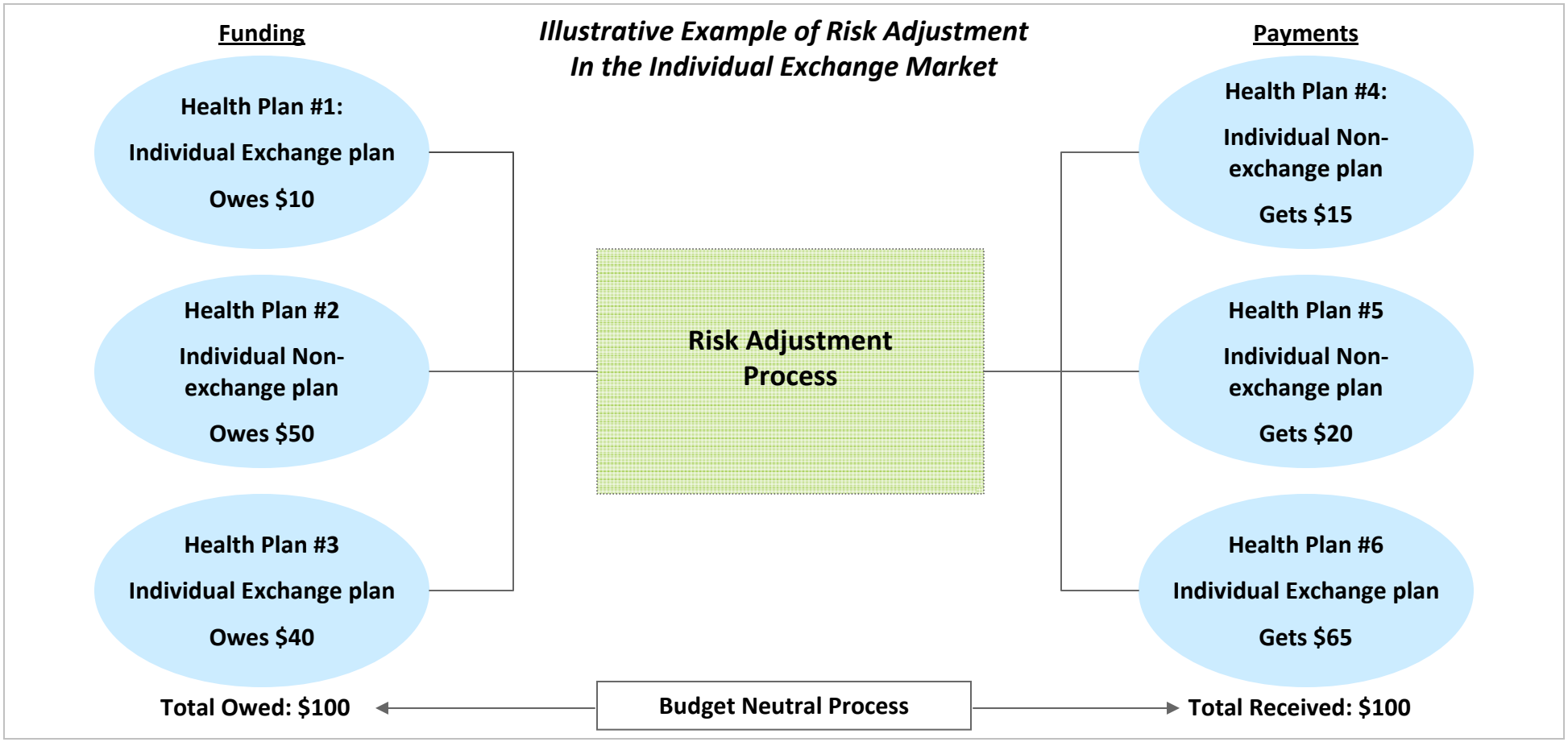
TAG Meeting #5 Issues for Discussion

Risk Adjustment and Reinsurance Discussion Items

- **Risk Adjustment:**
  - **Should North Carolina administer the federal risk adjustment model in the state for the first year or monitor the federal risk adjustment process for future administration?**
  - **If the state elects to administer, should the NC DOI or another entity take on these administration responsibilities?**
  - **If the state elects to administer, should the state use a distributed model in the first year?**
- Reinsurance:
  - Should North Carolina administer reinsurance in the state or defer administration to the federal government?
  - If the state elects to administer, should the NC DOI or another entity be tasked with establishing the reinsurance entity?

