

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

In-Person TAG Meeting #7

July 31, 2012



MERCER

OLIVER WYMAN

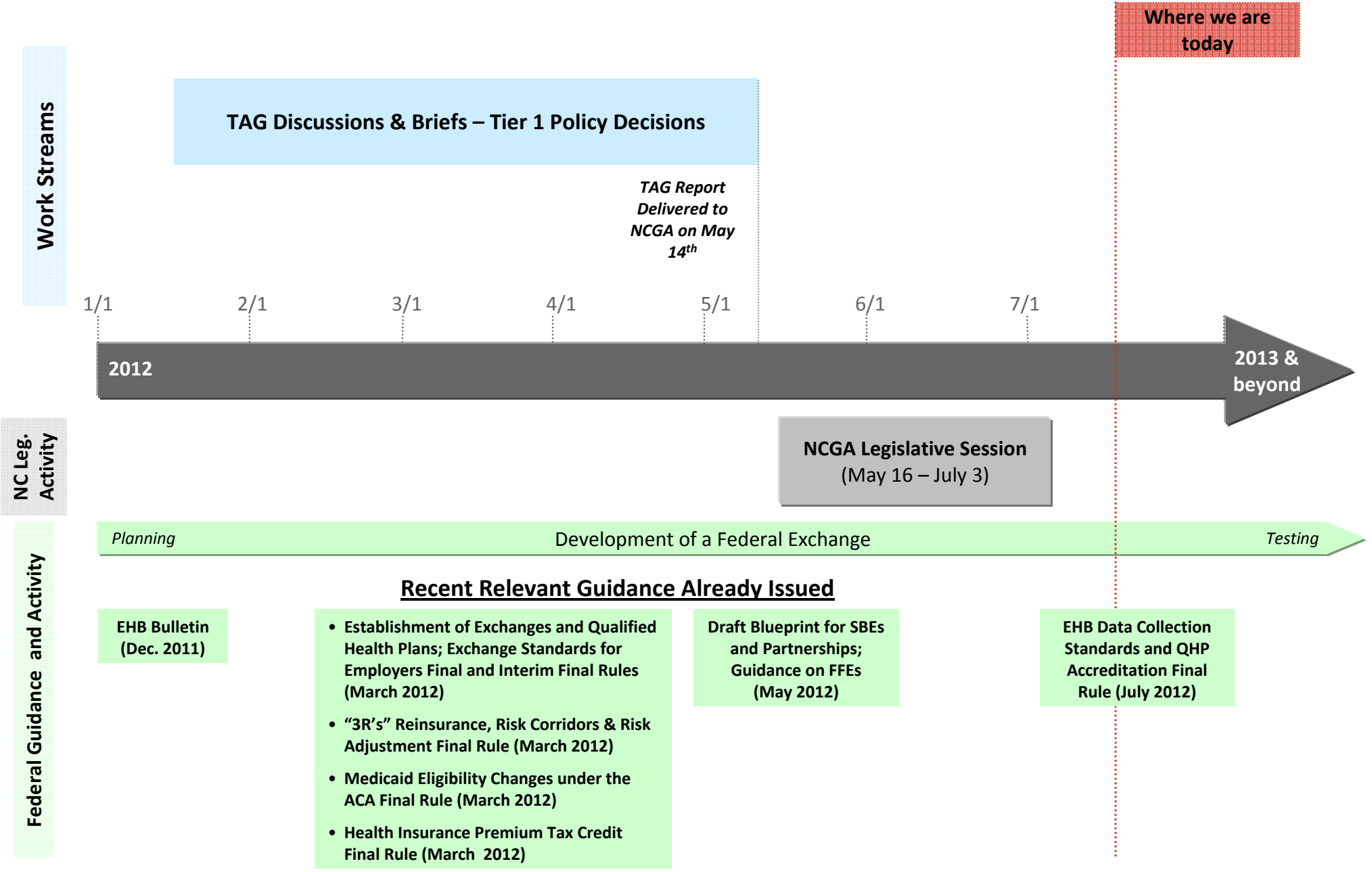
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9:35 – 9:40	Project Timeline, Goals/Objectives of Today’s Discussion, and Statement of Values for TAG
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10:00 – 10:30	Topics for Phase II Consideration and Input
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12:15 – 12:30	Wrap Up and Next Steps

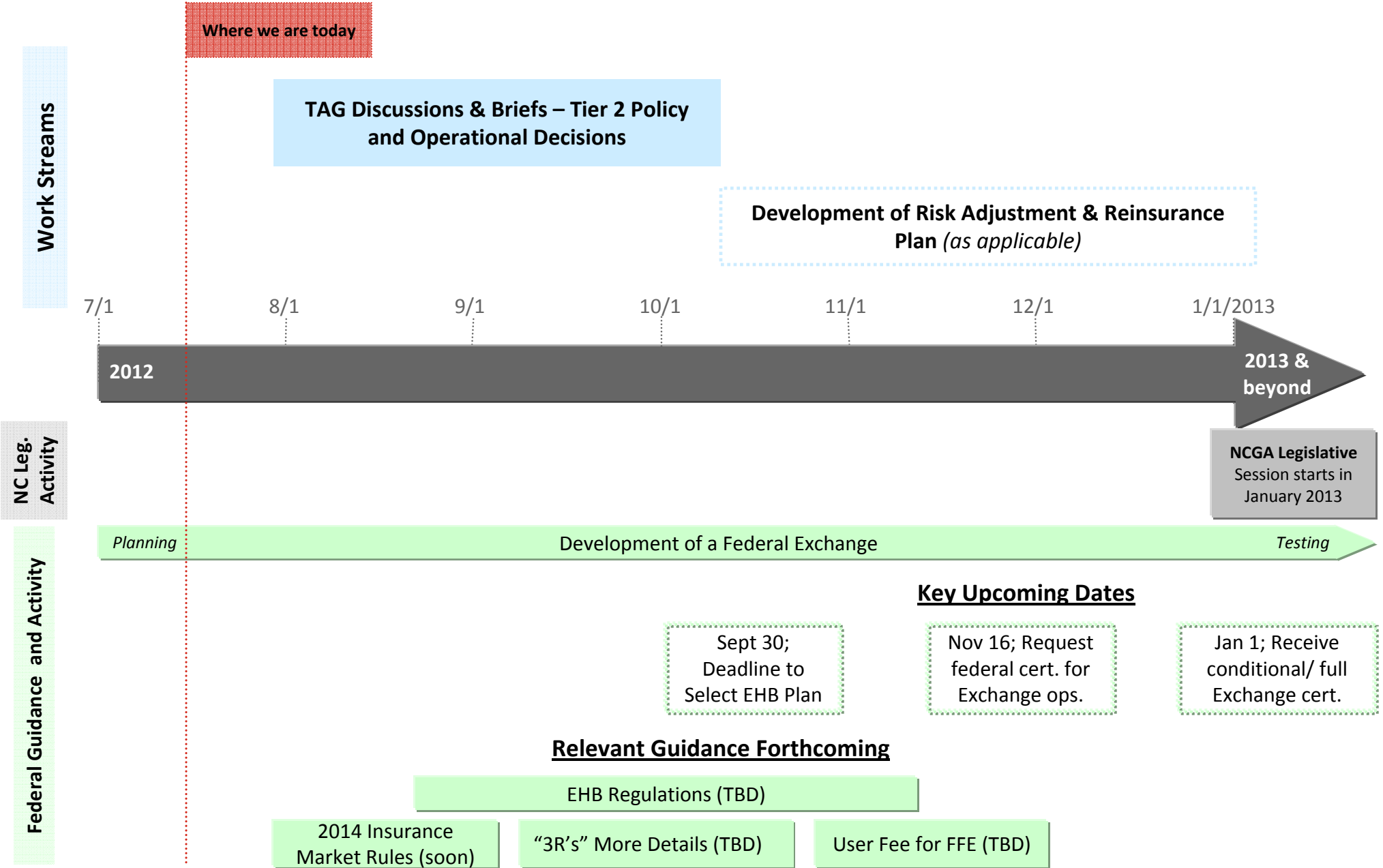
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Past Project and Regulatory Timeline



