Issue Brief #2

Rating Areas and Leveling the Playing Field Issues and Recommendations

Key Takeaways

- The Affordable Care Act (ACA) requires that each state establish rating areas that must be applied consistently inside and outside the Exchange. The Technical Advisory Group (TAG) **recommends that the North Carolina Department of Insurance (NC DOI), in consultation with health insurance carriers (insurers), be responsible for the establishment of geographic rating areas for the individual and small group markets.** This change should be reflected in North Carolina statute.

- The ACA requires as a condition of participation in the Exchange that insurers offer at least one silver level and one gold level Qualified Health Plan (QHP) in the Exchange and allows states the option of establishing additional insurer participation requirements. The TAG **recommends that insurers should not be required to participate in additional metal levels as a condition of Exchange participation in 2014 and 2015.** No change is required to North Carolina statute to implement this recommendation.

- North Carolina has a five-year prohibition on market re-entry if an insurer leaves any of the individual, small and large group markets.[1] The TAG discussed putting limitations on insurers' ability to re-enter the Exchange after an exit. The TAG **recommends that 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.** This change should be reflected in North Carolina statute.

- While not addressed in the ACA, North Carolina could establish insurer participation requirements across the Exchange and non-Exchange markets. The TAG **recommends that the NC DOI actively monitor the individual and small group markets, including the interplay between the Exchange and non-Exchange markets, and make recommendations to the North Carolina General Assembly (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.**

- Most favored nation (MFN) clauses were raised as an issue for discussion in light of ACA implementation. **A significant majority of TAG members strongly believe that the ACA increases the need for the NCGA to act to prohibit the use of MFN clauses which inhibit insurers' ability to negotiate competitive service rates with health care providers.** This change should be reflected in North Carolina statute.

[1] N.C.G.S. § 58-68-65(c)(2)(b), N.C.G.S. § 58-68-45(c)(2)(b)

Issue #1: Development of Geographic Rating Areas

The ACA requires each state to establish one or more rating areas within that state, subject to the review and approval of the Secretary of the Department of Health and Human Services ("the Secretary"). Rating areas are separate from service areas. Service areas are geographic regions in which an insurer elects to operate. Rating areas are geographic areas across which insurers can vary premium costs. In addition to rating areas, which must be established and rated on a non- discriminatory basis, insurers can also vary rates based on age (no more than a 3:1 rate band), family composition, and tobacco use (1.5:1 rate band). Rating areas will apply to all non-grandfathered, fully-insured small group and individual plans and will be applied consistently inside and outside of the Exchange.[2]

Under current North Carolina statute, insurers are required to define geographic rating areas in the small group market around "medical care systems." Medical care system rating factors must: reflect the relative differences in expected costs; produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas; and be revenue neutral to the small employer carrier.[3]

In practice, most insurers in North Carolina use counties to determine rating areas. Most insurers also use a limited number of geographic rating factors and group counties based on costs, which often creates non-contiguous rating areas. In the individual market the number of rating factors ranges from 2 to 8.[4] In the small group market, the number of rating factors varies from 9 to 23.[5] Several insurers use different geographical rates by market type (*e.g.*, the small group market has different rating than the individual or large group markets).

In developing ACA-compliant rating areas, the State will need to determine whether rating areas can be non-contiguous under the ACA and how much rate variation to allow in geographical rating factors. More variation will better align geographic cost variation and premiums, but it also could increase premiums in rural or otherwise underserved areas, which have less competition among delivery systems.

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

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

[2] Fully-insured large group plans are only subject to rating areas, and other rating requirements, in states that allow large groups to purchase through the Exchange.

[3] N.C.G.S. § 58-50-130(b)(7)

[4] Analysis based on select insurers with greater than 5,000 lives in North Carolina.

[5] Analysis based on select insurers with greater than 5,000 lives in North Carolina.