Risk Adjustment Overview

Risk adjustment is <u>funded</u> by non-grandfathered plans with a lower than average risk population in or outside of exchange in a state. Risk adjustment <u>payments</u> are made to non-grandfathered plans with a higher than average risk population. Risk adjustment is done separately for individual and small group markets, unless they are merged into a single pool.



Relevant Laws and Regulations

ACA and Federal Guidance

- ACA provides for a program of risk adjustment (RA) for all non-grandfathered plans in the individual and small group markets both in and out of the exchange. (*PPACA Section 1343)*
- States operating HBEs are eligible to establish risk adjustment programs. HHS will run the risk adjustment program for states that elect not to establish an exchange and/or administer a risk adjustment program. *(45 CFR153.300(a)(1) & (2))*
- States that elect to operate an Exchange but do not elect to administer risk adjustment will forgo implementation of all state functions related to risk adjustment administration. *(45 CFR 153.310(3))*
- If a state operates a risk adjustment program, the state may elect to have an entity other than the Exchange perform the state functions, provided the entity is eligible to carry out Exchange functions *(45 CFR 153.310(3)(b))*
  - Eligible entities include state Medicaid agencies or other state agencies. The entity must also meet specified requirements related to the structure of its governing board and related governance principles. *(45 CFR 155.110)*
- If a state operates a risk adjustment program, the state must collect the risk adjustment data. The state may vary the amount and type of data collected, but the state must collect or calculate individual risk scores generated by the federal risk adjustment model. *(45 CFR 153.340(a) & (b))*
  - The state must require that issuers offering risk adjustment plans comply with data privacy and security standards, including limiting the information collection what is reasonably necessary for use in the applicable risk adjustment model or calculation *(45 CFR 153.340(b)(2) & (3))*
- HHS will use a distributed approach when operating risk adjustment on behalf of a state. *(45 CFR 155 preamble)*

Considerations

NC can choose to administer the risk adjustment program or defer to HHS, who will use a distributed model to collect data. If NC opts to administer the risk adjustment program, NC must decide how to administer the model and meet other federal requirements. The state can select qualified entities such as the state exchange, insurance department or a new entity to perform these tasks.

Pros of Administering	Cons of Administering
▪ Better coordination with reinsurance *(if administered at a state level)*, rate review and other state programs ▪ Better able to address questions or resolve issues as they arise in the process ▪ With a distributed model option, easier for the state to administer	▪ Would take time/resources to implement, thereby distracting from other areas of health reform implementation ▪ Does not take advantage of federal resources and experience in risk adjustment programs ▪ Not as easy to comply with federal rules as opposed to deferring

At this time, it is unclear what costs will be associated with participation in the federal risk adjustment model or how those costs will compare with the cost of administration at the state level.

Options and Action Steps

Question: Should North Carolina administer the federal risk adjustment model in the state for the first year or monitor the federal risk adjustment process for future administration?

Options	Action Steps
Monitor the federal risk adjustment process for future administration	• Cede all administration responsibilities to the feds for the first year
Administer the federal risk adjustment program at the state level	• Administer entirely at the state level • Determine risk adjustment program details such as the entity who will administer and establish applicable financing, governance and oversight mechanisms • Determine if North Carolina will use a distributed or non-distributed approach and the amount of information that is to be collected
Other?	• TBD

Characteristics of Entities Eligible for Risk Adjustment Administration

- Incorporated under or subject to state laws
  - State agencies, such as the DOI and Medicaid are eligible
- Demonstrated experienced with small group and individual markets and not a health insurance issuer
- A neutral risk adjustment administrator with no conflict of interests
- Has risk adjustment expertise to administer the program, or be well-positioned to hire or contract for that expertise
- Has authorization and budget to administer the risk adjustment program
- Provides operational transparency, including a hotline for issuer questions and maintenance of records for audits
- Complies with any regulatory requirements potentially subject to oversight by responsible agency, as applicable

Options and Action Steps

Question: If the state elects to administer, should the NC DOI or another entity take on these administration responsibilities?