Future Project and Regulatory Timeline



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

- Outline parameters of broader discussion to be addressed at in-person meeting, including update on relevant Federal guidance/initiatives
- Initiate TAG thinking and solicit input regarding Phase 2 topics for discussion
- Begin to discuss if select certification requirements should apply outside the Exchange market
 - Network Adequacy Requirements with a focus on essential community providers, mental health providers and overall regulations
 - Enrollment Rules/Regulations in the individual market

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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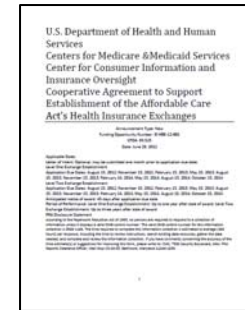
Federal Actions and Reports

1.



Supreme Court Decisions on the ACA
June 2012

2.



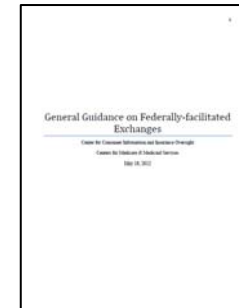
Cooperative Agreement to Support Establishment of the ACA's Health Insurance Exchanges
June 2012

3.



Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges
Released May 2012

4.



General Guidance on Federally-facilitated Exchanges
Released May 2012

A divided Court ruled that:

- The ACA requirement for individuals to have insurance or pay a tax penalty is constitutional.
- States can choose not to expand Medicaid to cover all state residents under 133% FPL, without risking federal funding for their entire Medicaid program.

“The Affordable Care Act’s requirement that certain individuals pay a **financial penalty for not obtaining health insurance may reasonably be characterized as a tax.**

Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.”

– Chief Justice Roberts in Majority Opinion

“In this case, the financial ‘inducement’ Congress has chosen is **much more than ‘relatively mild encouragement’—it is a gun to the head.**”

– Chief Justice Roberts in Majority Opinion

With the exception of the ruling that states can forgo Medicaid expansion, the Court leaves intact the entire ACA.

Impact on ACA: With One Exception, All Provisions Stand

Insurance Reforms

- Insurance reforms, including guaranteed issue, pre-existing condition restrictions, premium increase review, premium rebates based on medical loss ratio, etc.

Exchange Establishment

- Federal funding for the creation of health insurance Exchanges in every state

Affordability

- Premium and cost sharing subsidies to those with incomes under 400% of FPL to purchase insurance through Exchanges

Delivery System Redesign

- Substantial payment and delivery reforms, including duals demonstration, patient centered medical home initiatives, accountable care organization pilots and support for primary care

Eligibility & Enrollment

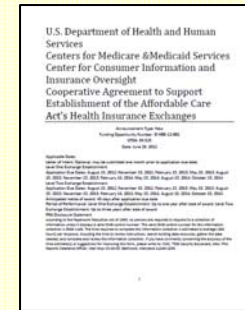
- Redesigned eligibility and enrollment systems across insurance affordability programs

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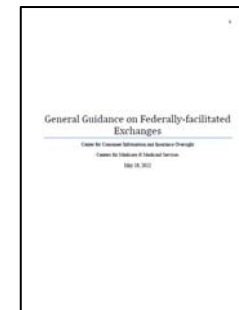
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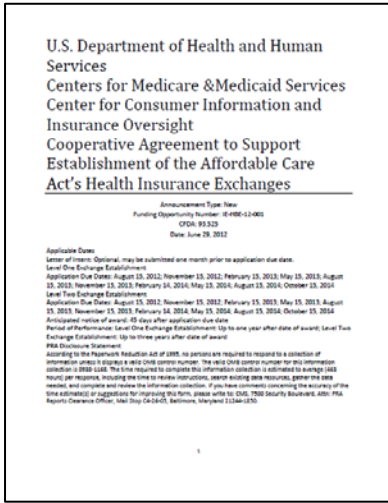


Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges
Released May 2012

4.



General Guidance on Federally-facilitated Exchanges
Released May 2012



Provides states with financial assistance for the establishment of health insurance exchanges, including “Level One” and “Level Two” Establishment grants.

Exchange Grants

- On June 29, HHS announced 10 new opportunities to apply for exchange grants, starting with Aug. 15 and then every three months until Oct. 15, 2014.
- HHS clarified that grants can be used *"until the end of the start up year that coverage is provided through the Exchange"* and that *"at HHS's discretion, a project period can be extended for a maximum of five years past the date of the award."*
- States may receive funding for a State-based or a State Partnership Exchange, as well as for transitioning from a Federally-facilitated Exchange to either a State-based or State Partnership Exchange.

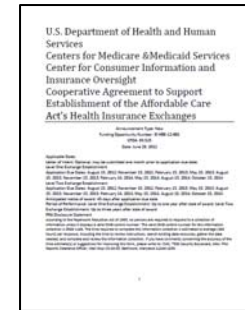
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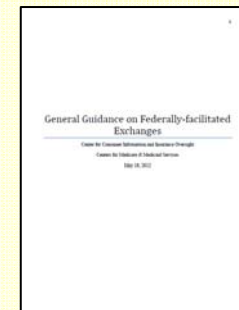
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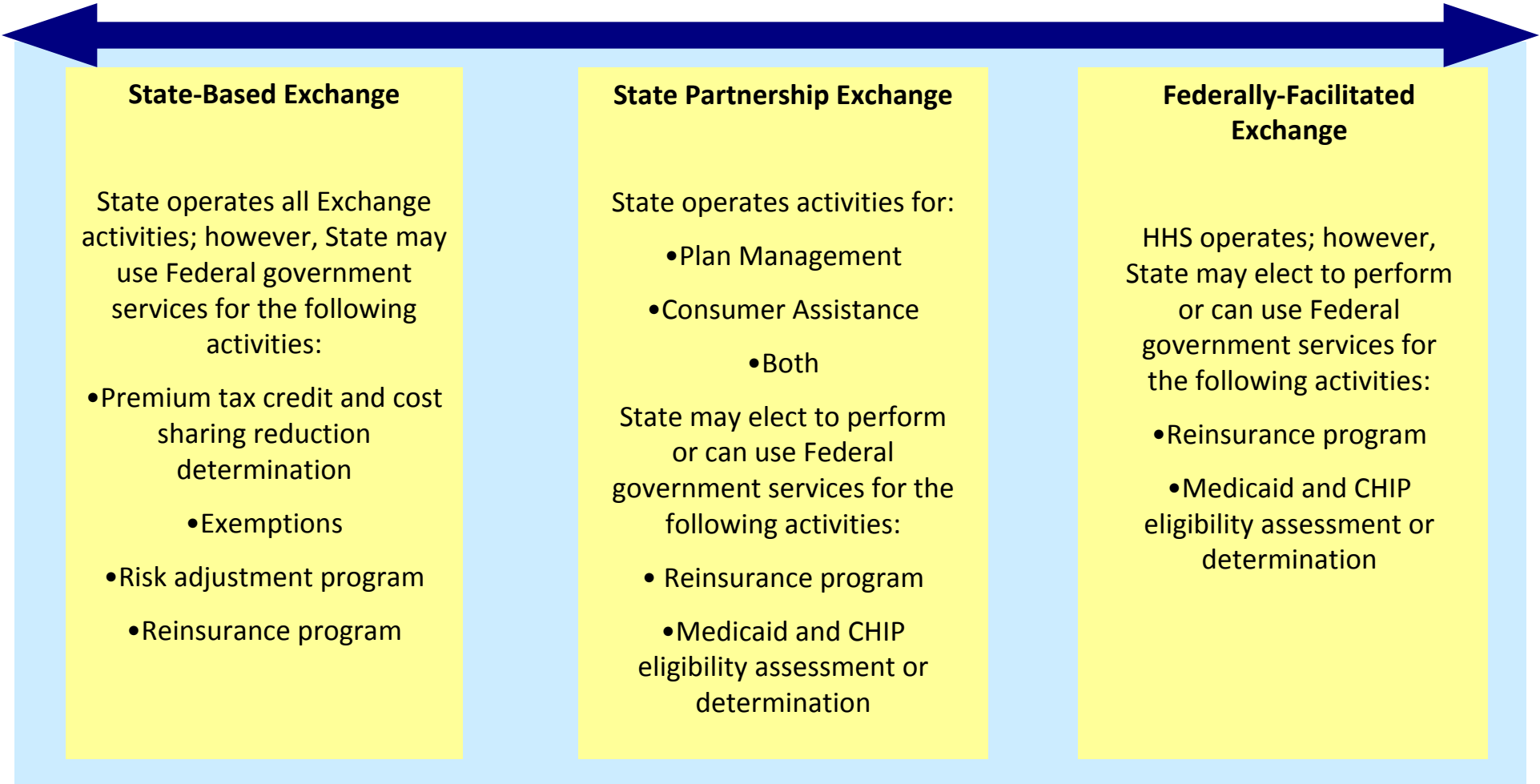
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Five Core Functions of Exchanges