The Need to "Level the Playing Field"

The ACA includes multiple measures designed to mitigate adverse selection in the small group and individual markets, including minimum coverage requirements, tax credits for small businesses, premium subsidies, risk adjustment, and reinsurance. However, adverse selection remains a concern. The ACA gives states broad discretion to take additional steps to mitigate adverse selection, which can occur whenever individuals at greater risk of high health spending are more likely to seek coverage or choose a particular coverage option than low-risk individuals. Once a particular market segment begins to attract a disproportionate share of higher-risk individuals, costs will rise in that segment. Unless there is some countervailing action, the higher costs will lead to higher premiums, which will drive the better risks out of that market, thereby driving costs even higher. This process is typically referred to as a premium spiral.[6]

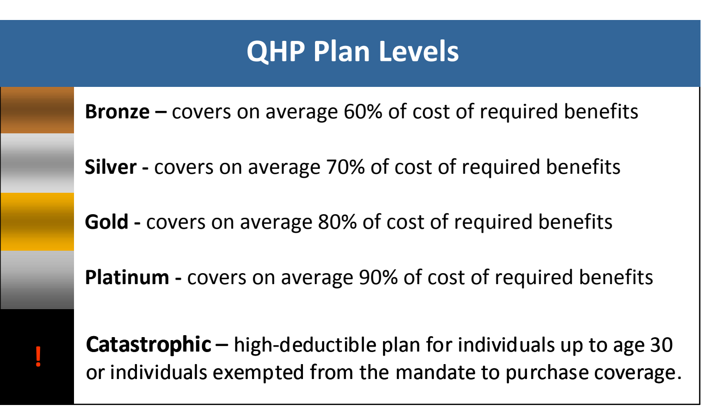
The issues that follow address various options that North Carolina may consider to mitigate adverse selection, including insurer participation and market re-entry requirements. Subsequent issue briefs will cover other risk-mitigation strategies.

In addition to leveling the playing field to prevent adverse selection, there may be a need to level the playing field so that all insurers have the ability to compete in the marketplace under the same terms and conditions. Thus, the issue of most favored nation contracting clauses is also addressed below.

Issue #2: Mitigating Adverse Selection Through Plan Participation Requirements Inside the Exchange

The ACA requires QHP insurers to offer at least one silver level and gold level plan in the Exchange as a condition of participation. States have the option to require that QHP insurers meet additional participation requirements in the Exchange, such as requiring insurers to offer plans at other benefit levels within the Exchange.

Establishing additional participation requirements for QHP insurers in the Exchange may help mitigate adverse selection among insurers and their QHPs. For example, requiring insurers to offer QHPs at all four metal levels may foster competition for both the most healthy and least healthy risks. Such a requirement may also expand choices for consumers purchasing coverage through the Exchange.



[6] Definition adapted from the American Academy of Actuaries definition of adverse selection, available at: http://www.actuary.org/pdf/Risk_Adjustment_IB_FINAL_060811.pdf

However, additional requirements could also reduce choices and lessen competition if they discourage insurers from participating in the Exchange. In short, there is a fine balance to be struck, particularly in the start-up period of the Exchange.

The TAG recommends that additional participation requirements that mandate insurer participation in additional metal levels within the Exchange are not advisable in 2014 and 2015.

Issue #3: Mitigating Adverse Selection Through Market Re-Entry Requirements Inside the Exchange

North Carolina currently has a five-year prohibition on market re-entry if an insurer leaves the individual, small or large group markets in the State.[7] Extending this policy to the Exchange would limit market disruptions and potential adverse selection by insurers exiting and re-entering the Exchange at opportune times.

However, any "re-entry policy" should be thoughtfully crafted, especially with regard to the length of time that QHP insurers would be barred from re-entering the Exchange, as the Exchange will be a new entity and will require operational flexibility to ensure adequate participation among insurers to meet consumer demand.

The TAG recommends that the Exchange board have the authority to develop a policy regarding QHP insurers' re-entry into the individual and small group Exchanges after exiting either Exchange market.

Issue #4: Mitigating Adverse Selection Through Plan Participation Requirements Between the Exchange and Non-Exchange Markets

Because it is projected that the Exchange will attract individuals with higher than average risk, some insurers may prefer to participate in the non-Exchange market only, fearing that risk-mitigating mechanisms (such as reinsurance or risk adjustment) will not adequately offset costs. To limit the resulting potential for adverse selection between the Exchange and non-Exchange markets, North Carolina could impose additional insurer participation requirements. Options include requiring that certain insurers participate in the Exchange as a condition of offering products in the non-Exchange market, and putting parameters in place regarding the types of plans that insurers must offer inside and/or outside of the Exchange.

[7] N.C.G.S. § 58-68-65(c)(2)(b), N.C.G.S. § 58-68-45(c)(2)(b)

There are multiple strategies for protecting the Exchange against adverse selection. For example, insurers could be prohibited from offering catastrophic or bronze plans outside the Exchange unless they also offered those same plans inside the Exchange. This would prevent insurers from participating in catastrophic or bronze plans only outside of the Exchange, which would pull good risks out of the Exchange and disadvantage insurers participating in the Exchange.