Options	Action Steps
The NC DOI should administer the NC risk adjustment program	• Provide NC DOI statutory authority to administer the program or contract with a vendor to administer the program starting with plan year 2014
Elect another entity for risk adjustment administration responsibilities	• TBD

Distributive Risk Adjustment Model Overview

- Issuers will reformat and summarize their data to map to the risk assessment database, and pass on individual risk scores to the entity responsible for assessing risk adjustment charges and payments across all issuers
  - Issuers need to maintain data in a manner that complies with state/ HHS specifications and may be required to run risk adjustment software depending on the distributed model used
- The risk adjustment entity will process individual risk scores and summarized claims data to determine payments each health issuer will receive or charges they will need to pay
  - States operating risk adjustment will need to collect or calculate, at a minimum, individual risk scores
  - A state or HHS will not be required to collect detailed claims and eligibility data although the data and audit process will be more involved

Options and Action Steps

Question: If the state elects to administer, should the state use a distributed model in the first year?

Options	Action Steps
Employ a distributed model	• Use federal regulations and subsequent guidance to administer the program • Gain knowledge of federal model to provide oversight for calculations done by insurers
Employ a non-distributed model	• Determine what data is needed to be collected by the state • Initiate development of capabilities associated with a data warehouse or initiate development other data gathering tools and analysis, such as APCD
Other?	• TBD

TAG Meeting #5 Issues for Discussion

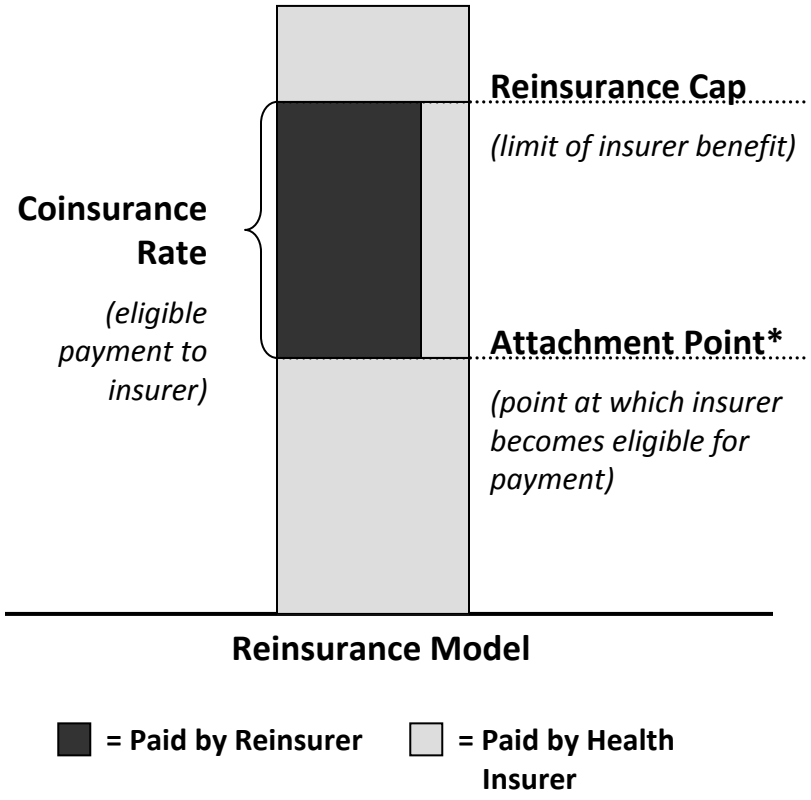
Risk Adjustment and Reinsurance Discussion Items

- Risk Adjustment:
  - Should North Carolina administer the federal risk adjustment model in the state for the first year or monitor the federal risk adjustment process for future administration?
  - If the state elects to administer, should the NC DOI or another entity take on these administration responsibilities?
  - If the state elects to administer, should the state use a distributed model in the first year?
- **Reinsurance:**
  - **Should North Carolina administer reinsurance in the state or defer administration to the federal government?**
  - **If the state elects to administer reinsurance, should the NC DOI or another entity be tasked with establishing the reinsurance entity?**

Reinsurance Background

Reinsurance is funded by all commercial health insurers and TPAs of self-insured plans both in and out of the exchange, including grandfathered plans. Benefits are paid to non-grandfathered individual market plans in or outside of the exchange.

Payment Model for Reinsurance



Sample Reinsurance Calculation

Reinsurance Parameters	
Attachment Point	$50,000
Coinsurance Rate	80%
Reinsurance Cap	$150,000
Insurer Liability if Total Claims Cost is $200,000	
Initial Claims Up to Attachment Point	$50,000
Claims Cost Up to Reinsurance Cap	$20,000 (20% x $100,000)
Claims in Excess of Reinsurance Cap	$50,000
Total Claims Cost Insurer	**$120,000**
Total Reinsurance Benefit	**$80,000**

*Attachment point is met when expenses for all covered benefits in a benefit year meet a certain $ amount

Source: Manatt Analysis; Wakely Consulting, *Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment*, July 2011

Relevant Laws and Regulations

ACA and Federal Guidance-

- Each state must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of exchange operation. *(PPACA Section 1341)*
- Each state is eligible to establish a reinsurance program for the years 2014 through 2016 regardless of if they elect to operate a state-based exchange. HHS will establish a reinsurance program for each State that does not elect to establish its own reinsurance program. *(45 CFR 153.210(a) &(c))*
- For states that elect to establish a reinsurance program, each state must enter into a contract with one or more applicable reinsurance entities (not-for-profit organization(s)). *(45 CFR 153.20; 153.210(a)(1))*
- If a state establishes a reinsurance program, it may elect to collect more than the amounts that would be collected based on the national contribution rate for the applicable year to provide either 1) funding for administrative expenses or 2) additional funding for reinsurance payments and it may modify the reinsurance payment formula. *(45 CFR 153.220(g)); (45 CFR 153.230(d))*
- HHS will collect reinsurance payments from the self-insured market in all states, irrespective if a state elects to establish a state-based reinsurance program or not. *(45 CFR 153 Preamble)*
  - States that establish a reinsurance program have the option to collect contributions from the fully insured market. If a state does not elect this option, HHS will collect contributions from both the fully insured and self-insured plans. *(45 CFR 153.220(b))*

North Carolina Statutes-

Small Group Reinsurance Pool Statute (*NCGS 58-50-150; no longer active*), NC Motor Vehicle Reinsurance Facility Act (*NCGS 58-37*), Mandatory or Voluntary Risk Sharing Plans (*NCGS 58-42*), Life and Health Guaranty Association Statute (*NCGS 58-62*) address establishment of reinsurance programs within NC.

Considerations

Final regulations stipulate that the feds will collect contribution funds from self-insured plans and that states have the option to establish a reinsurance program which collects contribution funds from fully-insured plans and disburses reinsurance payments. States that elect to establish a reinsurance program also have the option to collect more than the national contribution rate and modify the payment formula.

Pros of Administering in North Carolina	Cons of Administering in North Carolina

▪ Allows flexibility to increase the contribution rate collected to cover claims
▪ Allow flexibility in:
  ▪ Increasing or decreasing the attachment point
  ▪ Increasing, decreasing or eliminating the reinsurance cap
  ▪ Increasing or decreasing the co-insurance rate
▪ May allow for more timely coordination and response time to questions, etc.
	▪ Creates another "to do" on an already busy agenda to implement health reform
	▪ Does not take advantage of federal resources, which may be cheaper for administration if costs are leveraged across many states
	▪ May be harder to comply with federal rules

Options and Action Steps

Question: Should North Carolina administer reinsurance in the state or defer administration to the federal government?

Options	Action Steps
Administer reinsurance within the state and collect contributions from fully insured market	• Identify a Reinsurance Entity for Administration of the Reinsurance Program (discussed next) who will: collect contributions from fully insured market, disburse contributions, and weigh in on decisions about increasing the payment formula and modifying the payment formula
Administer reinsurance within the state and do not collect from fully insured plans	• Identify a Reinsurance Entity for Administration of the Reinsurance Program (discussed next) who will: disburse contributions and weigh in on decisions about increasing the payment formula and modifying the payment formula
Monitor reinsurance options for administration in the 2015 & 2016 benefit years	• Defer reinsurance to the federal government for 2014; monitor for consideration at a state level for 2015 and 2016, if permitted by HHS
Defer administration to the federal government	• Defer reinsurance to the federal government
Other?	• TBD

TAG Agreed Points of Consensus on Reinsurance

Authority to Make Reinsurance Policy Decisions

- The TAG reached consensus that the NCGA should establish the reinsurance entity and determine the assessment amount on carriers (i.e., whether the carrier assessment should be increased beyond what is federally required), but that the reinsurance entity itself should have the authority to make decisions on the remaining operational considerations.

Technical/Operational Capabilities of Reinsurance Entity

- The TAG reached consensus that the reinsurance entity should have:
  - The ability to collect contributions, process claims and make payments promptly; Familiarity with reinsurance programs; Capacity to house significant amounts of data for a long period of time to comply with federal auditing standards; Sufficient longevity to pay reinsurance claims after 2016; Use of HIPAA transaction standards for data collection; Low administrative costs; Authority to collect contributions and pursue payments; Transparency to build carrier's trust and the Ability to perform tasks quickly and efficiently.

Governance Characteristics of Reinsurance Entity

- The TAG reached consensus that the reinsurance entity should have a governing board composed of carrier representatives. Board representation should primarily consist of those carriers eligible to receive reinsurance payments, while also including carriers subject to assessment but not eligible for payments.
- The TAG reached consensus regarding the role of the DOI in relation to the reinsurance entity, agreeing that the DOI should be legislatively authorized to serve in a technical advisory capacity and to enforce the collection of carrier assessments, as necessary.

Options and Action Steps

Question: If the state elects to administer reinsurance, should the NC DOI or another entity be tasked with establishing the reinsurance entity?

Options	Action Steps
Task the NC DOI with authority to establish the reinsurance entity	• Give NC DOI statutory authority to establish the reinsurance entity, which could either be a new entity or an existing entity • Place a timeframe by which the NC DOI must establish this entity • Take into account the TAG recommendations regarding the authority of the entity, the technical/operational considerations of the entity and the governance characteristics of the entity
Task another entity with establishing the reinsurance entity	• TBD

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Group Participation Requirements

- **Should NC have an employer participation rate in the SHOP exchange?**
- **If North Carolina has an employer participation rate in the SHOP, who should determine that rate?**

Relevant Laws and Regulations

ACA and Federal Guidance

- "The SHOP may authorize uniform group participation rules for the offering of health insurance coverage in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer." *(CFR 155.705(10))*

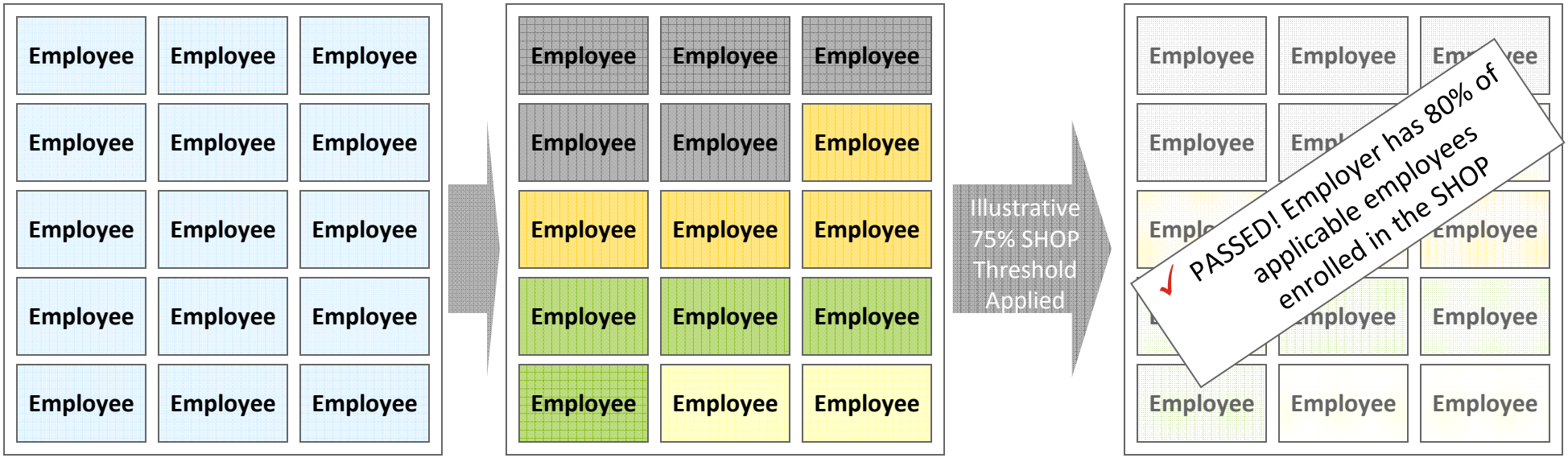
North Carolina Existing Statute

- A carrier may enforce reasonable employer participation and contribution requirements on small employers applying for coverage. Participation and contribution requirements can vary only by the size of the small employer group and not because of the health benefit plan involved.
  - A small employer carrier shall not consider employees or dependents who have qualifying existing coverage[1] in determining whether an applicable participation level is met. *(NCGS 58-50-130(a)(4a))*
- Carriers can refuse to issue coverage to a small employer if they fail to meet participation and contribution requirements. *(NCGS 58-68-40(d))*
- Carriers can non renew or discontinue an employer group health plan for failing to meet participation and/or contribution requirements. *(NCGS 58-68-45(b)(3))*

[1] "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan.

Background

Final regulations give exchanges the option of establishing a participation rate for the SHOP. Participation rates must be the same across all employers eligible for SHOP, and are not dependent on the number of individuals enrolled in a particular QHP or with a QHP insurer. Only employees without alternative coverage options are counted in the participation rate.



- Small employer has 15 employees
- Purchases health insurance through the SHOP
- Gives employees the choice of a metal level

= 5 employees are covered either under Medicare, Medicaid or a spouse's plan

= 4 employees select QHP A

= 4 employees select QHP B

= 2 employees elect to not pay for coverage; take penalty

- Since 5 employees have other coverage options, 8 out of 10 applicable employees are enrolled in SHOP
- QHP A and QHP B each have 4 out of 10 enrolled (40%)

Considerations

Establishing a specific participation rate may further mitigate adverse selection in the SHOP although it may exclude some employers from being able to participate in the SHOP.

Pros of Setting a Participation Rate in the SHOP	Cons of Setting a Participation Rate in the SHOP
▪ Ensures that employers only come into the SHOP when they intend to cover most of their employees ▪ Reduces adverse selection by limiting employer participation in the SHOP to employers who are seeking coverage for most of their employees rather than a few, sicker ones	▪ Depending on where the participation line is drawn, may exclude some employers who can not persuade enough of their employees to participate

Setting the participation rate in the SHOP does not address the issue of individual carriers being selected against, as QHP participation rates are not permissible under the ACA.

Options and Action Steps

Question: Should North Carolina have an employer participation rate in the SHOP Exchange?

Options	Action Steps
Yes, NC should have a participation rate	• Determine who should establish the rate
No, NC should not have a participation rate at this time	• Recommend that no participation rate be established at this time • Recommend that this issue be monitored
Other?	• TBD

Options and Action Steps

Question: If North Carolina has an employer participation rate in the SHOP, who should determine that rate?

Options	Action Steps
The Exchange	• Grant the exchange statutory authority to do this
NC DOI	• Grant the NC DOI statutory authority to do this
NCGA	• NCGA to set the participation threshold
Other?	• TBD

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Points of Consensus and Recommendations- Small Group Market

The final regulations confirm that states continue to have flexibility in key small group market provisions.

TAG Recommendations	Relevant Changes in Final Regulations
Merging of Risk in the Individual and Small Group Markets	
The TAG recommends that the small group and individual markets maintain separate risk pools at this time.	• Final regulations still provide states the option to maintain separate pools.
Expanding the Definition of the Small Group Market Prior to 2016	
The TAG recommends the small group market definition remain at 50 or less employees until required to change in 2016.	• Final regulations still provide states the option to not expand the definition until 2016.
Determining Choice in SHOP	
The TAG recommends that employers should not be prohibited from restricting employee choice of plans down to one or more specific plan(s) within a single metal level in the Small Business Health Options Program (SHOP) Exchange. The TAG also recommends further consideration of the extent to which the employer should be allowed to offer expanded choice.	• The preamble clarifies that SHOPs may offer employers the option to allow access to one plan, in addition to meeting the ACA requirement. *(II.A.6.b.)*

Source: Issue Brief #1

Points of Consensus and Recommendations- Small Group Market

The final regulations restate the intent of using the same definition of employee as established by the PHS Act and confirm that sole proprietors without employees are not eligible for SHOP.

TAG Recommendations	Relevant Changes in Final Regulations
Reconciling the Definition of "Employee" in Light of ACA *The TAG recommends that North Carolina align the methodology for determining employer group size with the ACA effective January 1, 2014.*	• The final regs define "employer," "small employer," and "large employer" based on the PHS Act. • Preamble further explains that HHS is not finalizing a rule for determining employer size (counting employees) at this time and is considering future rulemaking as there are different state and federal methodologies, and implications beyond SHOP. *(II.A.6.c)*
Reconciling the Definition of Sole Proprietors *The TAG recommends that North Carolina's treatment of sole proprietors align with the ACA effective January 1, 2014, allowing sole proprietors with no employees to be eligible for individual but not small group market coverage.*	• Final regulations confirm that sole proprietors that do not have any employees are not eligible for SHOP participation. An employee would not include a sole proprietor or the sole proprietor's spouse. *(II.A.6.c)*

Source: Issue Brief #1

Points of Consensus and Recommendations- Rating Areas

The final regulations suggest, but do not require, that rating areas be the same as service areas and that service areas generally be set at least at the county level.

TAG Points of Consensus	Relevant Changes in Final Regulations
Development of Geographic Rating Areas *The TAG recommends that the North Carolina Department of Insurance, in consultation with health insurance carriers, be responsible for the establishment of geographic rating areas for the individual and small group markets.*	• The preamble reiterates that the ACA directs states to establish rating areas, with HHS review. *(II.B.2.h)* • The preamble recommends, but does not require, that Exchanges require QHP service areas to be the same as rating areas. *(II.B.2.g)* • Regulations require a QHP service area to **cover a minimum geographic area that is at least a county or group of counties**, unless the exchange determines that serving a smaller area is necessary, nondiscriminatory, and in the best interest of employers and individuals. *(155.1055(b))*

Source: Draft TAG Issue Brief #2

Points of Consensus and Recommendations- Insurer Participation

The final regulations do not change the participation requirements for QHP insurers in the exchange, and continue to remain silent on non-exchange market participation requirements.

TAG Points of Consensus	Relevant Changes in Final Regulations
Participation in the Exchange Market	
The TAG recommends that additional insurer participation requirements are not advisable in 2014 and 2015.	• HHS clarifies in preamble that Exchanges may establish additional issuer participation standards in addition to requiring silver and gold participation standards. *(II.B.2.a)*
The TAG recommends the exchange board have the authority to develop a policy regarding insurers' re-entry into the individual and small group exchanges after exiting either exchange market.	
Participation in the Non-Exchange Market	
The TAG recommends that the NC DOI have the authority to actively monitor the individual and small group markets, including the interplay between the Exchange and non-Exchange markets, and to make recommendations to the NCGA, in consultation with the Exchange as appropriate, if insurer participation or other adjustments are needed to minimize adverse selection in the individual and small group markets.	• Non-Exchange market participation requirements are not address in regulations.

Source: Draft TAG Issue Brief #2

Points of Consensus and Recommendations- Risk Adjustment & Reinsurance

The final regulations state that the feds will use a distributed model for administration of the federal risk adjustment model and gave new options to states for reinsurance administration.

TAG Points of Consensus	Relevant Changes in Final Regulations
Development of a North Carolina-Specific Risk Adjustment Model/Methodology *The TAG reached consensus to defer to federal risk adjustment model for now, but evaluate a state-specific model later.*	• **Feds will use a distributed model for administration of federal risk adjustment which was previously discussed** • **Numerous changes to reinsurance which were also previously discussed.**
Administration of Reinsurance in North Carolina *The TAG reached consensus that the NCGA should establish the reinsurance entity and determine the assessment amount on carriers.* *The TAG reached consensus that the list of required technical and operational capabilities for the reinsurance entity was complete, including authority to collect contributions, transparency to build carriers' trust and ability to perform tasks quickly and efficiently.* *The TAG reached consensus that the reinsurance entity should have a board composed of insurers eligible to receive reinsurance payments and insurers/TPAs subject to assessment but not eligible for payments.* *The TAG reached consensus regarding the role of the DOI in relation to the reinsurance entity, agreeing that the DOI should be legislatively authorized to serve in a technical advisory capacity and to enforce the collection of carrier assessments, as necessary.*	

Source: Meeting Notes

Agenda

9:30 – 9:40	**Welcome and Introductions**
9:40 – 9:45	Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG
9:45 – 10:45	Issues for Discussion in TAG Meeting #5 • Risk Adjustment *(30 min)* ▪ Should North Carolina administer the federal risk adjustment model in the state for the first year or monitor the federal risk adjustment process for future administration? ▪ If the state elects to administer, should the NC DOI or another entity take on these administration responsibilities? ▪ If the state elects to administer, should the state use a distributed model in the first year? • Reinsurance *(30 min)* ▪ Should North Carolina administer reinsurance in the state or defer administration to the federal government? ▪ If the state elects to administer, should the NC DOI or another entity be tasked with establishing the reinsurance entity?
10:45 – 11:05	Issues for Discussion in TAG Meeting #5 • Group Participation Requirements *(20 min)* ▪ Should NC have an employer participation rate in the SHOP exchange? ▪ If North Carolina has an employer participation rate in the SHOP, who should determine that rate?
11:05 – 11:15	*Break*
11:15 – 12:00	Review Points of Consensus from Prior TAG Meetings, TAG #4 Meeting Minutes
12:00 – 12:20	Discussion on Most Favored Nation Issue ▪ Should the TAG review the implications of MFN clauses in health care provider/insurer contracts in the North Carolina marketplace in light of the ACA? ▪ If MFN requires TAG review, what items should specifically be addressed by the TAG during that review to assess the impact of MFN on the post-ACA marketplace?
12:20 – 12:30	Wrap Up and Next Steps

Discussion on Most Favored Nation (MFN) Issue

- **Should the TAG review the implications of MFN clauses in health care provider/insurer contracts in the North Carolina marketplace in light of the ACA?**
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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
  - Email comments or thoughts on additional considerations or options to agarcimonde@manatt.com
- **Review Issue Brief #3 Once Released**
  - Brief will focus on Reinsurance and Risk Adjustment
- **Attend next in person meeting on Monday, April 9th 2012 from 12:30PM to 3:30PM at the NCIOM**
  - **No webinar will be held in advance of that meeting**
  - **Purpose of the meeting will be to:**
    - **Review What Essential Health Benefits Are and the Bulletin Issued by HHS**
    - **Discuss the Analysis Conducted to Date to Assess the Potential Benchmark Plan**
    - **Validate a Process Which the TAG Can Recommend for Selection of the Benchmark Plan**

Appendix

- Cost Data on Risk Adjustment Administration

Costs for Performing Medicaid Risk Adjustment Model Only

Mercer Assessment of Costs for Performing Risk Adjustment*

	Low	High
Initial Discussion, Implementation and First Year Estimated Costs	$200,000	$300,000
Estimated Annual Ongoing Risk Adjustment Costs	$150,000	$250,000

- Leading factors that influence costs, include:
  - the type of model used,
  - the familiarity of the individuals performing the risk adjustment methodology with the model and the data,
  - the number of plans, and
  - the amount of information shared with the plans who contribute data into the model
- On average, it takes 3 to 5 years for a state to reach "steady state" with risk adjustment
  - Use of a federal model may lessen learning curve
- The degree of sophistication of the risk adjustment model used varies by states
  - Some states use off the shelf while others use customized models, which are initially more expensive to implement
  - Exchange risk adjustment process will be significantly more complex than Medicare or Medicaid

*Mercer performs risk adjustment on behalf of several Medicaid agencies. Costs are not reflective of total state costs, as states may need to oversee risk adjustment work and share findings. Costs are based performing risk adjustment activities for approximately 5 to 8 plans.

Rough Estimate of Total Costs for a Non-Distributed Model for Performing State Risk Adjustment

$300,000	+	*$1,000,000*	=	*$1,300,000*	÷	*1,196,627*	=	***$1.09**PMPY or **$.09**PMPM*
Year 1 Risk Adjustment Costs (High Estimate)		Estimated Database Costs to Perform Non-Distributed Risk Adjustment Model		Estimated Costs		Number of Individuals Subject to RA in NC[2]		

- Risk adjustment has three primary costs:
  - Administering the risk adjustment model (discussed on the prior slide)
  - Collecting and properly storing data to be used for risk adjustment administration
  - Disbursement and collection of risk adjustment payment(s)
- All Payer Claims Databases are used as a proxy to assess the upper end for costs associated with collecting and property storing data for risk adjustment administration
  - Reported annual funding for establishing an APCD ranges from $350,000 for a "bare bones" system to $1 to $2 million to establish a more robust data system[1]
  - APCDs perform many more functions and have many more uses than those needed for risk adjustment
- Disbursement and collection of risk adjustment payment(s) is unknown at this time, but is anticipated to be nominal

[1]http://www.apcdcouncil.org/sites/apcdcouncil.org/files/Cost%20Fact%20Sheet_FINAL_1.pdf

[2] Milliman, North Carolina Health Benefit Exchange Study, July 18, 2011; 600,836 Est. Small Group Market Participants + 795,791 Indiv. Market Participant minus 200,000 to account for grandfathered plans which are not subject to risk adjustment