Consumer Assistance	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Eligibility	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
Enrollment	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
Financial Management	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

Source: CCIIO

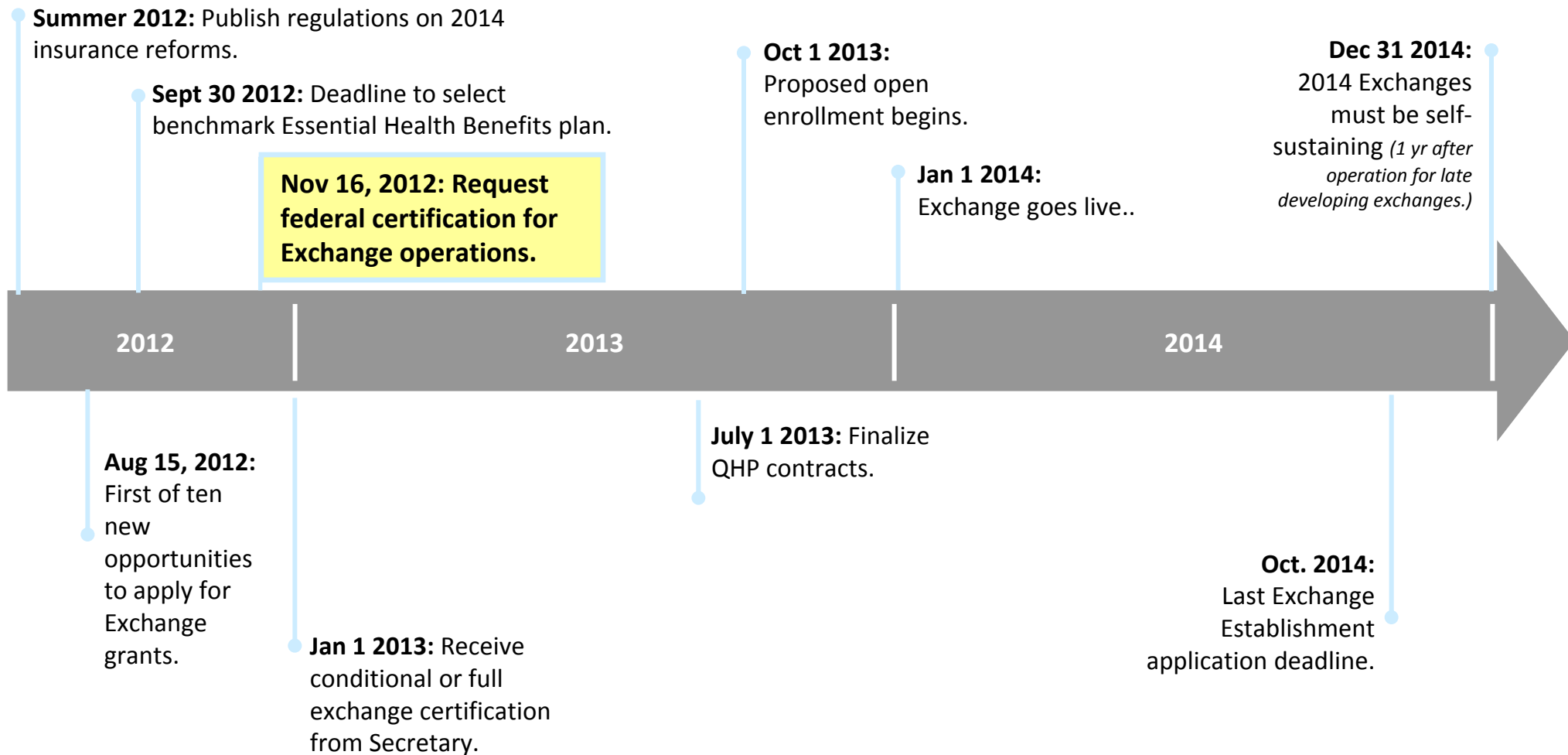
Three Exchange Options for States

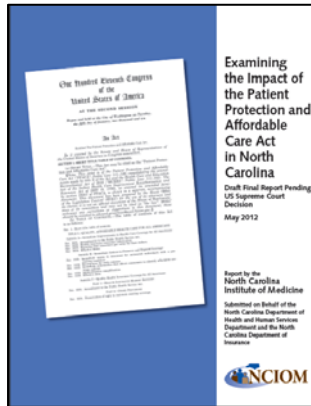


Partnership Exchange can be a way station to a State-based Exchange or a long term allocation of responsibilities.

Source: CCIIO, Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchange

Exchange: Key Dates





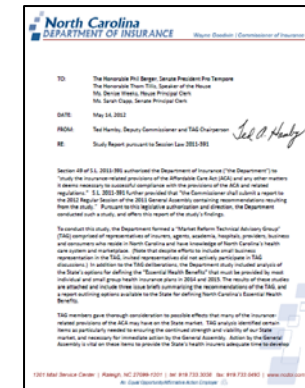
Examining the Impact of the PPACA in North Carolina
May 2012

- Written response from the convening of “*stakeholders and other interested people to examine the new law and ensure that the decisions the State makes in implementing the ACA serve the best interest of the State as a whole.*”



North Carolina General Assembly
May-July 2012

- Pursuant to Section 49 of S.L. 2011-391, the NC DOI submitted a report on May 14th to the NCGA which outlines the recommendations from the study of “*insurance-related provisions of the Affordable Care Act (ACA) and any other matters it deems necessary to successful compliance with the provisions of the ACA regulations.*”
- No discussion was formally raised on ACA implementation, including Exchanges, during the session.