Individuals enrolling in the Exchange are expected to have health expenditures that are approximately 12% more on average than individuals enrolling in coverage outside the Exchange as a result of health differences beyond those explained by age.[8]

However, imposing additional requirements on insurers operating outside of the Exchange market, or prohibiting them from selling certain products, may cause some insurers to leave the individual and small group markets entirely or dissuade potential new entrants from participating in the market. Despite many theories about possible approaches, insufficient information exists at this time to know how required reforms will play out, or the impact that any additional requirements for carrier product offerings both inside and outside of the Exchange would have on the market.

Accordingly, the TAG recommends that the NC DOI actively monitor the individual and small group markets, including the interplay between the Exchange and non-Exchange markets, and make recommendations to the NCGA, in consultation with the Exchange as appropriate, if plan participation or other adjustments are needed to minimize adverse selection in the individual and small group markets.

Issue #5: Most Favored Nation Clauses in Provider Contracts

Most favored nation (MFN) clauses in light of ACA implementation was raised as an issue for discussion. Because this issue was not under the original scope of the TAG, independent information and analysis was not provided to define considerations related to MFN, unlike other issues addressed by the TAG. The TAG defined MFN for the purposes of its discussion as contract clauses between a health care provider and an insurer which give the insurer the ability to do one or more of the following: 1) audit contracts providers have with other insurers to determine if the rates offered to other insurers are more favorable; 2) apply the best rate identified in the audit; and 3) mandate that a corridor exist between the insurer's contracted rate with a provider and the provider's negotiated rates with other insurers, such that if the corridor is breached the insurer would get a price reduction to maintain the corridor.

[8]Milliman, North Carolina Health Benefit Exchange Study, July 18, 2011. Findings based on non-group enrollment, only.

The TAG supports effective implementation of the ACA in North Carolina, which includes anticipating and addressing any potential adverse interactions between ACA and current State statute.

A significant majority of TAG members expressed serious concerns about strategies utilized in health care provider contracting, known as MFN clauses. According to this majority, use of these clauses, particularly in markets that are dominated by a single insurer, inhibits market competition by limiting most other health insurers' ability to negotiate satisfactory health service rates with certain health care providers. Currently in North Carolina, insurers are able to mitigate some of the impact of these clauses on market competition by utilizing available product underwriting and pricing flexibility. Much of that flexibility will be eliminated under ACA. Most TAG members believe that the anti-competitive impact of MFN clauses will be intensified in a post-ACA environment, further limiting competition among carriers and creating barriers to market entry for new carriers, thus restricting consumer choice. Although there was not unanimity within the TAG, a significant majority of TAG members strongly believe that the ACA increases the need for the North Carolina General Assembly to act to prohibit the use of MFN clauses which inhibit insurers' ability to negotiate competitive service rates with health care providers.

The health insurer TAG member with the largest health insurance market share in North Carolina expressed concerns that the TAG was not the forum for MFN consideration. This TAG member further asserted that there was little evidence of the impact of these provisions on prices or competition, and indicated that such clauses may help keep consumer costs low. This TAG member concluded that any consideration of MFN in North Carolina should be based on a thorough assessment of the impact of such change specific to the State's 2014 market, including the impact to health care cost and quality.

About the Market Reform Technical Advisory Group (TAG)

The TAG is comprised of representatives of insurers, agents, academia, hospitals, providers, business and consumers who reside in North Carolina and have knowledge of North Carolina's health care system and marketplace. The TAG considers and makes recommendations on each issue after a review of applicable State and federal laws, relevant literature, national stakeholder recommendations, and pending or passed legislation in other states.

The TAG evaluates 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 Exchange; empower consumers to make informed choices; support predictability for market stakeholders, competition among plans and long-term sustainability of the Exchange; 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. The TAG acknowledges that tension exists between these values and seeks to provide policy recommendations that are best aligned with the overall public interest, while ensuring the continued strength and viability of the State marketplace.

The purpose of the TAG is to develop options and considerations and to identify areas of consensus to inform the recommendations to the North Carolina General Assembly (NCGA) on ACA-related market reforms. The TAG was convened pursuant to North Carolina Session Law 2011-391, which authorized the Commissioner of Insurance to 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.

For more information on the TAG go to: http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx