Report on the Development of a State-based Health Benefits Exchange

to

The Joint Legislative Oversight Committee
on General Government

and

The Joint Legislative Oversight Committee
on Health and Human Services

Pursuant to Section 30.9 of Session Law 2023-134

May 15, 2024

The North Carolina Department of Insurance

NC DEPARTMENT of INSURANCE
MIKE CAUSEY, COMMISSIONER

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I. Introduction

This report is prepared pursuant to Section 30.9 of S.L. 2023-134 which directs the Commissioner of Insurance, in consultation with the Secretary of the Department of Health and Human Services, to develop a detailed plan for the development of a state-based health benefits exchange as well as a draft State Innovation Waiver pursuant to Section 1332 of the patient Protection and Affordable Care Act, P.L. 111-148, as amended (the ACA).[1]

After S.L. 2023-134 was passed, the Department of Insurance (the Department) was contacted by multiple parties interested in meeting or speaking with the Department regarding transitioning to a state-based exchange. Several of the parties have experience assisting other states in establishing state-based exchanges. At the request of the Department, some parties gave presentations to the Department on the topics to be covered by this report. All parties shared their thoughts and concerns on the topic with the Department. The information they shared, along with the Department's own research on the topic, helped the Department prepare this report.[2] The Department shared a draft of the report with the Department of Health and Human Services (DHHS) and DHHS provided valuable feedback and comments, which are reflected in the final report.

The ACA created "marketplaces," or "exchanges," as sites where consumers can shop for Qualified Health Plans and Stand-alone Dental Plans.[3] Exchanges also support the Small Business Health Options Program (SHOP), for small employers looking for health coverage for their employees. As of 2021, there is effectively no SHOP exchange operating in more than half of the states including North Carolina. These states use a direct enrollment approach where small groups connect directly with agents or brokers. There are three options for operating an exchange under the ACA:

- A state can operate a state-based exchange (SBE).[4] With a state-based exchange, the state handles all exchange functions and would charge a fee to insurers to cover the cost of the operation of the exchange.

- If a state does not establish a state-based exchange, the marketplace is run by the federal government (the federally facilitated exchange or FFE).[5] The federal government charges a user fee to insurers offering plans on the exchange that is a percentage applied to the average per member per month premium to fund the operation of the FFE.

- A state can also operate a state-based exchange using the federal platform (SBE-FP).[6] When a state operates a state-based exchange on the federal platform, the federal government is responsible for the eligibility and enrolment platform and the call center, and the state is responsible for the remaining exchange functions

like its Navigator program and plan management functions. The federal government will charge states a reduced user fee for its services with an SBE-FP. A state would typically charge insurers the difference between the reduced fee and the FFE fee to help fund its exchange operations.

Since the start of the ACA, North Carolina, like a majority of states, has used the federally facilitated exchange, HealthCare.gov, as the method for North Carolina consumers to enroll in individual health insurance. For plan year 2024, there are 29 FFEs, 19 SBEs and 3 SBE-FPs.

Additionally, North Carolina consumers can use HeathCare.gov to learn if they are eligible for Medicaid or subsidized coverage through the Exchange. As authorized by the General Assembly, DHHS worked with the Centers for Medicare & Medicaid Services (CMS) and the FFE to begin performing Medicaid determinations for individuals applying through the FFE effective February 1, 2024. This helps consumers as they only have to go to one place to determine what their options are for finding health coverage for themselves and their families. It also eases the burden on county departments of social services which are otherwise responsible for determining Medicaid eligibility in North Carolina and have had to manage large volumes of eligibility redeterminations and new applications following the end of the continuous coverage requirements of the Families First Coronavirus Response Act and Medicaid expansion, respectively. In addition to performing eligibility determinations, the FFE also supports eligibility appeals.

Recently, there has been a renewed interest in state-based exchanges. Over the last five years, nine states have moved or are in the process of moving to state-based exchanges.[7] This is partly attributable to policy reasons like states taking control of their healthcare marketplaces back from the federal government, having more targeted branding, improved data access, and more freedom to innovate if it operates its own exchange. There are practical reasons too. There are now companies that have developed software platforms for operating a state-based exchange. These software platforms have made the cost of operating a state-based exchange cheaper and easier than having to develop a platform from scratch. States have also switched to a state-based exchange to help address larger policy issues. Both Georgia and Virginia have made a state-based exchange part of their plan for reducing their states' overall uninsured population. Georgia has also used fees from its exchange to fund a reinsurance program, to help lower premiums. As a result, more states are looking at transitioning to a state-based exchange.

After seeing what other states, like Georgia, are doing, the Department believes that moving to a state-based exchange would benefit North Carolina. However, the foremost consideration in transitioning to a state-based exchange should be minimizing the impact of the transition to consumers. A state-based exchange should offer the same or better experience for consumers seeking health coverage

either through Medicaid or private insurance through integrations across programs like through eligibility systems, call centers, and coordination with Navigators. Ensuring a smooth transition to a state-based exchange will require three things:

- adequate funding,
- adequate staffing, and
- time.

This includes resources for DHHS and county departments of social services to build, test and adequately train staff to ensure there are effective connections between Medicaid and exchange eligibility systems and changes to eligibility appeals processes, which are currently partially supported by the FFE.

II. Structure and Oversight of a State-based Exchange

A state-based exchange can be established in either a new or existing state agency or a nonprofit entity established by the State.[8] State-based exchanges must meet certain requirements for how they are governed. An exchange established as an independent state agency or a nonprofit entity is required to have a clearly-defined governing board.[9] The governing board must meet a list of requirements:

(1) Is administered under a formal, publicly-adopted operating charter or by-laws;
(2) Holds regular public governing board meetings that are announced in advance;
(3) Represents consumer interests by ensuring that overall governing board membership:
    (i) Includes at least one voting member who is a consumer representative;
    (ii) Is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and
(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.[10]

All exchanges are required to have "a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest."[11] Of course, there are advantages and disadvantages to each option.

The major advantage to housing an exchange in an existing state agency is that most of the agency infrastructure for the exchange already exists. The exchange

will benefit from being able to use the existing agency's human resources, information technology, controller's office and procurement office to help make the exchange operable. Being able to use these resources in an existing agency means that a state can establish an exchange more quickly than starting a new agency or non-profit entity. If the exchange is established in a state's department of insurance, the exchange will benefit from the department's experience as it already regulates the health plans, reviews and approves qualified health plan offerings and, as is the case in North Carolina, reviews premium rates. If established in a state's Medicaid agency, an exchange can benefit from the agencies experience with eligibility determinations for public benefits and communicating program benefits to consumers and other stakeholders and, with DHHS, contracting with health plans. Illinois, while housing its exchange in its insurance department, has taken a hybrid approach, given authority to both its insurance department and its state Medicaid agency over aspects of its exchange.[12]

There are potential disadvantages to housing an exchange in an existing state agency. Possible limitations that were shared with the Department included state government salary constraints and state procurement rules. Having to comply with state rulemaking procedures could also cause delays. State budget requirements, like having to rely on appropriations for spending and employees could make it difficult for an exchange to grow as needed. Some of these issues could be addressed or mitigated through the legislation needed to establish a state-based exchange.

Establishing a new state agency has similar advantages and disadvantages to an existing state agency but there are some differences. By creating a new state agency, stakeholders can feel like they are more involved and the agency can be specifically designed to function as an exchange. However, creating a new state agency also requires creating the whole organizational infrastructure required for an agency to operate, including staffing administrative functions like human resources and budget positions, finding a physical location to house the agency and establishing new IT systems. Additionally, creating an independent state agency to house an exchange requires a governing board, which can be inefficient.

Creating a nonprofit entity to house an exchange also has both advantages and disadvantages. A nonprofit entity generally would be more nimble - not being subject to things like state procurement rules and salary restrictions. Fees may not have to be deposited in a state's general fund. But these flexibilities can also make a nonprofit entity less accountable and less transparent.

When states have housed an exchange in an existing state agency, it has either been the agency responsible for insurance regulation or the agency responsible for the state's Medicaid program.

Looking at the nine states that have moved towards a state-based exchange over the last 5 years, it appears that there has been an even split with three states establishing an independent agency or entity, three states housing their exchanges under their Medicaid agencies, and three states housing their exchanges with the agency responsible for insurance regulation.

After considering the advantages and disadvantages of the different options for housing a state-based exchange and looking at what other states making the change have done, the Department recommends housing a state-based exchange within the Department of Insurance. With any option for housing a state-based exchange, there will need to be close cooperation between the Department and DHHS to make sure the handling of Medicaid eligibility determinations, transitions for consumers moving between Medicaid and Exchange coverage, and other needed data exchanges operate smoothly. Coordination will also be needed to support effective outreach to uninsured individuals and defining and working towards reducing the number of uninsured North Carolinians.

III. Timeline for the Implementation of a State-based Exchange

The Department believes that the 2027 plan year is the earliest realistic target for moving to a state-based exchange. This would allow for a minimum of roughly two years to make the transition. The Department's target is also based on the assumption that the necessary legislation would be passed in either the General Assembly's current short session or early in its next long session, that the exchange would be housed in the Department, and that adequate staffing and funding will be provided to establish the exchange and develop and test connections with Medicaid. The Department's target may still be too optimistic given the additional complexities of integrating the Medicaid determination process. NC Medicaid will need to engage its vendors to determine a feasible project plan, cost, staffing resources and timeline for implementing the necessary changes to connect to the new state-based exchange instead of the FFE. The project plan will need to factor in timelines for other planned changes in NC Medicaid, for example, launch of the Children and Families Specialty Plan, managed care for duals, and ongoing Medicaid Enterprise System (MES) updates and implementations. Additionally, the project plan will need to consider how the State will take on the additional Medicaid determinations and appeals that were recently transitioned to the FFE.

Neither the Department nor DHHS can begin working on a transition to a state-based exchange without authorizing legislation from the General Assembly. G.S. § 143B-24 prohibits state agencies from taking any action not authorized by the General Assembly towards establishing a state-based exchange.[13] A delay in passing the necessary legislation or issues encountered by either the Department or DHHS while working towards implementation could require a revision of the proposed target.

There are certain required steps in the transition that can serve as milestones. They are: a letter from the Governor declaring North Carolina's intent to establish a state-based exchange, the submission of an Exchange Blueprint to CMS, the transition to a state-based exchange on the Federal Platform, and, finally, the transition to a state-based exchange. Milestones on the timeline for implementation are:

- Enactment of Legislation Authorizing State-Based Exchange – To Be Determined

Any timeline will start with the passing of authorizing legislation. Initial steps will include hiring the initial staff for the exchange, preparing and issuing a request for proposals (RFP) for consultant services to assist with the transition process and work on RFP for other exchange related services like the software platform for the exchange. The Department and DHHS will also need to begin working together on the integration of the Exchange and the Medicaid determination process. The agencies will also need to begin reaching out to their stakeholders to involve them in the process. Depending on the authorizing legislation, the Department may have to begin the rulemaking process to further implement or execute what the legislation directs the Department to do. Some of these tasks will not be completed until later in the timeline.

- Declaration Letter – To Be Determined

The next milestone in transitioning towards a state-based exchange is a letter from the Governor to CMS declaring the State's intent to establish a state-based exchange as well as a state-based exchange on the federal platform. It represents a milestone as it starts the process of working with CMS on the transition. The declaration letter can be sent shortly after the authorizing legislation becomes law, but it can also be sent later as long as it is submitted with enough time to be ready to submit the Exchange Blueprint.

- Submit Exchange Blueprint – August 1, 2025

States wishing to operate a state-based exchange must submit an Exchange Blueprint to CMS for approval. The Exchange Blueprint must be submitted at least 15 months prior to the proposed start of open enrollment for the state-based exchange, which would be August 1, 2025. A state must receive conditional approval of its Exchange Blueprint and pass an operational readiness assessment in order to be considered an approved Exchange.[14]

- Open Enrollment for SBE-FP – November 1, 2025

A recent rule change in the Centers for Medicare and Medicaid Services' 2025 Notice of Benefit and Payment Parameters now requires that states seeking approval to operate a state-based exchange must first operate a state-based exchange on the Federal platform for at least one year.[15] To begin operating a state-based exchange for the 2027 plan year, the transition to a state-based exchange on the Federal platform must happen on November 1, 2025, the beginning of open enrollment for the 2026 plan year.

- Open Enrollment for SBE – November 1, 2026

Having the 2027 plan year as a target means the target date for getting the state-based exchange up and running would be November 1, 2026, which is the beginning of open enrollment for that plan year. Most major milestones will work backwards from that date.

As the transition progresses, there will be many more tasks to be accomplished to be prepared for the exchange to begin operating. There will need to be training and education for navigators, producers, local departments of social services and Medicaid eligibility workers. The Exchange will need to grow its staff as its responsibilities increase, including staffing a call center. There will need to be a high level of public outreach to ensure that consumers are aware that the exchange is where to go to purchase individual health plans.

IV. Anticipated Costs of a State-based Exchange

There are costs associated with establishing a state-based exchange and there will be costs for the ongoing operation of the exchange.

- Establishment of an Exchange

From information presented to the Department, overall costs to establish a state-based exchange could range from $8,000,000 to $32,000,000 in operational costs and an additional $14,000,000 for platform software and call center technology. Additionally, once established, an exchange will need to be staffed by between 20 and 50 full-time employees. There will be additional one-time costs for DHHS associated with connecting to the new SBE. Additional costs may apply if the SBE needs to leverage the federal data Hub to support income verifications for subsidy eligibility determinations. These are new fees effective July 1, 2024.

There will be different phases for the establishment of an exchange and the costs can be broken down for those different phases. One of the presentations to the Department broke the estimated operational costs down as follows:

Typical SBE Costs	Org Establishment	SBE Implementation	Annual Ongoing Operations
Organizational Standup • Create SBE agency and governance/advisory board • Recruit, hire & train • Secure office space & equipment	10 -15 FTEs	15 – 20 FTEs	20 – 50 FTEs
Program Vision & Branding • Create and market the brand • Establish stakeholder engagement strategy • Generate awareness	$1 - $2M	$1 - $2M	N/A
Program Policy, Design & Implementation • PMO & CCIIO coorindation • Plan Management/Issuer Coordination • Agent/Broker & Assister Programs & Certification Training • Consumer processes (e.g., appeals, exemptions)	$1 - $2M	$2 –$6M	Variable
Marketing & Outreach Campaign • Communicate changes to consumers migrating from the FFE • Conduct outreach to attract uninsured population • Provide communication for Medicaid population • Navigator Grants	$1 - $2M	$2 – $18M	Variable

As the breakdown shows, between $3,000,000 and $6,000,000 in initial funding will need to be appropriated to get a state-based exchange established. Funding for Medicaid requirements to connect to the SBE are not included in the estimates above. While it will require additional appropriations after that, once the exchange transitions to a SBE-FP, further costs can be covered through user fees collected.

For the ongoing operation of a state-based exchange a major cost will be its platform choice. The State can develop its own platform. This would be the most expensive, time consuming, and difficult option for the State to implement but would cost less per year to operate. The State can also contract with a company that has already developed a platform for the State to use. This is the easiest and fastest route and there are companies that have successfully set up platforms for other state-based exchanges. Of course over time, long-term contracts for information technology services may not be the most advantageous for the State and conflict with state purchasing laws that generally require contracts to be rebid every three to five years. However the exchange could contract with a company to develop and provide a platform that the exchange could own at the end of the initial contract period, which would likely be the best long-term solution. The annual cost for the platform could be as much as $40,000,000, which would be the greatest cost for the ongoing operation of the exchange. Another costs for the ongoing operation of the exchange would be costs associated with operating a call center. This could add another $8,000,000 to $12,000,000 in recurring costs. Overall, annual operating costs could approach $60,000,000.

V. Sources of Funding

If housed within a state agency like the Department of Insurance, the General Assembly will need to provide funds and FTE positions through appropriations for the exchange like it does for other agency operations. Like the federally facilitated exchange, a state would charge a user fee that would be a percentage added to the average per member per month premium. Even when operating a state-based exchange on the federal platform, user fees paid to the State would offset the

operating costs of the exchange, allowing it to be revenue neutral or essentially self-funded. The Department assumes that the fees collected would go to the General Fund.

Additionally, the more closely the state-based exchange is integrated with Medicaid, it may be eligible for Medicaid enhanced matching funds to help cover the costs of integration of Medicaid determination systems with the exchange. Additional input would be needed from CMS to confirm eligibility for enhanced funding.

VI. Estimated Savings to the State and Its Citizens

A state-based exchange does not create direct savings for the State or its consumers. Savings is generally seen as the difference between user fees paid to the FFE and the costs of operating a state-based exchange. Any savings would be seen indirectly in possibly slightly lower overall premiums, assuming the cost of operating a state-based exchange is less than the amount of FFE user fees paid to the federal government. These lower premiums would mostly benefit the federal government through reduced subsidies (premiums for subsidized consumers are based on income). Consumers who receive subsidies would likely not see a difference in what they pay.

Five years ago, in 2019, the FFE user fee was 3.5%. Since that time, it has been slowly decreasing.[16] In 2024, the user fee was set at 2.2%. Even factoring in the reduction in member months due to Medicaid expansion, the estimated amount of fees that will be paid to the federal government is $127,376,876, much more than the estimated annual costs for operating a state-based exchange. However, the proposed FFE user fee for 2025 is only 1.5% and the Department projects that FFE user fees may only be $71,101,741. While this is still more than the estimated costs of a state-based exchange, the difference is not that great. Exchange enrollment, and associated fees, may also decline further starting in 2026 if enhanced subsidies passed as part of the American Rescue Plan Act and extended under the Inflation Reduction Act are not renewed before the end of 2025.

The Department understands that the user fee for some state-based exchanges is around 3%. Although the FFE user fee has been shrinking, the Department was advised that as more states shift to state-based exchanges, the FFE user fee could increase as the cost of the FFE will be spread among fewer states.

VII. Methods For Educating and Referring Individuals Receiving Public Assistance to Products and Financial Assistance Offered Through a State-based Exchange

Moving to a state-based exchange will require a large campaign to educate and inform consumers of the new North Carolina exchange. This will start with branding for the exchange. Additionally, there will need to be a plan for educating

agents, navigators and other community partners who will help individuals looking for coverage. These efforts will need to begin several months before the beginning of open enrollment for the state-based exchange on the federal platform.

There can also be targeted outreach efforts in areas with higher percentages of uninsured individuals. For its 2023 open enrollment, Georgia Access spent $5,000,000 on a campaign targeted to its uninsured population and achieved a 25.4% increase in open enrollment plan selections compared to the prior plan year.[17]

VIII. Legislative Changes Necessary to Implement a State-based Exchange

Legislative changes that are necessary to implement a state-based exchange are:

- Repeal or amend G.S. § 143B-24 to allow the Department, DHHS and any other necessary state agency work towards establishing a state-based exchange.

- Enact enabling legislation authorizing the establishment of a state-based exchange. This legislation could vary depending on decisions the General Assembly may make regarding the agency or entity that will house the exchange. The Department believes that the legislation passed in Georgia to establish its state-based exchange is a good model as it would give the Department flexibility in making decisions regarding the Exchange. However, to help minimize potential delays, it would be helpful if the enabling legislation included exemptions from state procurement, state DIT procurement requirements and also included an exemption from the rulemaking process, at least for Part 3 of Article 2A of Chapter 150B of the General Statutes.

- There will need to be appropriations made to get the exchange up and running. At the beginning, there will need to be at least 4 FTE positions to be the initial staff for the exchange, but after the first six months, that number will need to grow quickly. Additional staff and appropriations will also be needed to support Medicaid's transition to connect with the SBE. Currently, Georgia has approximately 40 FTEs as it prepares to transition from an SBE-FP to an SBE. Money is also needed to contract with consultants to help with the transition process and for items like the exchange platform, call center software as well as marketing and consumer outreach. Once the State has transitioned to a state-based exchange on the federal platform, it will begin receiving fees that will offset the costs of the appropriations.

IX. Section 1332 State Innovation Waiver Considerations

North Carolina does not need to pursue a waiver under Section 1332 of the ACA (1332 Waiver) to transition to a state-based exchange. Any 1332 Waiver must have a funding source, usually in the form of a new fee. Some states have funded 1332 Waiver programs from SBE user fees. Georgia is funding a reinsurance program

from its SBE user fees. With the reduced FFE user fee for the 2025 plan year and uncertainty as to how much Medicaid expansion will reduce ACA enrollment, it is not certain that operating a 1332 waiver program and a state-based exchange could be done while still charging a user fee less than the FFE user fee. The Department would not recommend pursuing a 1332 Waiver as part of a transition to a state-based exchange. It would be better to wait until there is more certainty regarding the costs of a state-based exchange. Additionally, if there is a change with the federal administration next year, there may be more options for 1332 waiver programs.

A 1332 Waiver should be trying to address a specific issue in a state's individual market, like affordability. The Department studied 1332 Waiver ideas roughly six years ago as a way to address two problems in the market at that time that affected the affordability of coverage. At that time, there were individuals who earned too much to qualify for Medicaid but did not earn enough to qualify for individual market subsidies and had to pay the full premium for coverage. On the other end of the spectrum was the subsidy cliff: individuals who earned more than 400% of the Federal Poverty Level (FPL) did not receive subsidies and also had to pay the full premium for coverage. Because of the expansion of Medicaid, the first problem is no longer an issue. And at least through the 2025 plan year, the subsidy cliff has been eliminated as subsidies have been expanded above 400% of FPL so that premium payments are capped at 8.5% of an individual's income. Our state's individual market has also been improving—rates have been slowly decreasing and there is increased competition with more insurers offering plans on the Exchange. While premiums may still be high, expanded subsidies are helping with affordability.

Any 1332 Waiver application must be approved by the federal government. To be approved, the waiver application must demonstrate that the waiver program meets four basic guardrails: the benefits for consumers must be at least as comprehensive as without the waiver; a comparable number of people must be covered under the waiver; plans must be at least as affordable for consumers with the waiver; and the projected spending under the waiver cannot increase the federal deficit. The Department has reviewed the seven concepts the legislation asks it to consider in preparing a draft 1332 waiver.[18] Of the concepts listed, the Department believes that a reinsurance program is the only concept that would likely be approved under the current administration. Some concepts listed, like the state-based exchange, would not require a waiver.

The Department has prepared a simple draft 1332 Waiver application for a reinsurance program, similar to what other states have done. The waiver application is missing several key parts, such as the actuarial work required to show that the waiver proposal meets the guardrails as there was not time to have that done. While rough estimates are that a reinsurance program could reduce premiums by 21%, most consumers would not see this reduction because it would

not change what they are paying after subsidies are included (premiums would be less and subsidies would be less). While savings in what the federal government pays in subsidies does get passed through to the State to help pay for the reinsurance program, the amount passed through is not guaranteed and the State would always be responsible for the cost of the reinsurance program. The State would be liable only up to the contribution fund collected, however. If the reinsurance reimbursements exceed the fund available for the payments, the reinsurance parameters would be adjusted to reduce the available fund amount.

X. Conclusion

North Carolina should transition to a state-based exchange as it will give the State more control over its health insurance market. Any transition to a state-based exchange should include integrating the Medicaid determination process, with the ultimate goal of improving the consumer experience and increasing overall enrollment. To ensure that any transition goes smoothly, the General Assembly will need to provide positions and funding to support the transition.