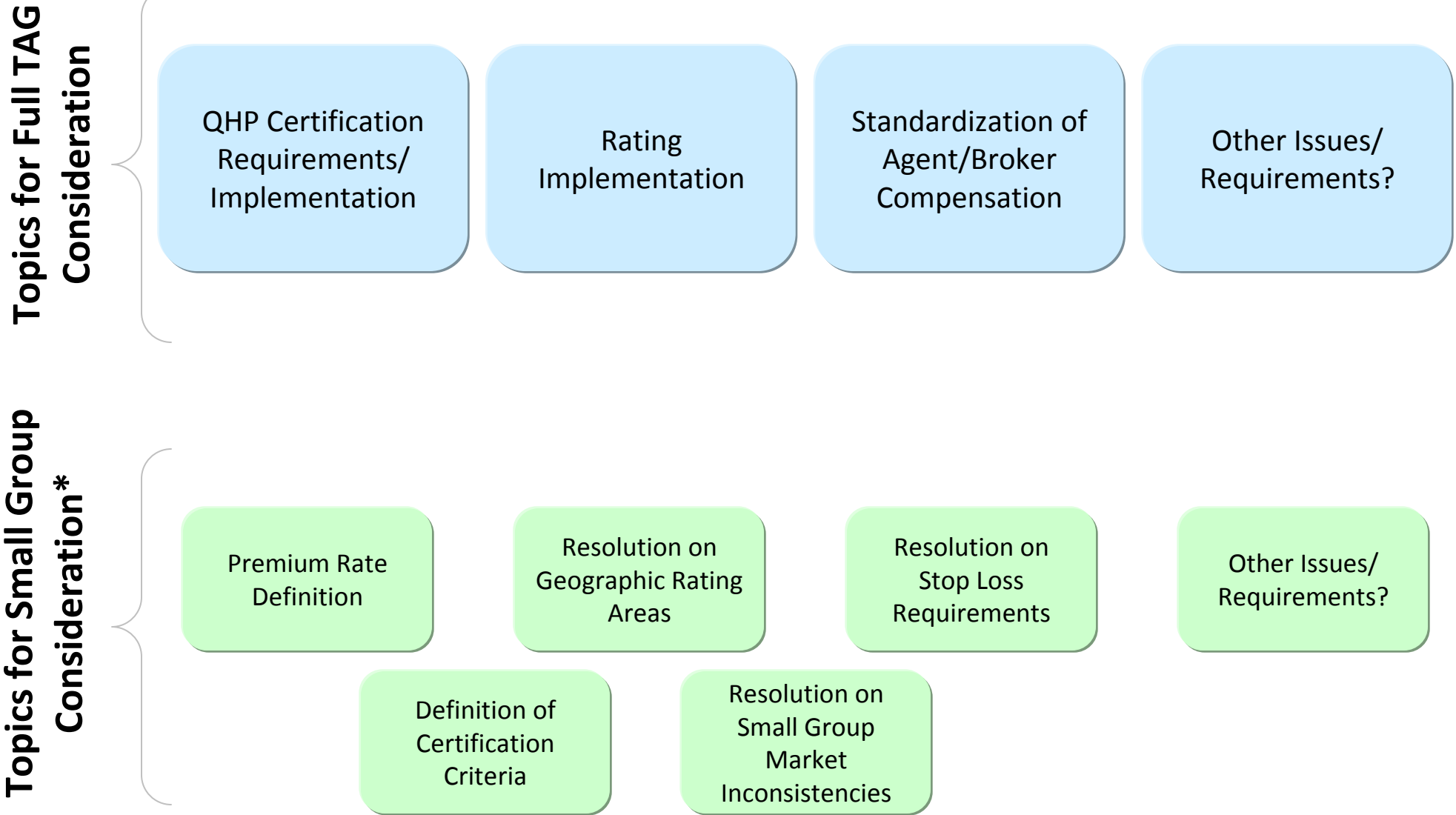


Source: North Carolina Institute of Medicine, Examining the Impact of the Patient Protection and Affordable Care Act in North Carolina. Morrisville, NC: North Carolina Institute of Medicine; May 2012

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Potential Topic Areas for TAG Deliberations



**Small Group Discussions will be held as needed to address technical issues and to arrive at a recommendation to set before the TAG.*

Summary of Potential Full TAG Topic Areas

QHP Certification Requirements

- **Federal Requirements:** QHPs must perform or adhere to a number of functions and requirements, including network adequacy, enrollment standards, accreditation, marketing, transparency, quality, rate review, benefit design and licensing/ solvency.
- **Open Questions:** Should requirements be the same both in the Exchange and out of the Exchange? What State standards need to change, if any?

Rating Implementation

- **Federal Requirements:** States must implement distinct rating practices, including age rate bands (3:1 maximum), family composition, tobacco rate bans (1.5:1 maximum) and geographic rating areas (addressed in the small group discussion items).
- **Open Questions:** How should each of the ACA rating requirements be implemented in North Carolina? Should North Carolina have a more stringent rating rules than those in the ACA?

Agent/Broker Compensation

- **Federal Requirements:** QHP issuers must charge the same premium rate for plans regardless of if the plans is offered through an Exchange or directly from the issuer or a broker/agent.
- **Open Questions:** Should carriers have to set same compensation inside and outside of the Exchange to align incentives? What are the market impacts/implications?

Other?

- TAG to weigh in on other areas for group deliberation.

The TAG's work will focus on market requirements and dynamics inside and outside the Exchange (as applicable) and validating or confirming the NC IOM's recommendations in light of more recent guidance, if needed.

Summary of Potential Work Group Topic Areas

Premium Rate Definition

- **Federal Requirements:** QHP issuers must charge the same premium rate for plans outside the Exchange that are “substantially the same” as plans inside the Exchange.
- **Open Questions:** How should the definition of the “same premium rate” be determined? What are the market implications/considerations (to be discussed with the larger group?)

Stop Loss Requirements

- **Relevant Requirements:** TAG #2 discussed that self-insuring may become attractive to certain employers with better than average risk starting on January 1, 2014. Current NC statute limits certain employer’s ability to self-insure, but does not prohibit it.
- **Open Question:** Should NC revise the existing statute or issue additional guidelines and/or regulations?

Geographic Rating Areas

- **Federal Requirements:** Insurers may vary premiums by standard geographic rating areas to be determined in each state and approved by HHS. TAG #4 assessed current geographic rating areas used by NC insurers and requested that NC DOI set the rating areas.
- The TAG work group may be asked to assess the work NC DOI does to set the rating areas and provide technical input.

Small Group Market Resolution

- **Open Question:** What areas not already addressed should be discussed in consideration of streamlining regulations/statute between the Exchange and the outside market (e.g. enrollment, etc) or any other areas of small group law that might be impacted by ACA market rules?

Definition of Certification Criteria

- Definition of certification areas, such as the approach to defining sufficient number and geographic distribution of ECPs. Discussions may include groups that extend beyond TAG membership .

Other?

- TAG to weigh in on other areas for work group deliberation.

Discussion on TAG Topics for Phase II

Full TAG Topics

1. QHP Certification Requirements*
2. Rating Implementation
3. Agent/Broker Compensation
4. Other?

Work Group Topics

1. Premium Rate Definition
2. Stop Loss Requirements
3. Geographic Rating Areas
4. Small Group Market Resolution
5. Definition of Certification Criteria
6. Other?

TAG Topics for Phase II:

1. *To be discussed*
2. ?
3. ?
4. ?
5. ?
6. ?
7. ?
8. ?
9. ?
10. ?

*With a focus on if requirements should be applied outside of the Exchange

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Certification Questions for Consideration

Network Adequacy

- Should issuers of plans outside the Exchange be required to have Essential Community Providers in network?
- Should North Carolina's network adequacy standard be changed?

Enrollment

- Should enrollment requirements in the Exchange be applied outside the Exchange in the Individual market?

Relevant Federal Laws and Regulations - Network Adequacy

- Issuers must ensure that the provider network for each QHP:
 - Includes essential community providers (ECPs) *(45 CFR §156.230(a))*
 - 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.”
 - Any provider that meets the criteria for an ECP must be considered an ECP and, as such, a QHP issuer in an Exchange may not be prohibited from contracting with any ECP.
 - QHP issuers are not required to contract with ECPs that refuse to accept “generally applicable payment rates.”
 - A QHP issuer must pay an FQHC 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)*
 - 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 Issuer must also make its provider directory available to the Exchange. *(45 CFR §156.230(b))*

1) This network adequacy standard was developed specifically to align with the standard contained in the NAIC Managed Care Plan Network Adequacy Model Act (except that the Model Act does not specifically call out mental health and substance abuse). *77 Fed Reg. 18418*

“A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: provider-covered person ratios by specialty; primary care provider covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.”

-- NAIC Managed Care Plan Network Adequacy Model Act¹

1) The NAIC Network Adequacy White Paper mentions that the NAIC Model Act may need to be updated to ensure compliance with ACA standards by adding in mental health providers. However, the paper also states that “while the Affordable Care Act and the final rules prescribe that mental health providers be incorporated into networks for plans inside the Exchange, it must be recognized that mental health is covered under many circumstances outside the Exchange such as federal mental health parity, State specific mental health mandates and plans that choose to cover mental health. Therefore, mental health providers should be a component of networks inside and outside the Exchange.”

North Carolina Existing Statute & Administrative Code

- NC Statute defines health insurers¹ and those insurers are subject to the administrative code, as follows:
 - **Provider Availability Standards.** Each network plan carrier shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the members. The methodology shall provide for the development of performance targets that shall address the following:
 1. The number and type of PCPs, specialty care providers, hospitals, and other provider facilities, as defined by the carrier;
 2. A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier;
 3. A method for arranging or providing health care services outside of the service area when providers are not available in the area. (*NC Administrative Code 11 NCAC 20 .0301*)

¹ § 58-1-5(3) ""Company" or "insurance company" or "insurer" includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business....." § 58-65-1 (a) defines hospital, medical and dental services plans. NC also has HMO adequacy standards for initial reviews of HMO plans.

North Carolina Existing Statute & Administrative Code (cont.)

- **Provider Accessibility Standards.** Each carrier shall establish performance targets for member accessibility to primary and specialty care physician services and hospital based services. Carriers shall also establish similar performance targets for health care services provided by providers who are not physicians. Written policies and performance targets shall address the following:
 1. Proximity of network providers as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care and hospital services, taking into account local variations in the supply of providers and geographic considerations;
 2. The availability to provide emergency services on a 24-hour, seven day per week basis;
 3. Emergency provisions within and outside of the service area;
 4. The average or expected waiting time for urgent, routine, and specialist appointments. (*NC Administrative Code 11 NCAC 20 .0302*)

North Carolina Existing Statute & Administrative Code (cont.)

- **Services Outside Provider Networks.** No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan, including an insured receiving an extended or standing referral under NCGS 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay. (*NCGS 58-3-200(d)*)

- North Carolina's statute generally follows the NAIC Model Act.
- North Carolina's statute is likely sufficient for meeting ACA network adequacy requirements, with the exception of Essential Community Providers.
- North Carolina offers strong consumer protections if in-network providers are not available.

In addition, NCGS § 58-3-190 requires insurers to provide coverage for emergency services, without prior authorization, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

Definition of ECP

- ECP includes a broad range of provider types, including those that serve predominately low-income, medically underserved communities including, but not limited to, federally qualified health centers, family planning entities receiving federal funds, Ryan White grantees, black lung clinics, comprehensive hemophilia diagnostic treatment centers, public health entities receiving funding for sexually transmitted diseases or tuberculosis, disproportionate share hospitals, children's hospitals, critical access hospitals, free standing cancer centers, rural referral centers, sole community hospitals, and other state agencies or nonprofits that provide the same types of services to the same population.¹

ECPs in North Carolina

- According to HRSA, 671 340B IDs are located in North Carolina.²
- According to the North Carolina Community Health Center Association, there are 34 FQHC organizations with nearly 160 clinical sites in North Carolina.³
- There are 19 state-funded rural health centers in North Carolina.
- All 85 of the local health departments in the state get federal funding for STDs and tuberculosis.
- The distribution of ECPs is focused on the eastern half of the State where there are more highly concentrated low income populations.

Importance of ECPs

- ECPs were included in the ACA to “strengthen access in medically-underserved areas and for vulnerable populations.”⁴

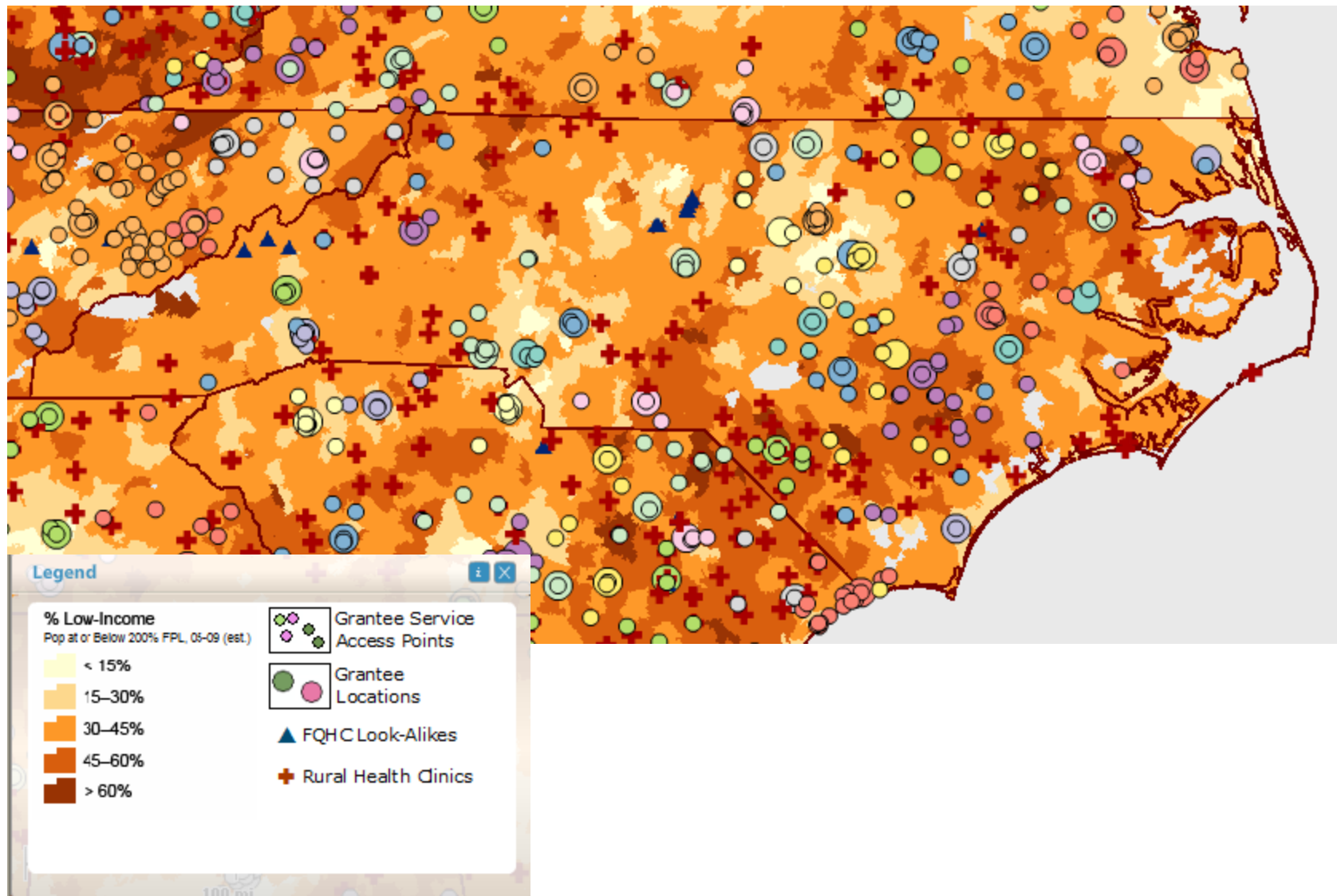
¹ <http://www.nciom.org/wp-content/uploads/2012/05/Full-Report-Online-Pending.pdf>

² <http://opanet.hrsa.gov/OPA/CESearch.aspx>

³ <http://ncchca.org/>

⁴ United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475 at p. 18419.

Sample of ECPs in North Carolina



Source: UDS Mapper, July 2012; does not include all providers defined as ECPs

Other States' Approaches to Essential Community Providers

- 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)*
- The California Exchange Board is reviewing options and recommendations for QHPs. Preliminary recommendations include: expanding the definition of ECPs to include private practice physicians, clinics and hospitals that serve Medi-Cal and low-income populations; establish criteria to identify providers that meet the definition of ECPs; and require plans to demonstrate sufficient participation of ECPs by showing the overlap between ECPs and the region's low-income population.¹
- Minnesota's 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)*

Excerpt from National Dialogue

- **NAIC:** "... it would make sense for the State to extend [its own adequacy] requirements to QHPs to minimize adverse selection against the Exchange. However, in some cases, the ACA's network adequacy standards may go beyond a State's existing requirements, particularly as related to its requirement that essential community providers be included in the QHP's provider network.each State will need to consider whether to apply the same standards for QHP certification to the outside market, the potential for adverse selection against the Exchange if they choose not to require the same standards and the cost to issuers in the outside market to comply if they choose to require the same standards."²

¹ <http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20HBEX%20-%20QHP%20Options%20Webinar.pdf>

² http://www.naic.org/documents/committees_b_exchanges_120626_network_adequacy_white_paper.pdf

Including Essential Community Providers (ECPs) in the network adequacy standards further minimizes the risk of adverse selection against the Exchange. However, requiring ECPs in provider networks outside the Exchange generates additional work for plans whose existing enrollees may not use those providers.

Pros from requiring inclusion of ECPs in network

- Further minimizes the potential for adverse selection against the Exchange.
- Further minimizes consumer confusion/disruption if consumers switch between the Exchange and non-Exchange markets.

Cons from requiring inclusion of ECPs in network

- Requires insurers already participating in the market to add new providers- which may not be used by their existing membership.
- May attract a different population mix outside the Exchange (although unlikely due to subsidies and traditional patient mix of ECPs), which may be unattractive to some insurers.

Options and Action Steps

Options	Action Steps
Yes, ECPs should be required outside, creating the same network adequacy requirements	<ul style="list-style-type: none">• Require that insurers outside the exchange market be required to contract with ECPs under the same ACA rules and provisions as QHPs
No, ECPs should NOT be required outside	<ul style="list-style-type: none">• Do nothing
Other?	<ul style="list-style-type: none">• ???

Considerations - Changing NC's Network Requirements

North Carolina's network standards are likely sufficient to meet most ACA requirements but could be updated. Some states are considering more robust criteria which would provide a standard definition for adequacy while still allowing flexibility at the plan level to test quality-driven and innovative delivery models.

Reason to Change NC's Network Requirements

- A standard definition would facilitate more objective certification reviews of network adequacy.
- Current standards are based on older concepts of insurance (delineation of HMO/PPO/Indemnity). A newer definition could be the same across all products.

Reasons to not Change NC's Network Requirements

- Changing the standard generates additional change, which is not required, to meet ACA requirements.

Options and Action Steps

Options	Action Steps
Yes, the network adequacy standards should be updated in preparation for 2014	<ul style="list-style-type: none">• Task NC DOI, or another entity, with a review and updating of the standards
Yes, the network adequacy standards should be updated by 2016	<ul style="list-style-type: none">• Table network adequacy discussion until after the launch of the Exchange, and re-engage in discussion in late 2014 for roll out in 2016
No, the network adequacy standards should not be updated	<ul style="list-style-type: none">• Do nothing
Other?	<ul style="list-style-type: none">• ???

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11:45 – 12:15	Issues for Discussion in TAG Meeting #7, continued <ul style="list-style-type: none">• Enrollment (30 min)<ul style="list-style-type: none">▪ Should enrollment requirements in the Exchange be applied outside the Exchange in the Individual market?
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Certification Questions for Consideration

Network Adequacy

- Should North Carolina's network adequacy standard be changed?
- Should issuers of plans outside the Exchange be required to have Essential Community Providers in network?

Enrollment

- **Should enrollment requirements in the Exchange be applied outside the Exchange in the Individual market?**

Relevant Federal Laws and Regulations - Individual Exchange

- Insurers offering coverage in the individual or group market must accept every employer and individual in the State that applies for coverage. Insurers may restrict enrollment through open or special enrollment periods.¹ (PPACA Section 2702)
- In the Exchange, HHS shall determine an initial open enrollment and annual open enrollment periods. Special enrollment periods specified in Section 9801 of IRS Code-1986 and in the Social Security Act. (PPACA Section 1311(c)6))
- Initial open enrollment period begins 10/1/13 and ends 3/31/14; allows a qualified individual to enroll in a QHP. (45CFR §155.410(b))
- Annual open enrollment period from 10/15 each year through 12/7 of each year starting in 10/2014 and effective on the first day of the following benefit year. (45CFR §155.410(e) & (f))
- Special enrollment period exists for 60 days past the triggering event¹ in cases of:
 - Birth, adoption or placement for adoption, effective on the date of the event. (45CFR §155.420(b)(2)(i))
 - Marriage or loss of minimum essential coverage, effective on the 1st day of the following month. (45CFR §155.420(b)(2)(ii))

¹Insurers shall establish special enrollment periods for qualifying events under Section 603 of the Employee Retirement Income Security Act of 1974.

²45 CFR §155.420(c); Section 603 is summarized in the appendix

Relevant Federal Laws and Regulations - Individual Exchange (cont'd)

- Grace Period for disenrollment due to non-payment of premiums is 3 months for individuals receiving advance payment tax credits (APTCs) and at a policy to be set by the Exchange for all others. (45 CFR §155.430(b))
 - For the APTC population, QHPs must pay all claims for the first month of the grace period and may pend claims for months 2 and 3. QHPs must also notify HHS and providers of APTC enrollee non-payment. (45 CFR § 156.270(d))
- QHPs must provide notice of termination of coverage at least 30 days prior to the last day of coverage. (45 CFR §156.270(b)(1))
- QHP must generally process enrollee-requested terminations 14 days from the request. (45 CFR §155.430(d)(2))
- If an enrollee remains eligible for coverage in a QHP upon annual redetermination, then such enrollee will remain in the QHP selected the previous year. (45 CFR §155.335(j))

¹Insurers shall establish special enrollment periods for qualifying events under Section 603 of the Employee Retirement Income Security Act of 1974.

²45 CFR §155.420(c); Section 603 is summarized in the appendix

Relevant State Laws and Regulations - Individual Coverage

Topic	Federal Standard	State Standard	State Citation
Renewal of Coverage	Eligible enrollee remains in the QHP selected the previous year	Guaranteed renewable with stated exceptions	G.S. 58-68-65
Initial Open Enrollment	Begins 10/1/13 and ends 3/31/14	N/A	N/A
Annual Open Enrollment	Begins Oct 15th and ends Dec 7th	N/A	N/A
Effective Dates for Open Enrollment	Coverage begins on the 1st day of following benefit year	N/A	N/A
Special Enrollment			
Case of birth, adoption or placement for adoption	Coverage is effective on the date of birth, adoption, or placement for adoption	Coverage is effective on date of birth, adoption, placement for adoption, or placement in a foster home	G.S. 58-51-30 and 58-51-125
Case of marriage or loss of minimum essential coverage	Coverage is effective the first day of the following month	N/A	N/A
Length of Special Enrollment Period	60 days from the date of the triggering event	N/A	N/A
Grace Periods for Non-Payment	3 months for APTC, set by the Exchange all others	Generally 30 days	58-51-15(a)(3)
Termination of Coverage			
Notice	At least 30 days prior to the last day of coverage	Generally 45 days	Numerous statutes
Effective Date of Termination	The date specified by the individual, or 14 days after request if no date is specified	N/A	N/A

Guaranteed issue requires insurers to offer coverage in the individual market in 2014. The Exchange has defined enrollment rules which limits the impact of guaranteed issue on the Exchange market place. North Carolina could also limit guaranteed issue in the non-Exchange market through defined enrollment rules and regulations.

Pros from offering the same Enrollment rules in and out of the Exchange market

- Further levels the playing field by mitigating the risk that a person may “game the system” by having access to more open enrollment periods throughout the year.
- More uniformity allows for educational campaign (e.g., easier to “market” enrollment options at certain periods in time; easier for people to understand rules associated with enrollment).

Cons from offering the same Enrollment rules in and out of the Exchange market

- Administrative costs associated with open enrollment can not be managed across the year outside of the exchange.
- Limits flexibility in establishing separate enrollment rules, by insurer.

It is likely that insurers will be prohibited from offering more restrictive enrollment criteria than in the Exchange.

Other States' Approaches to Enrollment

- CO has stated that enrollment periods will be the same both in and out of the Exchange ¹
 - *“The open enrollment period for the Individual and SHOP exchanges should be the same as the open enrollment periods outlined in the final rules released by HHS. COHBE should not include more special enrollment periods beyond what is stated in the final HHS rule.”*
- MA requires all insurers must guarantee issue all products, with open enrollment periods that are the same both in and out of the Connector.
 - MA currently weighing how to reconcile ACA requirements with existing state requirements.
- In New Jersey, individual market insurers must guarantee issue standardized policies continuously, unless the individual is eligible for group coverage.
- In Ohio, individual market insurers must guarantee issue standardized policies on a periodic basis. For non-HMOs, this timeframe is limited to 30 days.

Excerpt from National Dialogue

- **NAIC:** “States may wish to consider applying many of the QHP-specific standards in federal law (such as open enrollment periods and minimum offering standards) to issuers both inside and outside the Exchange market, as a means of making market rules consistent and minimizing the risk of adverse selection.”

¹<http://www.getcoveredco.org/COHBE/media/COHBE/PDFs/Board/July%209,%202012/10-Open-Special-Enrollment.pdf>

²http://www.naic.org/documents/committees_b_exchanges_120626_form_review_white_paper.pdf

Options and Action Steps

Options

Action Steps

**Yes, enrollment rules/
regulations should be
the same**

- Require that insurers outside the exchange market will follow the same enrollment rules as inside the exchange market

**No, enrollment rules/
regulations should
remain as they are
today**

- Do nothing

**No, enrollment
rules/regulations should
be looked at on a case-
by-case basis to
determine where they
should be the same and
where they could be
more flexible**

- Define which rules/regulations should be addressed and the proposed standards for each (open enrollment, effective dates, termination of coverage, etc.)

Other?

- ???

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- **Send Ideas for Discussion for Phase II to:**
 - AGarcimonde@manatt.com or Lauren.Short@ncdoi.gov
- **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
- **Attend next in person meeting on August 30th 2012 from 9:30AM to 12:30PM**

Questions?

Definition of Qualifying Event

Legal Information Institute- Section 603 of ERISA

For purposes of this part, the term “qualifying event” means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

- (1) The death of the covered employee.
- (2) The termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment.
- (3) The divorce or legal separation of the covered employee from the employee’s spouse.
- (4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.
- (5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.
- (6) A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 1167 (3)(C) of this title within one year before or after the date of commencement of the proceeding.

<http://www.law.cornell.edu/uscode/text/29/1163>

National Dialogue on TAG #7 Issues

National Association of Insurance Commissioners (NAIC)

Comments on Enrollment

NAIC Form Review Draft White Paper

“States may wish to consider applying many of the QHP -specific standards in federal law (such as open enrollment periods and minimum offering standards) to issuers both inside and outside the Exchange market, as a means of making market rules consistent and minimizing the risk of adverse selection.”

“States will need to consider additional, anticipated federal guidance on open enrollment periods outside an Exchange.”

http://www.naic.org/documents/committees_b_exchanges_120626_form_review_white_paper.pdf

Comments on Enrollment

“States might want to consider adopting additional policies similar to the Massachusetts approach... In 2011, individuals are able to enroll during two open enrollment periods. In 2012, this will be reduced to one open enrollment period. Furthermore, individuals in Massachusetts are not eligible to enroll in the non-group market if they are eligible for employer-sponsored coverage that is at least actuarially equivalent to minimum creditable coverage, as defined by the Commonwealth Health Insurance Connector.”

“Outside of special enrollment periods, as required under the ACA, the states could prohibit individuals from purchasing coverage, whether inside or outside of the Exchange, only during a specified time period each year. In considering this option, the states will need to weigh the impact it would have on the market and consumer access to coverage. The states also could institute a penalty for late enrollment or limit the number of times a person can change coverage to once a year to limit the adverse selection due to a consumer “buying up” once faced with a health problem...”

NAIC White Paper: Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act

National Association of Insurance Commissioners (NAIC)

Comments on Enrollment Periods (cont'd)

“When considering these policy options, state policymakers will need to consider the penalties imposed under the ACA for individuals who fail to maintain minimum essential coverage. State policymakers also should recognize that, if an individual can only purchase or change coverage during a limited period of time each year, an aggressive outreach and education program should be in place to help ensure that consumers are informed about their choices and the consequences of their decisions. Enrollment periods should be sufficiently long to give consumers time to understand the requirements and their options, particularly prior to 2014.”

NAIC White Paper: Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act

UnitedHealth Group

Comments on Open Enrollment Periods

“Open enrollment period rules must create incentives for consumers to maintain continuous coverage and attract a stable risk pool of members to avoid suffering from severe adverse selection. Both initial and ongoing open enrollment periods should be structured to encourage consumers to maintain continuous health care coverage, rather than permitting consumers to wait to purchase coverage until they incur high health care costs and then cease coverage immediately thereafter. Specific steps Exchanges should consider to mitigate the possibility of adverse selection include: Limiting the open enrollment to a single 30 to 45-day time frame each year; Prohibiting plan changes between open enrollment periods, and limiting increases in coverage at open enrollment to one step (e.g. bronze to silver) per year; Providing clear rules about the limited exceptions that should be allowed for individuals to enroll outside the open enrollment period; and Establishing staggered open enrollment periods tied to a policyholder’s date of birth to distribute the administrative process evenly throughout the year. For programs with income eligibility criteria, the open enrollment periods and eligibility determination process must promote continuity of coverage and reduce shifts between types of coverage and subsidy levels.”

http://www.uhc.com/live/uhc.com/Assets/Documents/Maximizing_Consumer_Benefits.pdf

American Academy of Actuaries (AAA)

Comments on Network Adequacy

“Stronger rules ensuring consistency for in- and off-exchange market practices—in areas such as network adequacy, marketing (including roles of agents and navigators), plan designs, and ancillary offerings—could help mitigate the degree of adverse selection.”

“It is important to establish network adequacy standards to meet the needs of consumers in both urban and rural areas as well as to ensure a reasonably robust network of all types of providers. This will be important as more consumers seek access to primary care services, and as there will be a pent-up demand for services across the nation with the expansion of health insurance coverage. The standards should be flexible to meet local patterns of care and include various primary service providers, such as physician assistants, nurse practitioners, and others to meet the needs and address some of the pent-up demand issues.

Carriers may use network design as a way to drive selection in their plan offerings. For example, carriers could minimize enrollment among individuals in high-cost areas by not including providers these individuals typically would access. Establishment of minimum standards—such as an access ratio of members to primary care providers and/or to a particular type of specialist and geographic access standards to ensure proximity to residence or workplace of members—will be critical. These standards should be monitored on an ongoing basis to ensure compliance and adequacy of networks. While it is desirable to have adequate networks in the underserved areas, it may not be an easy or practical process to establish networks in these areas.”

“Because risk adjustment will not be able to fully reflect the underlying risk of enrollees, CMS may wish to consider additional marketing or network adequacy requirements.”

http://www.actuary.org/pdf/health/Academy_comments_on_NPRM_on_exchanges_100611_final.pdf

Association of American Medical Colleges

Comments on Network Adequacy

“The AAMC is concerned that the standards as proposed for QHP network adequacy are not well enough defined and potentially are ripe for the development of tiered plan networks that exclude teaching hospitals and faculty physicians from Exchange plans based on these providers being deemed “high cost,” while not accounting for the value added by the other missions and societal benefits AMCs provide.”

“The AAMC believes that, as proposed, the network adequacy standards are insufficient. Patients who currently rely on AMCs for their care, as AMCs disproportionately care for the uninsured, should be able to continue to receive their care at these institutions once covered by an Exchange plan and should not be penalized by having to enroll in a plan that prevents them from seeing their long-standing providers, or makes those providers prohibitively expensive by imposing high enrollee out-of-network cost sharing. QHPs should reflect the range of providers in a community, insuring enrollee choice and access to the most appropriate source of care.

At the overall insurance level, the ACA takes a number of steps, including underwriting reforms and adjusted community rating, to assure that health coverage is provided without regard to a person’s medical condition, and plans do not cherry-pick lower cost individuals. It is essential that QHP network standards reinforce these policies and do not undermine them by allowing networks to be constructed in a manner that discourages access, and thus enrollment, of those with unique or high cost conditions, as a means to lower premiums. Excluding major teaching hospitals altogether from the networks of QHPs, or subjecting them to exceptionally high cost sharing, would reduce access for these medically frail individuals because it is precisely these institutions that treat these patients. This has already been seen within the Medicaid population where, as state reimbursement for Medicaid has decreased, fewer providers are willing to treat Medicaid patients. As a result, these patients are forced to seek care at community safety net institutions, often an AMC...

The rules for QHPs and Exchanges should not undermine those policy objectives and provisions by allowing for an exclusion of the providers that incur legitimately higher costs because they respond to these critical societal needs and ACA priorities. It is essential that provisions such as QHP networks standards reinforce rather than undermine the imperative for access in underserved areas.”

<https://www.aamc.org/download/261534/data/aamccommentsonestablishmentofexchangesandqualifiedhealthplans.pdf>

Center on Budget and Policy Priorities (CBPP)

Comments on Network Adequacy

“Insurers selling through the exchanges may also have to meet a variety of additional requirements, such as network adequacy standards, that some states do not currently require. In states with only one or two dominant insurers, these new rules will require some adjustment in their pricing and marketing strategies. In more competitive markets, insurers may need to make even more significant adjustments and will be especially concerned about the potential adverse selection effects of these new requirements.”

<http://www.cbpp.org/files/5-18-11health.pdf>

“HHS should set minimum standards for ‘sufficient choice of providers for enrollees’.”

[http://www.cbpp.org/files/State-Advocate-Letter-on-Proposed-HHS-Exchange-Regulations-\(September-2011\).pdf](http://www.cbpp.org/files/State-Advocate-Letter-on-Proposed-HHS-Exchange-Regulations-(September-2011).pdf)

American Association on Health and Disability

Comments on Network Adequacy

“The rule proposes that Exchanges make health insurance and therefore health care available to a variety of consumers, including those who reside or work in rural or urban areas where it may be challenging to access health care providers, by requiring Exchanges to ‘ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.’ We strongly support this goal.”

“The requirements of network adequacy and essential community providers are fundamental to ensuring that persons with disabilities receive all health related benefits that they require, in a timely, convenient, and appropriate delivery.”

“We believe that the final rule should establish national standards that will serve as a minimum level of protection for network adequacy across the country.”

“HHS should adopt the NAIC (National Association of Insurance Commissioners) Managed Care Plan Network Adequacy Model Act as the minimum national network adequacy requirements for QHP certification and add provisions to require QHPs that are health indemnity plans to demonstrate that they have a sufficient choice of providers accepting their health plan to meet the minimum national network adequacy standards.”

<http://www.aahd.us/site/static/pdfs/policy/AAHDExchRuleComnts.pdf?PHPSESSID=017c0586993b730611fa99eb00dd679e>

National Association of Insurance Commissioners (NAIC)

Comments on Network Adequacy

“HHS modified the language in 45 CFR §155.1050, as reflected in 45 CFR §156.230(a)(2) in the final rules, to better align with the language used in the NAIC Model.”

“mental health providers should be a component of networks inside and outside the Exchange.”

“To the extent that a State already has network adequacy standards, it would make sense for the State to extend those requirements to QHPs to minimize adverse selection against the Exchange. However, in some cases, the ACA’s network adequacy standards may go beyond a State’s existing requirements, particularly as related to its requirement that essential community providers be included in the QHP’s provider network. Whether a State has existing network adequacy standards or not, each State will need to consider whether to apply the same standards for QHP certification to the outside market, the potential for adverse selection against the Exchange if they choose not to require the same standards and the cost to issuers in the outside market to comply if they choose to require the same standards.”

“Areas in which the NAIC Model can be enhanced to ensure compliance with §156.230 include: 1) inclusion of essential community providers, as defined in §156.235(c), in networks; and 2) inclusion of mental health and substance abuse providers in networks.”

“States could consider relying on a QHP plan’s accreditation for network adequacy as a complementary tool, but not as a replacement for regulatory oversight, for assessing compliance with the ACA’s and final rules network adequacy standards for QHP certification.”

http://www.naic.org/documents/committees_b_exchanges_120626_network_adequacy_white_paper.pdf

National Association of Insurance Commissioners (NAIC)

Comments on Network Adequacy - NAIC Consumer Statement

“We strongly recommend a new charge that revises and expands the 1996 Managed Care Plan Network Adequacy Model Act with these considerations in mind:

The language of the law needs to be updated...

The requirements of the ACA must be incorporated, as described in the recent white paper.

Requirements for robust consumer transparency must be incorporated...

Revisit and broaden the concept of network adequacy and consider new ways of measuring provider networks.”

“NAIC needs to revisit the concept of network adequacy. Moreover, the model act does not envision a role for consumers in the process; it takes a very passive approach to enforcement and oversight of networks.”

“We believe regulators must become much more actively engaged in facilitating consumer knowledge and understanding of networks”

http://www.naic.org/documents/committees_b_120627_consumer_statement_network_adequacy.pdf

Robert Wood Johnson Foundation Center on Health Insurance Reforms, National Academy of Social Insurance

Comments on Network Adequacy

“Where a state does not currently have a network adequacy standard for commercial health plans, the exchange could rely on a general standard HHS has prescribed through regulation, or they could import some or all of the standards used for Medicaid plans. For a FFE run by CMS, the agency could require carriers to attest to network adequacy, rely on the state DOI to certify compliance, or leverage the standards and process used in Medicare Advantage.”

<http://www.rwjf.org/files/research/74373.planmgt.0512.pdf>