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[1] 2023 N.C. Sess. Laws 134.
[2] Copies of presentation materials, with minor edits, are included in the Appendix.
[3] *See generally* 42 U.S.C. § 18031 (2024).
[4] *Id.*; 45 C.F.R. § 155.100 (2024).
[5] 45 C.F.R. § 155.105 (amended, effective June 4, 2024)
[6] *Id.*
[7] Georgia (SBE-FP in 2024) Kentucky, Maine, Nevada, New Jersey, New Mexico, Oregon (SBE-FP in 2024) Pennsylvania, and Virginia.
[8] 42 U.S.C. § 18031(d) (2024).
[9] 45 C.F.R. § 155.110(c) (2024).
[10] *Id.*
[11] 45 C.F.R. § 155.110(d) (2024).
[12] 2023 Ill. Laws 103.
[13] G.S. § 134B-24 (2024).
[14] 45 C.F.R. § 155.105
[15] *Id.*
[16] FFE Exchange User Fee Summary by Year.
[17] Presentation to National Association of Insurance Commissioners Health Insurance and Managed Care (B) Committee, Orlando Florida, December 2, 2023.
[18] Seven Consideration Items

Appendix

State-Based Marketplace: North Carolina

January 17, 2024

Appendix 1

Agenda

1. Structure and Oversight of a Proposed State-Based Exchange
2. Timeline for State-Based Exchange Implementation
3. Funding and Operating Costs of a State-Based Exchange
4. Savings generated by operating a State-Based Exchange
5. Legislative Needs
6. Lessons Learned

Appendix 2

About GetInsured

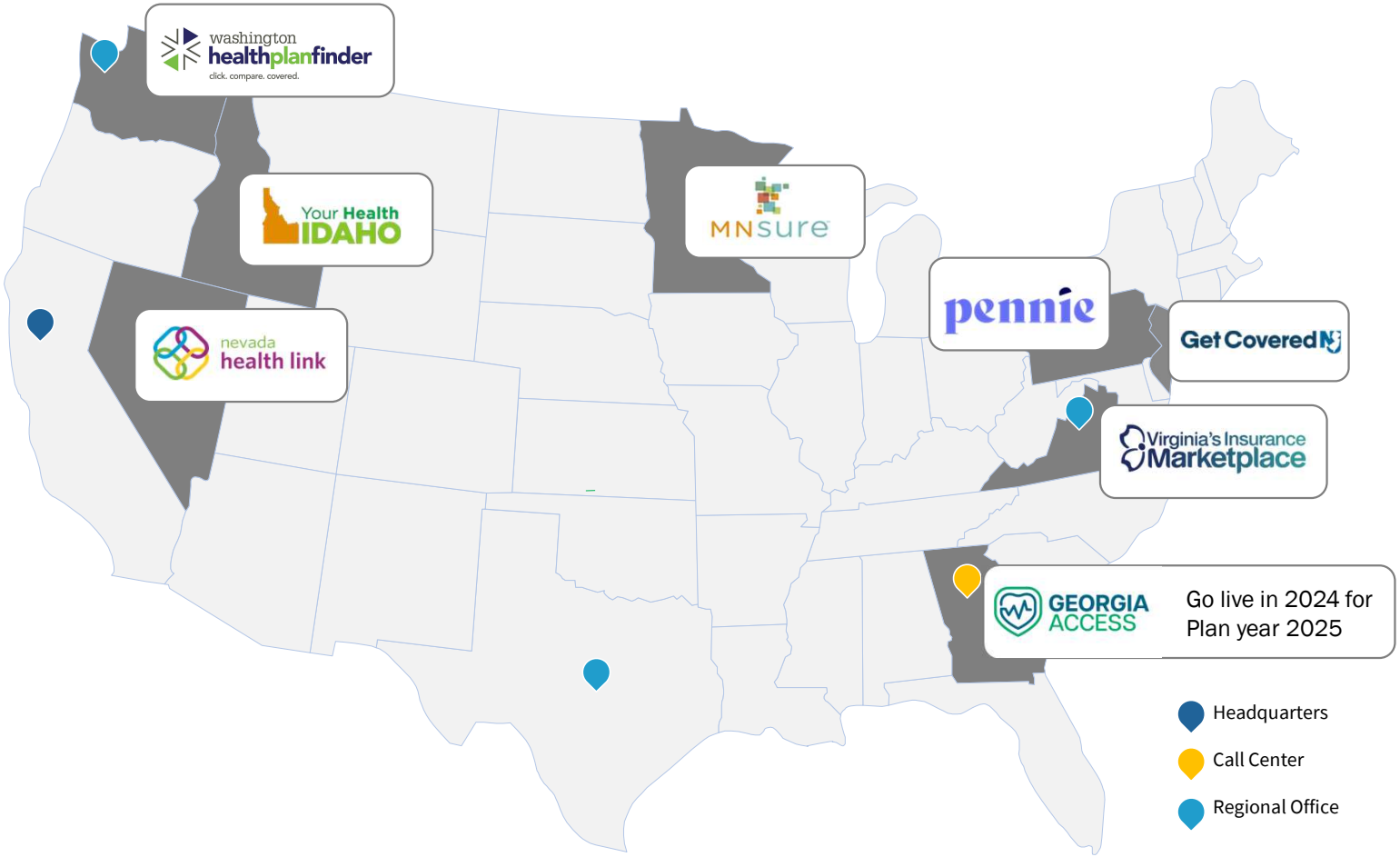
Implementing Integrated Marketplaces Serving Diverse Stakeholders with Unique Needs

- Pioneered SaaS platform for state-based insurance marketplaces
- National leader in implementing, maintaining, and operating state-based health insurance marketplaces since 2014
- Current customers include Idaho, Virginia, Pennsylvania, New Jersey, Georgia, Nevada, Minnesota, and Washington
- World-class engineering, management, policy, and implementation talent drawn from public and private sectors

Achievements

- **Nearly 20M** no touch eligibility and enrollments processed to date
- Supports **15K+** strong network of stakeholders who interact with consumers and agency administration

GetInsured National Footprint



Appendix 4

State-Based Marketplace Implementations

Integrated Solution, Seasoned Team, Low-Risk Project Approach

SBM Market Leadership and Scale: **Over half of all** SBM enrollments are processed on our platform. Nearly 20M no-touch eligibility decisions to date. 8 states, 8,000 brokers, and 1,000 plans

Proven Cloud-based SaaS Technology Platform: Configurable, scalable, and cost-efficient platform; award-winning user experience

Seamless FFM to SBM Transition Track Record: Comprehensive data migration blueprints; expertise in pre-built complex integrations

Integrated Consumer Assistance Center: SBM-ready, holistic consumer experience via efficient sharing of tools, workflows, and knowledge base

Low Risk Implementations: Flawless launch on-budget, on-time, every time; pass all CMS gate reviews

Seasoned Team: Strong expertise with regulatory requirements; deep engagement with all stakeholders

GetInsured Platform Metrics

5 STATES
Migrated from the FFE

Nearly 3.5M
Inbound and Outbound Account Transfers

Nearly 100%
Household Renewal Rates

Over 40
Successful Open Enrollment Periods

100% Uptime
During Open Enrollment

Nearly 26 MILLION
EDI transactions

Nearly
20 MILLION
No-touch Eligibility Determinations

Structure and Oversight of a Proposed State-Based Exchange

Structure and Oversight

Specific details for the structure and oversight of a proposed State-based exchange, including the makeup of any proposed board of directors or other governing body.

- **ACA Section 1311(d) requires that Exchanges**
  - Be housed in either a **pre-existing or new state agency**, or
  - In a **nonprofit entity** that is established by a state.
- **45 CFR 155.110(c) requires that**
  - If the Exchange is housed in an independent State agency or a non-profit entity established by the State, the State must ensure that the Exchange has in place a **clearly-defined governing board.**
  - If the Exchange is established in a **pre-existing state agency, a governing board is not required.**

Structure and Oversight

For exchanges required to have a governing board CFR 155.110(c) requires the following of the board

- Is administered under a formal, publicly-adopted operating charter or by-laws;
- Holds regular public meetings that are announced in advance;
- Represents consumer interests by ensuring that overall membership:
  - Includes at least one voting member who is a consumer representative;
  - Is not made up of a majority of voting representatives with a conflict of interest, including any individual or entity licensed to sell health insurance.
- Ensures that a majority of the voting members have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

Structure and Oversight

CFR 155.110(c) requires all Exchanges to:

- Have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.
- Implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

The choice of where to house an Exchange carries with it specific pros and cons

Structure and Oversight: Existing State Agency

Pros

- Exchanges can leverage pre-existing expertise in functions such as HR, IT, Accounting, Procurement etc.
  - This lowers startup costs and lessens operating costs.
- Existing state agencies likely already have robust accountability standards
- State DOI's possess unique expertise in plan management of QHPs

Cons

- State government salary constraints
- RFP requirements for procurements
- Political forces can affect an exchange's ability to function consistently over time

Structure and Oversight: New State Agency

New state agencies have many of the same pros and cons as an existing state agency, but there are some key differences

- Pros
  - Ability to establish an agency specific pay-scale or exemption to better attract talent
  - Stakeholders feel they are more a part of the process as they have a hand in choosing leadership
  - Agency can be designed specifically to function as an exchange
- Cons
  - Standing up entirely new state agencies tends to be unpopular
  - A governing board can be inefficient and slow progress

Structure and Oversight: Non-Profit

Pros

- Non-profits are generally not subject to state procurement rules
- Non-profits are generally not subject to state salary restrictions
- Non-profits are usually able to avoid placing user fees in a state general fund
- Non-profits are more agile and able to react quickly to market conditions and make policy

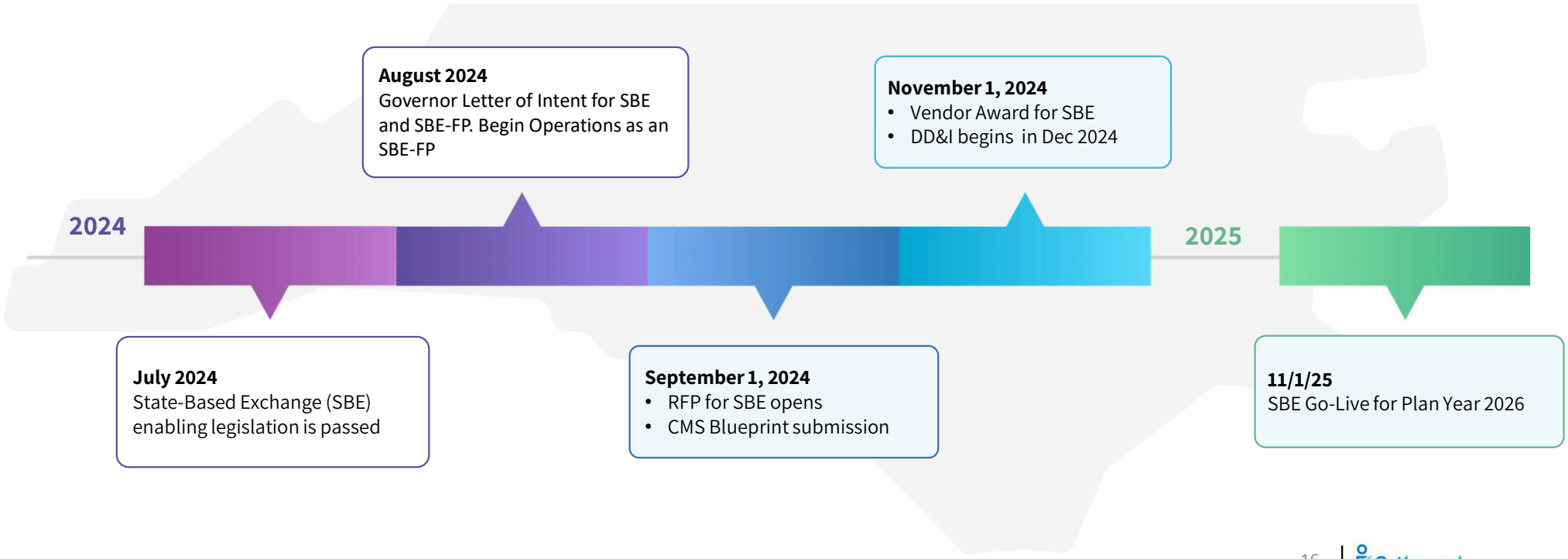
Cons

- Often seen as unaccountable, non-profits may be less politically viable as a model
- Creating a new non-profit entity may be as unpopular as creating a new state agency
- Non-profits require a more robust statutory underpinning as they often do not fall within existing statutory guardrails

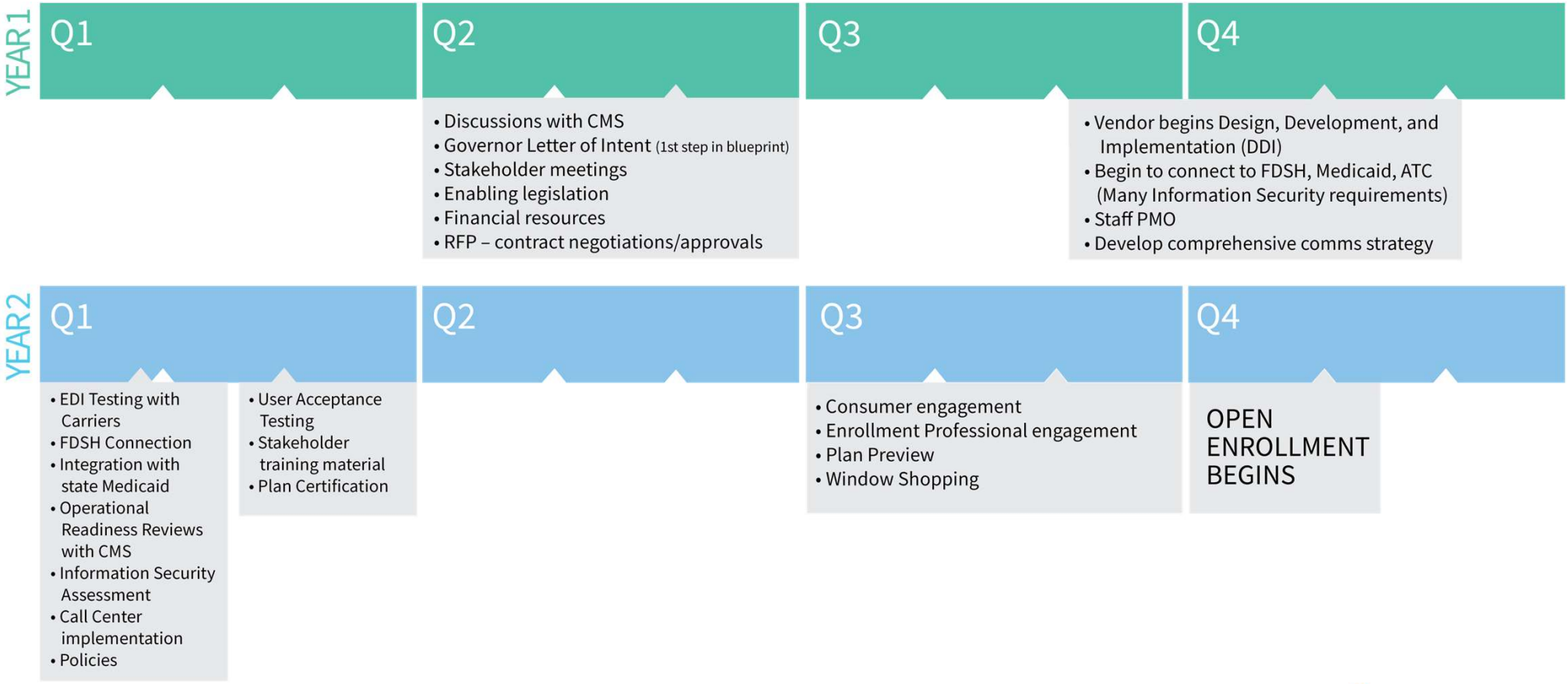
Timeline for State-Based Exchange Implementation

Implementation Timeline

A detailed timeline for the implementation of the State-based exchange, including identification of major milestones and a realistic “go-live” date.



Example Timeline: SSHIX Nevada



Blueprint Submission

- The Blueprint Application can be found here.
- The process is very deliberate
- All previously submitted blueprints by other states are publicly available.
- There are 2 types of SBE applications:
  - SBE-FP an exchange on the federal platform, and;
  - SBE a platform fully run by the state
  - Currently states must spend one year as an SBE-FP before transitioning to a full SBE

Blueprint Submission for an SBE-FP

For an SBE-FP a state must submit to CMS:

- A Declaration of Intent Letter;
- A Completed SBE-FP Blueprint Prior to the beginning of the SBE-FP's 1st open enrollment, and;
- An Executed Federal Platform Agreement with CMS prior to the beginning of the SBE-FP's first open enrollment

Blueprint Submission for a Full SBE

For a full SBE a state must submit to CMS:

- A Declaration of Intent Letter, and;
- A completed SBE Blueprint application at least 15 months prior to the beginning of the SBE's first open enrollment.

Funding a State-Based Exchange

The anticipated costs to the State for start-up and ongoing operations of the State-based exchange, including labor costs, information technology costs, and any foreseeable costs to any State agency outside of the Department of Insurance.

Money Flow for SBE Funding

- Customer selects coverage on State-Based Exchange (SBE); Many qualify for a tax credit
- Insurance carrier enrolls consumer and sends bill for so called User Fees to the federal government
- State exchange assesses carriers to pay for SBE operations; North Carolina retains the user fee
- Federal government reimburses insurance carriers premium tax credits in full

Cost Savings

North Carolina is paying the federal government more money to run and operate the Exchange than it would cost to keep funds in state to run a State-Based Exchange.

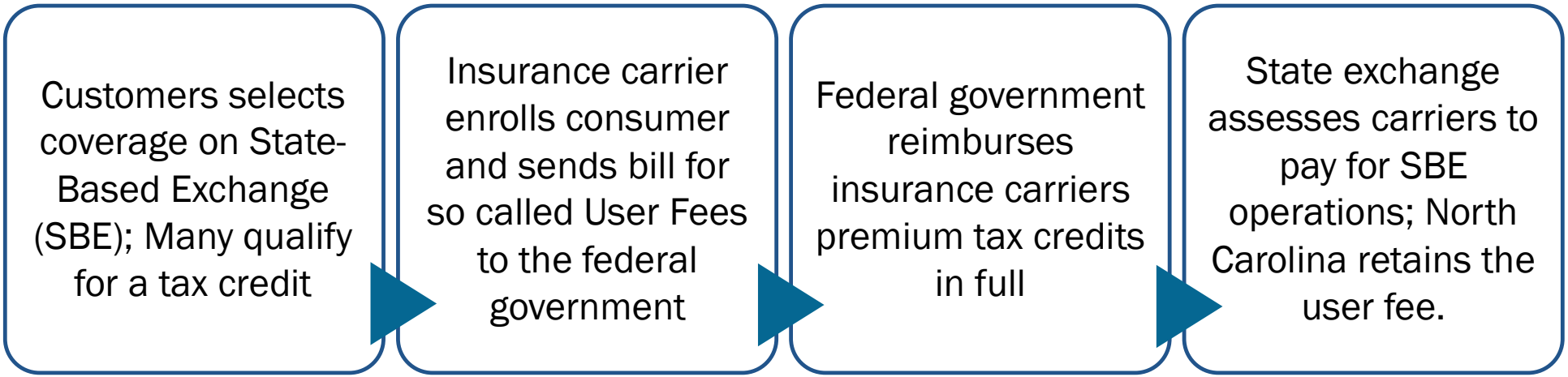
For 2023, North Carolina carriers will pay the federal government 2.75% of gross premiums collected on exchange enrollments – equivalent to more than $111M in 2023. Given the significant (~20%) increase in enrollments in 2023 (for PY 2024), the payments to FFM in 2024 will only increase.

Customers selects coverage on HealthCare.gov; Many qualify for a tax credit

Insurance carrier enrolls consumer and sends bill for user fees to the federal government

Federal government pays carriers but withholds 2.75% of each plan sold to pay for HealthCare.gov operations

If North Carolina had a State-Based Exchange, the state would collect the assessment fee and use it to operate the Exchange – any savings – approx. 50% of the user fees currently paid to FFM - could be reinvested into programs within the state.



Implementation of the State-Based Exchange

Legislation

Legislative changes necessary to effectuate the proposed plan.

- CCIIO requires that all states having SBEs confer appropriate authority on the SBE to carry out its duties.
- This is typically done via legislation.
- The enabling legislation can be simple, or it can be quite sophisticated depending on the desire of the state in question. However, the only thing required by CCIIO is a basic grant of authority.
    - Georgia opted for simplified language due to the desire of the Governor's office to give the SBE maximum flexibility.

Benefits to North Carolina

After covering exchange operations, North Carolina can use remaining dollars for state-specific initiatives including:

- Return savings to North Carolina's consumers
- Create state-funded reinsurance to lower consumer premiums
- Invest in state-specific programs

Lessons Learned from Georgia

The Problem

- As of 2021, an estimated 1.3 million people in Georgia lacked health insurance, an uninsured rate of 12.7%
- Only 3 in 10 Georgians responsible for purchasing insurance independently did so, as of 2021, through the Federally Facilitated Marketplace (healthcare.gov)
- Households between 100% and 400% of the Federal Poverty Level may qualify for subsidies through the Marketplace, yet many go uninsured. Plans for those near 100% are practically free

The Georgia Approach

Georgia took a three-pronged approach to addressing its uninsured population.

1. Pathways to Coverage: a partial expansion of Medicaid
2. A State-based Reinsurance Program
   - Instituted under a 1332 waiver.
   - It should be noted that a 1332 waiver is separate from an SBE and is not required to institute one
3. Transitioning to a state-based exchange

Benefits Georgia Saw Moving to a State-based Exchange

- Empowered the State to make decisions to better serve Georgians.
- Reduced federal control and bureaucracy and brought revenue back into the State.
- Incentivized private sector investment and innovation.
  - This point is distinctive to Georgia as the state elected to utilize an ‘EDE forward’ model.

What is EDE-forward and what are the benefits?

- Georgia's SBE is designed to serve the needs of its residents by facilitating a more competitive marketplace with greater consumer choice by engaging Georgia's private-sector entities (EDEs) to provide innovative solutions for plan shopping, enrollment, and support.
- Instead of having just a state portal, consumers can enroll through agents, carriers, EDEs (e.g. HealthSherpa) or the state portal.
- This increases consumer options, and consumer choice, while at the same time utilizing the creativity and efficiencies of the private sector.

What Happens to Georgians Who Use HealthCare.gov?

Consumers are auto re-enrolled into plans

- All FFE marketplace consumers will be auto re-enrolled into their same plans on Georgia Access ahead of OE 2024 to minimize the risk of consumer loss during the transition.
- Just like on the FFE, consumers will be able to update their information and select a new plan during OE.

Consumers are be able to keep preferred enrollment partners

- Enrollment growth on the FFE has been largely driven by Enhanced Direct Enrollment (EDE) partners over the last few years.
- Because these partners can also participate in Georgia Access, consumers who currently enroll through these web-brokers and issuers will experience no change in their consumer shopping and plan selection process with the transition to Georgia Access.

Consumers have an improved referral experience to/from Medicaid

- The State can improve the referral process to/from the Exchange and Georgia Gateway by aligning the eligibility assessment for Georgia Access with Georgia Medicaid/PeachCare for Kids rules and simplifying verified information shared between systems.
- This reduces the volume of “bounce-backs” that happens today with consumers referred to/from Georgia Gateway and the FFE.

Other Georgia Distinctives

Network Adequacy Analysis

- The study assessed the compliance of plans in the individual market with carrier requirements for availability and accessibility to providers.
- With an SBE, OCI has more power to hold carriers accountable for failing to maintain their provider networks to ensure patient access.

Health Market Scan

- This market scan provided coverage maps to identify the demographics of uninsured populations across the state.
- It enabled the Georgia OCI to target known uninsured “hot spots” while limiting marketing and outreach resources in counties that already have high insured populations.

Public Awareness Campaign

- OCI built on the brand recognition and successful marketing efforts of Georgia Access in OE 2023 for the transition to an SBE in OE 2024.
- This included, a new GeorgiaAccess.gov website, Social media campaigns, Newspapers advertisements, TV commercials, and YouTube marketing.

A Few Things to Keep in Mind

CCIIO is becoming increasingly stringent in how they evaluate SBE blueprints and transitions. Accordingly, it is best to mitigate risks that may cause CCIIO to disapprove of an application. In Georgia these included:

- Not building a homegrown enrollment and eligibility platform
- Using vendors and contractors who had previous experience in other state SBEs
- Ensuring that the process was overseen by state employees, something that was very important to CCIIO.
- Involving our Medicaid agency on some calls to make CCIIO comfortable with our level of coordination.

1332 Waivers

Section 1332 of the ACA permits state to submit innovation waivers to pursue innovative strategies for providing residents with access to high quality, affordable health insurance.

- As mentioned above, these waivers are not required to form an exchange.
- However, they can provide benefits in concert with an exchange depending on a state's priorities.

1332 Waivers

- 1332 waivers are subject to approval by the U.S. Department of Health and Human Services and the Department of the Treasury.
- To be approved the state must demonstrate that the waiver program will:
  - Provide coverage that is at least as comprehensive as the coverage provided without the waiver;
  - Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver;
  - Provide coverage to at least a comparable number of residents as without the waiver; and
  - Not increase the federal deficit.

1332 Waivers

In 2018 CMS offered 4 different 1332 waiver concepts that may be used by states to accomplish its own specific policy goals. They are:

- Account-based Subsidies
- State-Specific Premium Assistance
- Adjusted Option Plans
- Risk Stabilization Strategies

Account-based Subsidies

States can direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay for health insurance premiums or other health care expenses.

The account could be funded with pass-through funding made available by waiving the Premium Tax Credit (PTC) under section 36B of the Internal Revenue Code (IRC) or the small business health care tax credit under section 45R of the IRC.

The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions. An account-based approach could give beneficiaries more choices and require them to take responsibility for managing their health care spending.

This approach could also allow a consumer greater ability to select a plan based on the individual's or their family's needs, including a higher deductible plan with lower premiums.

State-Specific Premium Assistance

States can use a State-Specific Premium Assistance waiver to create a new, state-administered subsidy program.

A state may design a subsidy structure that meets the unique needs of its population in order to provide more affordable health care options to a wider range of individuals, attract more young and healthy consumers into their market, or to address structural issues that create perverse incentives, such as the subsidy cliff.

States may receive federal pass-through funding by waiving the PTC under section 36B of the IRC to help fund the state subsidy program.

Adjusted Option Plans

Under this concept, states would be able to provide financial assistance for different types of health insurance plans, including non-Qualified Health Plans, potentially increasing consumer choice and making coverage more affordable for individuals.

For example, states could choose to expand the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the ACA. Used in conjunction with the Account-based Subsidy concept, states could provide subsidies in the form of contributions to accounts, allowing individuals to use the funds to purchase coverage that is right for them and use any remaining funds in the account to offset out-of-pocket health care expenses.

Risk Stabilization Strategies

To address risk associated with individuals with high health care costs, this idea gives states more flexibility to implement reinsurance programs or high-risk pools.

For example, a state can implement a state- operated reinsurance program or high-risk pool by waiving the single risk pool requirement under section 1312(c)(1) of the ACA. Reinsurance programs can lower premiums for consumers, improve market stability, and increase consumer choice.

States can choose from a variety of models to operate their state-based reinsurance programs. These models include a claims cost-based model, a conditions-based model, and a hybrid conditions and claims cost-based model. If the state shows an expected reduction in federal spending on PTC, the state can receive federal pass-through funding to help fund the state's high- risk pool/reinsurance program.

1332 Waivers

- Any of the previously mentioned waiver concepts could be highly beneficial to a state depending on the landscape of its healthcare market.
- Additionally, other innovations, not mentioned or contemplated by CMS can also be requested.
- Ultimately the decision to move forward with a 1332 waiver is heavily dependent on the policy priorities of each individual state.

Thank you!

Deloitte.

STATE-BASED EXCHANGE (SBE) DISCUSSION WITH NC DOI

January 30, 2024

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DELOITTE TEAM

Wade Horn

Sam Gibbs

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Prasad Yarlagedda

Sadie Conrad

Charles Carter

About Health Insurance Exchanges

The Affordable Care Act (ACA) grants authority to states to operate their own Health Insurance Exchanges. Exchanges were first implemented in November 2013 for plan year (PY) 2014 coverage. States that opted not to operate their own Exchanges defaulted to using the Federally-facilitated Exchange (FFE), known as HealthCare.gov.

Exchanges are places where consumers can **apply for and enroll in** Qualified Health Plans (QHPs) and Standalone Dental Plans (SADPs). Consumers are assessed for **financial assistance** which are **premium tax credits (PTCs)** and **cost-sharing reductions** that help **lower out-of-pocket costs.**

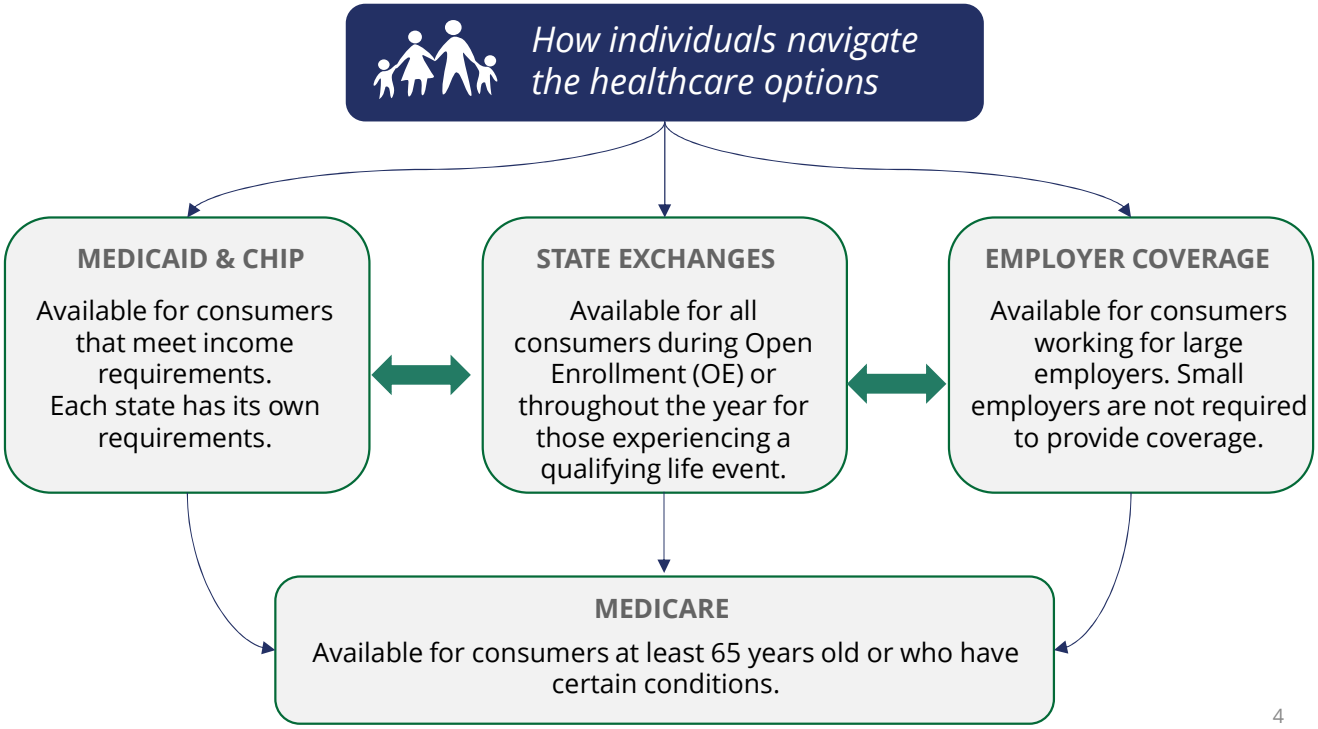
EXCHANGES TYPICALLY SUPPORT INDIVIDUALS WHO ARE:

19-64 years old

Not Eligible for

- Medicaid or CHIP
- Medicare
- Employer Coverage

Above **138%** of the Federal Poverty Level (FPL)



TYPES OF EXCHANGES AND FUNCTIONS

The following table outlines the primary functions of an exchange and ownership across the three exchange models.

	Eligibility and Enrollment System	Call Center[1]	Assistance & Outreach[2]	Plan Management[3]	Small Business Health Options Program (SHOP)[4]
Federally-Facilitated Exchange (FFE) *CMS charges issuers a 2.2% user fee to fund operations for a state on the FFE.*	FFE	FFE	FFE	FFE	FFE
State-based Exchange on the Federal Platform (SBE-FP) *CMS charges a 1.8% user fee. States can set their own user fee rate with carriers but have typically charged issuers the difference (e.g., 2.2% – 1.8%).*	FFE	FFE	State	State	State
State-based Exchange (SBE) *States can set their own user fees to fund ongoing operations.*	State	State	State	State	State

1 SBE-FPs are required to have a Toll-Free Hotline in addition to the FFE's Consumer Call Center.
2 SBE-FPs are required to run Navigator and Certified Application Counselor (Assister) Programs, provide outreach activities, and have website. SBE-FPs may also provide Agent Certification or default this to the FFE.
3 An FFE state can opt to perform plan management functions prior to becoming an SBE-FP.
4 SBE-FPs can opt to have the FFE run their SHOP program. The federal government and most SBEs use direct enrollment for SHOP rather than provide a centralized enrollment platform .

KEY: FFE State

LANDSCAPE OF EXCHANGES

For plan year (PY) 2024 there are 19 State-based Exchanges (SBEs), including the District of Columbia, and 3 State-based Exchanges on the Federal Platform (SBE-FP).

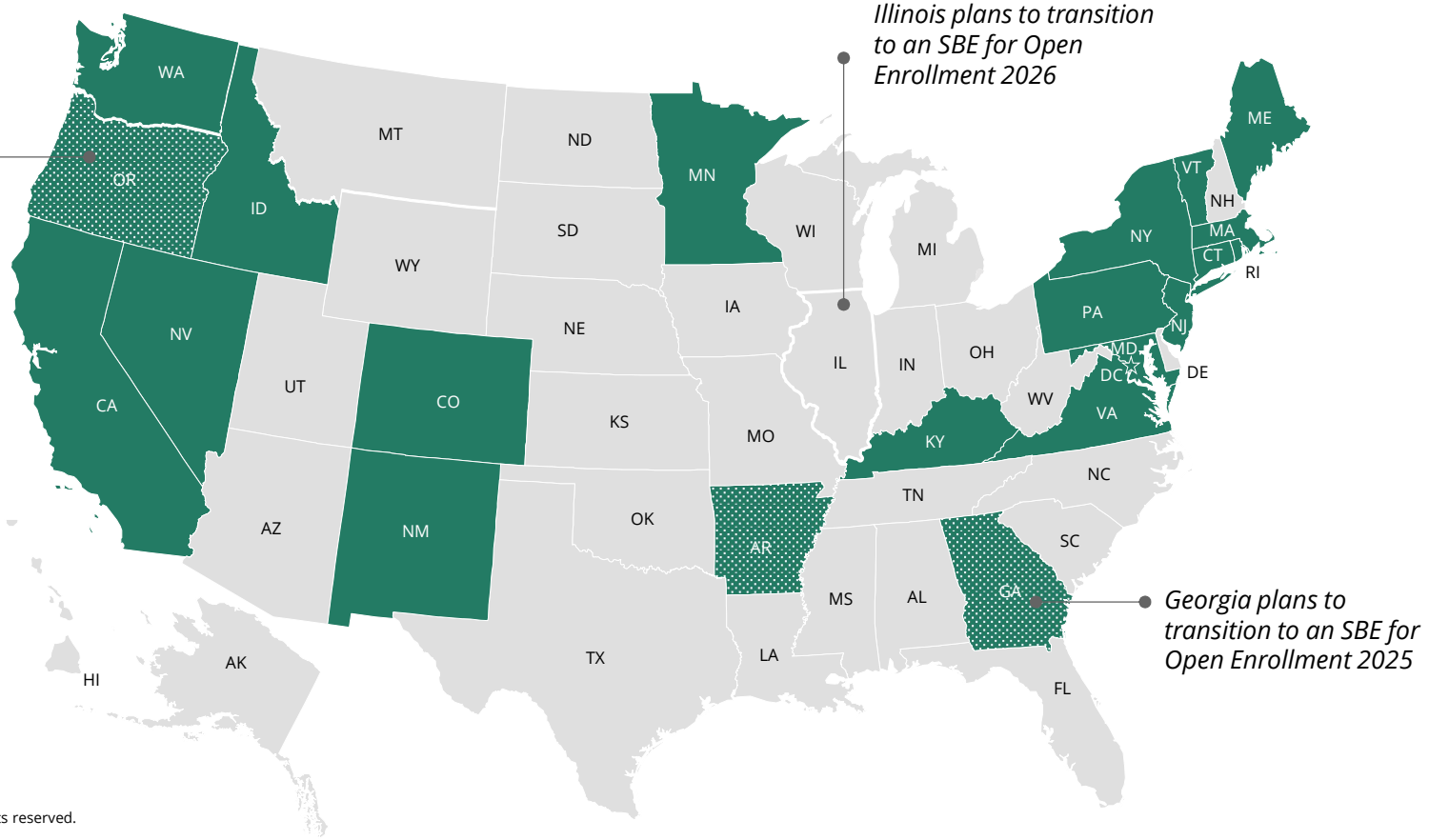
Oregon plans to transition to an SBE for Open Enrollment 2027

Illinois plans to transition to an SBE for Open Enrollment 2026

Georgia plans to transition to an SBE for Open Enrollment 2025

Map Key

FFE	29
SBE-FP	3
SBE	19



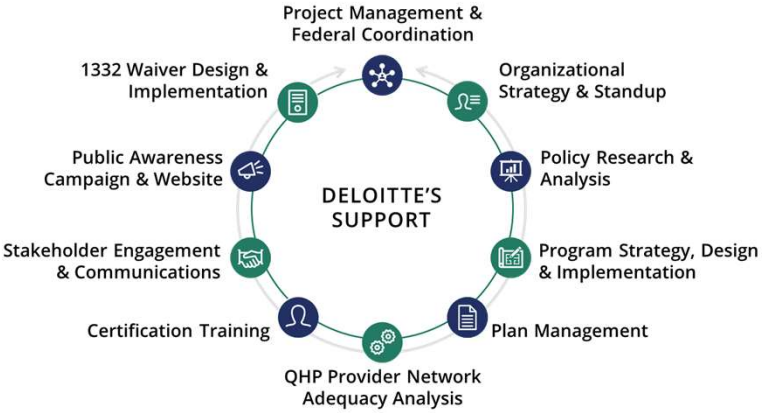
DELOITTE SBE SERVICES AND SOLUTIONS

Deloitte's SBE Services + Solutions

Deloitte has been a market leader in advising, implementing, and operating SBEs since the passage of the ACA. Our breath of services, solutions, and expertise enables us to provide end-to-end support for states transitioning their marketplaces from the FFE to an SBE.

GEORGIA SPOTLIGHT

Deloitte has supported the State since 2019 in its journey to improve the individual market with its 1332 Waiver and SBE.



HIGHLIGHTS

SUCCESS IN SBES

4 - Day-1 SBE technology implementations (RI, KY, WA, CT)

2 – Transition from existing SBE (CA, MD)

2 – Transition from FFE (KY, OR)

7 – Advisory, Policy, Program, and PMO Support (GA, NJ, PA, OR, WA, CA, NY)

CURRENT FOOTPRINT

We are the largest SBE Eligibility & Enrollment System vendor in the country. Deloitte is currently operating the eligibility & enrollment solution in multiple SBEs.

Over **46%** of health coverage enrollments through an SBE were with a Deloitte solution for 2024.

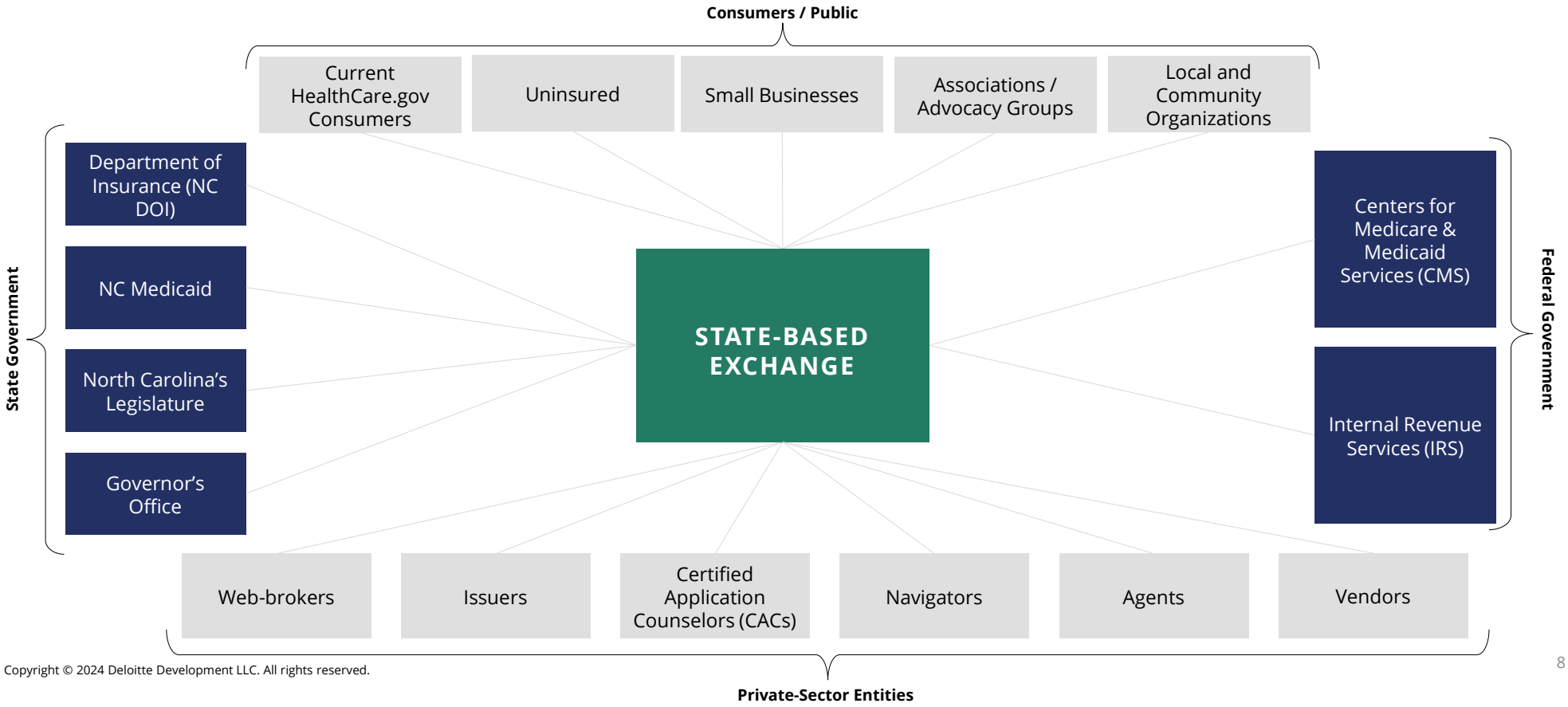
There are **6.1M+** users across consumers, health and dental carriers, and government staff on our platforms.

Deloitte can support SBE clients across four key areas:

PROGRAM DESIGN & IMPLEMENTATION	Comprehensive organizational and program support for the strategic design, implementation, and operations of all SBE functions
ELIGIBILITY & ENROLLMENT SOLUTION	Deep technical capabilities and experience implementing a range of SBE technical solutions including: custom builds, SaaS products, standalone solutions, and integrated SBE and Medicaid solutions.
CUSTOMER CONTACT CENTER	Full-service digital contact center operations including: agent staffing, training, and technical assistance.
PUBLIC OUTREACH AND MARKETING	Tailored marketing and outreach campaigns to engage the public and increase enrollment.

SBE STAKEHOLDERS

The ecosystem of stakeholders involved in an SBE is vast. Strategic planning, coordination, and communication with all groups is necessary for the successful implementation and ongoing operations of an exchange.



SBE QUESTIONS & DISCUSSION

SBE STRUCTURE & OVERSIGHT OPTIONS

Requested Information: Specific details for the structure and oversight of a proposed State-based exchange, including the makeup of any proposed board of directors or other governing body.

SBE Organizational Options			
	Standalone Agency or Non-Profit/ Quasi-Governmental Org	**Integrated within or aligned to the Medicaid Department**	**Integrated within or aligned to the Insurance Department**
Potential Benefits	• Not restricted by state procurement rules or salary ranges if implemented outside state government	• Provides a streamlined consumer experience for those that transition between programs • Ability to leverage existing Medicaid infrastructure • Increases potential for CMS 90/10 funding	• Allows for tighter coordination with carriers for communicating plan requirements to see on-Exchange • Provides greater access to data to improve DOI's regulatory capacity
Potential Challenges	• May require longer runway to standup new organization • Requires additional infrastructure (e.g., HR, Finance, Tech Support). • Not directly accountable to governor, legislator, or commissioner. Board governance is critical for effective oversight.	• May require longer runway to implement technology changes if integrated within the Medicaid system	• Introduce a new role of directly serving consumers to the agency • Typically need to "firewall" SBE staff to be compliant with CMS privacy & security and HIPPA-requirements

SBE STRUCTURE & OVERSIGHT OPTIONS

Requested Information: Specific details for the structure and oversight of a proposed State-based exchange, including the makeup of any proposed board of directors or other governing body.

State A

BOARD OF DIRECTORS

- Governor's Appointees (x2)
- Legislative Leadership Appointees (x7)
- Ex-Officio Members (x3)
- Ex-Officio Members – Non-Voting (x3)

ADVISORY COMMITTEES

- Health Equity, Outreach and Consumer Experience Advisory Committee
- Brokers, Agents and Navigators (dissolved)
- Health Plan Benefits and Qualifications
- Small Business Health Options Program (SHOP)

STANDING COMMITTEES

- Audit
- Finance
- Human Resources
- Strategy

State B

BOARD OF DIRECTORS

- Governor's Appointees (x5)
- Legislative Leadership Appointees (x5)

BOARD COMMITTEES

- Finance
- Operations
- Outreach & Education
- Native American Standing
- Executive Committee & Grievance
- Vision, Mission, Goals and Objectives
- Legislative Affairs Committee
- Research
- Innovation Committee (1332)
- Health and Benefits

State C

BOARD OF DIRECTORS

- Board Chairman
- Board Members (x10)

COMMITTEES

- Audit & Compliance
- Operations
- Policy
- Advisory
- Technical Advisory

SBE STRUCTURE & OVERSIGHT OPTIONS

Requested Information: Specific details for the structure and oversight of a proposed State-based exchange, including the makeup of any proposed board of directors or other governing body.

Medicaid and Exchange eligibility determinations are conducted by different systems with referrals between programs. A consumer applies specifically for Exchange coverage with financial assistance and is transferred to a separate portal and system if assessed eligible for Medicaid/CHIP.

Medicaid and Exchange eligibility determinations are conducted by the same system. A consumer applies for all state health coverage programs within one portal and is determined eligible for the appropriate program.

STATE A

State A wanted to procure a separate SBE technology solution that could be implemented on a **quick timeline,** with **minimal customization, and** which maintained the same referral process as the FFE to/from Medicaid.

STATE B

State B wanted to have **more customization control** over their system and **eliminate the erroneous data sync** between disparate systems. California chose to move from a loosely coordinated solution to a more **moderately coordinated** solution, featuring two consumer portals, with both portals using the same application and consumers receiving eligibility results in **real-time**.

STATE C

State C wanted all consumers seeking health coverage to have a **one-stop shop** for application and enrollment, which is why they built their Marketplace application and eligibility into their existing Medicaid system. This solution is **tightly coordinated** between the SBM and Medicaid systems—consumers visit a single portal to apply for health coverage, in addition to other state-subsidized benefits.

ESTIMATED FUNDING

Requested Information: Identification of sources of funding for the start-up and ongoing operations of the State-based exchange, including federal funding and assessments on commercial insurance products & Identification of any estimated savings to the State or the citizens of the State as a result of the proposed plan.

North Carolina's On- Exchange Market 2019 - 2024

	2019	2020	2021	2022	2023	2024
Number of Carriers	3	4	6	10	10	9
Plan Selections	501,271	505,275	535,803	670,223	800,850	1,027,930
Avg. Plan Premium/mo	$729	$660	$633	$637	$643	$643
Estimated Annual Federal Revenue Collected from North Carolina Carriers for 2024:						**$174M***
Estimated Revenue Per Member Per Year (PMPY) Revenue						**$170**

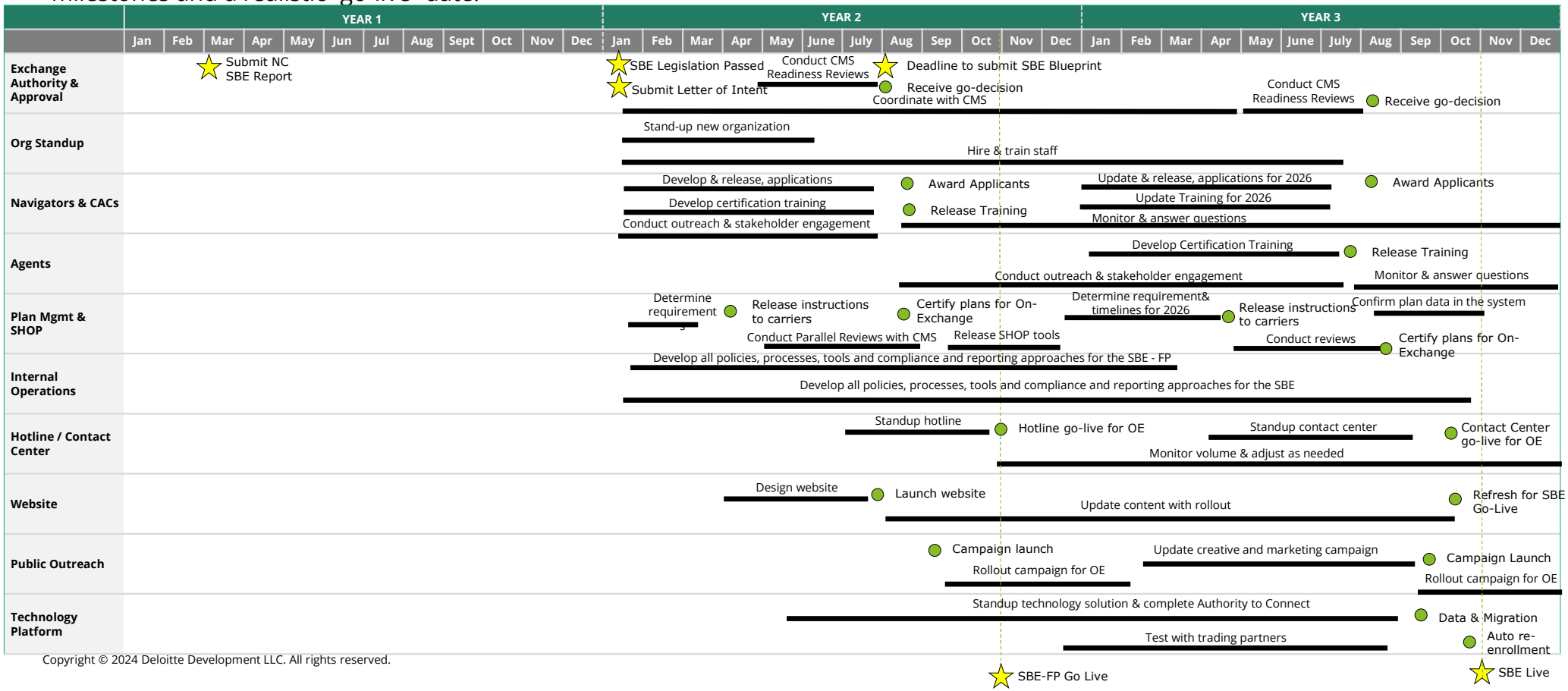
*Estimates above based on publicly available data from CMS. Premium data for 2024 has not yet been released; 2024 premiums in the table above reflect average 2023 premiums.

Funding Considerations

- Estimated User Fee Revenue = Plan Selections x Average Premium x 2.2% User Fee x 12 months.
- The federal government charges FFE states a 2.2% user fee and SBE-FP states a 1.8% user fee. Typically, SBE-FP states will charge carriers the difference (e.g., 0.4%). Based on 2024 estimates rates, this would be $30.86 PMPY ($32M annually).
- All exchanges implement a user fee to fund ongoing operations. Historically, states have been able to charge a lower fee than the federal government or use excess revenue to fund reinsurance programs.
- Some states such as Kentucky and Pennsylvania, have also be able to access Medicaid 90/10 matching funds to support the SBE through a Medicaid Implementation Advance Planning Document (APD).

EXAMPLE HIGH-LEVEL IMPLEMENTATION TIMELINE

Requested Information: A detailed timeline for the implementation of the State-based exchange, including identification of major milestones and a realistic “go-live” date.



LEGISLATIVE CHANGES AND KEY DEADLINES

Requested Information: Any legislative changes necessary to effectuate the proposed plan.

Area	Key Milestone
State Authority	Either through legislation or executive order, states must have authority to: • Operate an SBE, including a Small Business Health Options Program (SHOP) • Perform the certification of QHPs • Generate revenue • Perform risk adjustment (or defer to the federal government) • Establish a governance structure (including a board if applicable)
Federal Notification	CMS must be notified of the state's intent to implement an SBE by the following deadlines: • Declaration of Intent Letter (recommended no later than 21 months before SBE OE and 9 months before SBE-FP OE) • SBE-FP Blueprint Application (must be submitted at least 3 months before OE) • SBE Blueprint Application (must be submitted at least 15 months before OE) In the 2025 draft Notice of Benefit and Payment Parameters (NBPP), CMS proposed requiring states to first implement an SBE-FP prior to an SBE
1332 Waiver Considerations	Having an SBE provides the State greater autonomy to implement future innovative solutions in its market. For example, some states have used excess revenue collected from SBE user fees to fund reinsurance programs or state subsidies under a 1332 Waiver.

LESSONS LEARNED

Requested Information: Any lessons learned from working with other states that have recently transitioned to a state-based exchange & any other information regarding transitioning to a state-based exchange that is important for us to know.

Collaboration with CMS	• Maintain proactive and continuous communication with CMS. • Prepare for and schedule operational readiness reviews (ORRs) early. • Implement robust project management processes to track all requests, correspondence, and open items with CMS to ensure deadlines are met.
Medicaid Coordination	• Engage early with the Medicaid agency to establish a clear vision on how the programs will be coordinated. • Perform robust testing and document the integrations • Prepare for Medicaid Account Transfer demos with CMS.
Plan Management	• Perform a gap analysis on the activities the Department of Insurance (DOI) already performs for the market against new activities required when transitioning from the FFE • Clearly document roles & responsibilities for plan management activities between the DOI and SBE staff
Year 1 SBE Open Enrollment & Transition	• Enable seamless transition of all current FFE enrollees to the NC SBE, including auto re-enrollment and plan adjustments • Plan for enrollment data updates after initial data migration to account for new consumers who enroll or change their application on HealthCare.gov for the prior plan year after the initial data migration.
User Experience	• Implement flexible tools and dashboards to allow Exchange staff to easily review escalated cases and make real-time updates. • Plan for a surge in call volume during the transition. • Build process maps based of user profiles to map their journeys within the SBE
Issuer Engagement	• Maintain clear communication with issuers to ensure a seamless consumer enrollment process, especially for consumers transitioning between Medicaid and the Marketplace. • Prepare, review, and publish onboarding artifacts, including EDI guides, to promote transparency and prepare for go-live. • Perform integration testing with issuers to validate outbound and inbound EDIs and address issues quickly and collaboratively.
Agent and Assister Communication	• Engage with agents and assisters early to provide clear and explicit guidance on requirements and training. • Preemptively schedule office hours for agents and assister facing challenges during the transition.
Public Outreach	• Enrollment is driven by several factors, including economic conditions, federal tax credits, and how robust of a public marketing and outreach campaign the state launches to drive enrollment.

APPENDIX: 1332 WAIVERS

1332 WAIVER REQUIREMENTS

1332 Waivers must demonstrate compliance with four statutory guardrails in order to be approved by the U.S. Department of Health and Human Services and Department of Treasury.

1332 GUARDRAILS

1. **COMPREHENSIVENESS**
   Benefits for consumers must be at least as comprehensive with the waiver as absent the waiver
2. **COVERAGE**
   A comparable number of people must be covered with the waiver as absent the waiver.
3. **AFFORDABILITY**
   Plans must be at least as affordable for consumers with the waiver as absent the waiver.
3. **DEFICIT NEUTRALITY**
   Projected spending under the waiver cannot increase the federal deficit.

APPLICATION PROCESS

1. States must release a draft waiver application and actuarial and economic analysis for a **30-day** state public comment prior and hold at least two public hearings prior to submitting the application.
2. The federal government has a **45-day window** to conduct a completeness review.
3. The federal government has a mandatory **180-day clock** to issue a determination, inclusive of a **30-day** federal public comment period.

*CMS encourages state to submit their waiver applications, at a minimum, within the **first quarter of the calendar year** prior to the proposed year of implementation.*

PASSTHROUGH FUNDING

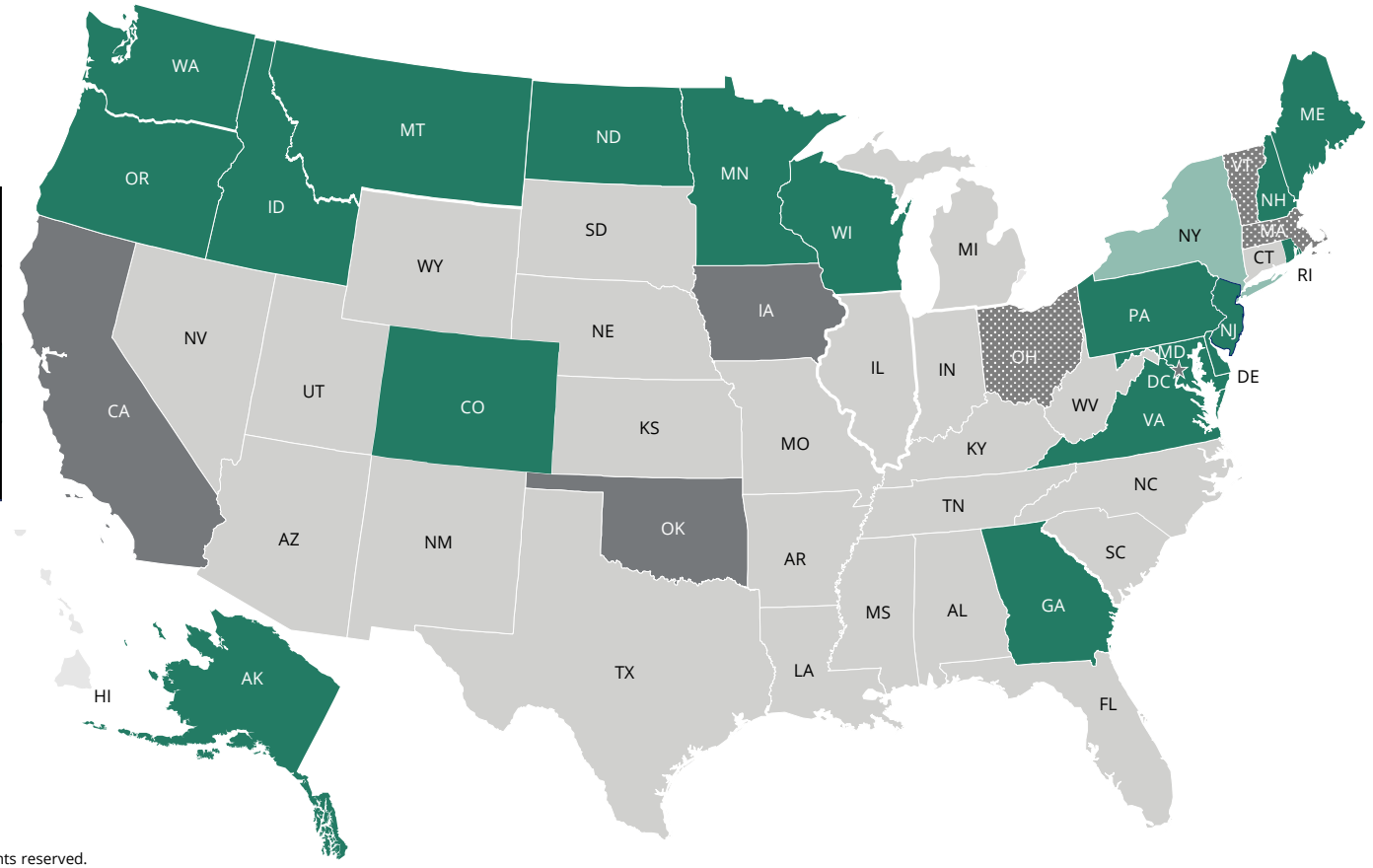
$ If a 1332 Waiver program reduces the federal spend on consumer premium tax credits (PTCs), the State may request the federal savings be passed through to the state to support the program.

1332 WAIVER LANDSCAPE

The map below provides an overview of the national landscape for 1332 Waivers as of January 2024.

Waiver Map Key

Withdrawn	3
Deemed Incomplete	3
Pending	1
Approved	19



DELOITTE 1332 WAIVER SERVICES

Deloitte provides end-to-end support for states pursing 1332 waivers from initial waiver strategy and design, to federal negotiations and approval, to program implementation and reporting.

Waiver Strategy & Design

- Analyze current healthcare landscape
- Facilitate design sessions
- Research state and federal policies and dependencies

Actuarial and Economic Analysis

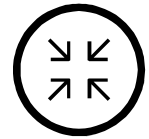
- Evaluate compliance with 1332 guardrails
- Provide 5- and 10-year estimates

Draft Waiver Application

- Draft the waiver application
- Confirm compliance with requirements
- Finalize and submit

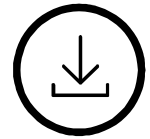
State Public Comment Process

- Prepare materials
- Collect & analyze comments received
- Draft responses



Federal Review & Negotiations

- Help prepare for and facilitate calls with CMS
- Provide supplemental information
- Track all action items for waiver approval



Implementation & Reporting

- Develop detailed program design
- Provide communications & engagement support
- Draft required federal and state reports

Project Management

Optum

State Based Exchange Overview

North Carolina Department of Insurance

February 1, 2024

Appendix 65

Agenda

1. Welcome & Introductions
2. Background Information
3. Questions & Answers
4. Closing Remarks

Optum team

Kevin Hutchinson

Vice President, Growth
State Government Solutions

Pinkul Goyal

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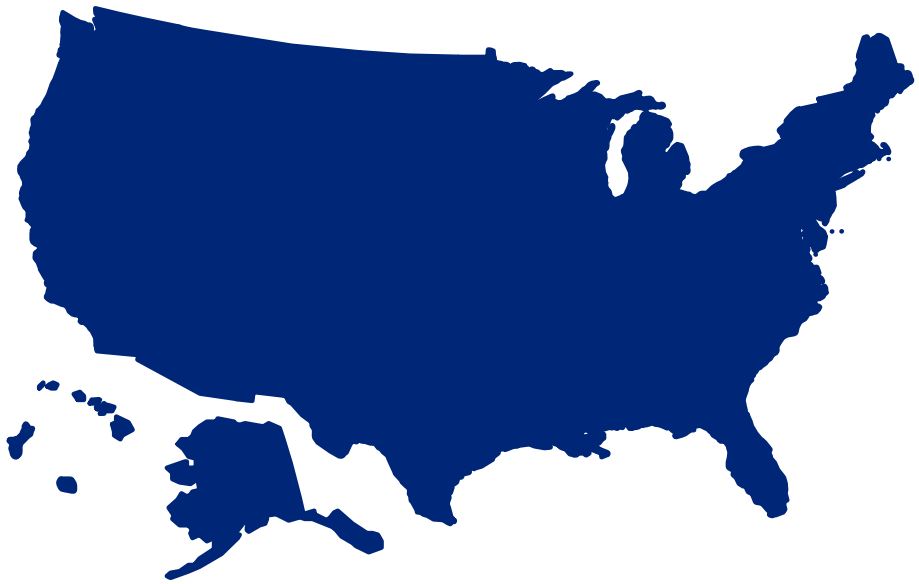
Scott Dunn

Senior Director, Health and
Human Services Programs

Scott Cerreta

Strategic Product Manager,
HIX and Integrated Eligibility

Optum serving Health and Human Services for 30 years



Our broad experience in
50 states and D.C.

Analytics and enterprise data warehouse service
10 states

SBM & Eligibility and enrollment solutions
4 states

Other population health management solutions
39 states

Fraud, waste and abuse detection
11 states

Provider Management
2 states

Behavioral health services
29 states

Long-term services and supports solutions
2 states

Program and policy consulting
12 states

Pharmacy benefit management
7 states

Optum proven state-based exchange experience

✓ Current client

Massachusetts
Deployed more than 340 people in less than 6 weeks to address the original application backlog. ✓

Minnesota
Provided Change of Circumstance planning and contact center support.

New Mexico
Building a stand-alone state-based exchange, including enrollment, financial management and more. ✓

Maryland
For 2015 open enrollment, leading outreach and tracking initiatives to renew coverage for more than 66,000 consumers.

Vermont
Facilitated Change of Circumstance efforts by placing 51,566 outbound calls and handling 22,426 inbound calls. ✓

Hawaii
Provided operations consulting to optimize operational processes including 834 processing, training and staffing planning.

Washington, D.C.
Provided operational and staff augmentation, supported the Small Business Health Options Program and facilitated the redesign of the exchange's call management system to improve call center operations and overall exchange business processes.

Healthcare.gov
CMS asked Optum to be General Contractor in late October 2013 to lead site improvements for HealthCare.gov technical and operational problems. By December 1, 2013, HealthCare.gov was a stable, robust site for more than 1.8 million daily users.

State-Based Exchange Overview

Two Approaches to State Based Exchanges

QHP-only Offering ("No wrong door")

ACA-compliant marketplace that enables:

Individuals and families

- Apply for coverage
- Get determined for various QHP related programs/subsidies
- Get **transferred to Medicaid** system via account transfer for Medicaid/CHIP determination (and future day to day operations)
- Complete QHP plan shopping using various decision support tools

Brokers/Agents/Navigators/CACs to help their customers using a self-service portal

Issuers to review their plan data using a self-service portal

Operations staff (CSRs, etc.) to support day-to-day operations of the marketplace

QHP with Medicaid offering ("Single door")

ACA-compliant marketplace that enables:

Individuals and families

- Apply for coverage
- Get determined for various QHP/**Medicaid/CHIP** related programs/subsidies
- Complete QHP plan shopping using various decision support tools

Brokers/Agents/Navigators/CACs to help their customers using a self-service portal

Issuers to review their plan data using a self-service portal

Operations staff (CSRs, etc.) to support day-to-day operations (**both for QHP and Medicaid/CHIP**)

bewellnm®

MASSACHUSETTS HEALTH CONNECTOR

VERMONT HEALTH CONNECT
Find the plan that's right for you.

Optum State Based Exchange Offerings

Streamlined User Experience

User friendly design with no wrong door access for enrollment and eligibility. (QHP with Medicaid option includes Single Door approach)

Lower cost of Ownership

Running your own state-based exchange could mean cost savings compared to user fees for the federally facilitated marketplace.

Data Control & Analytics

Better access to on-demand data and analytics that provides the flexibility to design marketing and outreach programs tailored to your residents.

Flexible Policy Implementation

A state can enact policies to serve the needs of its residents, customize user experience, extend open enrollment dates and more.

Full accessibility compliance

Our state-based health exchanges can support ADA including 508 compliance for end-user portals.

Online eligibility **application** & real-time data **verification**

508 compliance, mobile and multilingual support

Automated annual **renewals** for QHP (Medicaid single node mode)

Real-time **eligibility** determination

Plan shopping with decision support

Electronic and paper member **communications**

Household **case management** and operational support

Self-Service **portals** for CSRs, Brokers, Issuers & Navigators

Dashboards and analytics with 360-degree view

Account transfer for Medicaid/CHIP

Appendix 72

Questions & Answers

1. Specific details for the structure and oversight of a proposed State-based exchange, including the makeup of any proposed board of directors or other governing body

The ACA* requires states to establish a board and governance structure

- The state may establish a **new** governing board or leverage an **existing** governing body
- Requirements:
  - Publicly-adopted operating charter or by-laws
  - Regular public governing board meetings announced in advance
  - Voting member who is a consumer representative
  - Is not made up of a majority of voting representatives with a conflict of interest
  - Majority of the voting members on governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured
- States have established boards **within state agencies** or created **non-profit public entities**
- Important to consider the state governance and responsibilities between agencies (e.g., DHHS and DOI)

* ACA Section 1311(d) and 45 CFR 155.110;

1. Specific details for the structure and oversight of a proposed State-based exchange, including the makeup of any proposed board of directors or other governing body (cont'd)

Examples of governance boards:

New Mexico

Overseen by New Mexico Health Insurance Alliance, a nonprofit public corp. Governed by a 14-member Board of Directors. The New Mexico Superintendent of Insurance serves as the Chair of the Board

Vermont

No separate board. Managed by Vermont Agency of Human Services - Overseen by Vermont Department of Health Access (DVHA)

Massachusetts

Overseen by Commonwealth Health Insurance Connector Authority; Governed by a Board of Directors consisting of 11 members

2. A detailed timeline for the implementation of the State-based exchange, including identification of major milestones and a realistic "go-live" date.

- Submit letter declaring intent to establish an SBE approximately **21 months** prior to the first annual open enrollment, to allow for sufficient time for switching to **State-based Marketplace-Federal Platform for Year – 1**.
- Submit Blueprint Application for approval at least **15 months** prior to the first open enrollment period

High-Level Implementation Timeline

← **RFP for SBE procurement and contracting period, 12-month Hybrid Model**

Estimated 14 Month Timeline (Post 12 Month Hybrid):

- Implementation and Organizational Change Management Planning
- Map and Gap, Content review/update, Carrier onboarding, Integration connectivity setup
- SIT environment configuration
- System integration testing (SIT)
- User acceptance testing (UAT)6
- User Trainings/ UAT environment configuration
- Data Migration/Plan Loading/Renewals/OE Operational readiness
- Pre-Open Enrollment (OE) outreach
- Soft Launch
- Go Live

- Discussions with CMS will also start in advance of Operation Readiness Reviews (ORRs). The ORRs are conducted around the SIT start date when all the content incorporated
- Application for **Authority to Connect** (ATC) with CMS around 2 months to obtain ATC (and Authority to Operate (ATO) from IRS) before Production Data Migration

2. A detailed timeline for the implementation of the State-based exchange, including identification of major milestones and a realistic "go-live" date (cont'd)

Additional info on the 12-Month State-Federal Hybrid

The State-based Marketplace-Federal Platform (SBM-FP) (or "hybrid" approach) combines aspects of both the federal marketplace and state-based exchanges.

Federal	State

• Federal Healthcare.gov website for eligibility and enrollment functions. Consumers in these states apply for and enroll in coverage through Healthcare.gov.
• Agents and brokers must comply with the same FFM registration and training requirements before they may facilitate enrollments through the federal platform.
	• Responsible for performing all marketplace functions for the individual market, including:
	  • Establish and oversee certain standards for agents, brokers, and QHP issuers that are no less strict than those that apply in the FFM.
	  • Perform Plan Management functions
	  • Oversees Marketing and Outreach functions

3. The anticipated costs to the State for start-up and ongoing operations of the State-based exchange, including labor costs, information technology costs, and any foreseeable costs to any State agency outside of the Department of Insurance.

Cost Drivers: Anticipated costs will derive from a series of key decisions in the design and function of the exchange.

- **Financial Management / Payment Processing:** Executed by the Exchange vs executed by the carriers.
- **Call Center Support:** Level, locations, and range of support functions.
- **Notices**: Who will send out the notices and how will they be sent out?
- **QHP-only vs QHP with Medicaid:** QHP-only will lower costs to just the exchange, but may transfer a greater cost to Medicaid
    - States have utilized the Cost Allocation Methodologies (CAM) Toolkit for Federal Financial Participation (FFP) calculations. The CAM tool is not a requirement, and the State could use other methods to determine FFP if the State chooses.

Key Cost Categories: Stages and components of the marketplace platform to consider costs

Implementation:
Deliverables-based/milestone pricing during a design, development, and implementation (DDI)

Maintenance and operations:
Fixed or time and materials pricing

Product licensing:
Annual product enhancements, defect fixes, and minor compliance update

Hosting:
Capacity and non prod environment considerations

Discretionary funding:
Change Request category for solution enhancement and customizations

4. Identification of sources of funding for the start-up and ongoing operations of the State-based exchange, including federal funding and assessments on commercial insurance products.

Typical SBM funding sources

User fees are generally the most common funding sources for QHP only SBEs

Other state appropriations may be considered for funding sources

CMS 90/10 Medicaid funding is an option for SBEs with Medicaid system capabilities

Federal discretionary appropriations for program management and program integrity

ACA Section 1332 Innovation Waiver from CMS to support new and innovative ways to improve access and lower costs.

5. Identification of any estimated savings to the State or the citizens of the State as a result of the proposed plan.

There has yet to be highly definitive data confirmed that verifies the cost savings of transitioning to an SBE. However, there are several principles that point to the financial benefits:

- States have been able **operate SBEs with lower fees** than the Federal exchange
- Rather than paying fees to the Federal government, exchange carriers will pay fees to the state, **keeping funding in North Carolina**
- The state can afford **flexibility in how surpluses are applied**

Per a report from the Center on Budget and Policy Priorities:

While it is impossible to compare different exchanges' costs on a truly apples-to-apples basis, examining the budgets of longstanding exchanges — both state-run and the FFM — that serve millions of people can provide a sense of what it costs to operate one. As discussed in this paper, the new SBMs plan to operate at a lower cost than several existing SBMs, in the range of $100 to $200 per marketplace enrollee per year in several cases. For four "first-generation" SBMs that we examined, as well as FFM states, it costs about $240 to $360 per marketplace enrollee per year to operate.

Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges | Center on Budget and Policy Priorities (cbpp.org)

6. Any legislative changes necessary to effectuate the proposed plan.

Establish Oversight Body:

- Structure and function of the board
- Ability establish policies and procedures for the certification, recertification and decertification of health benefits plans as qualified health plans
- Determine the criteria and process for eligibility, enrollment and disenrollment of enrollees and potential enrollees in the exchange and coordinate that process with the human services department in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverages

Enabling Legislation – Factors to Consider:

- QHP-only or QHP + Medicaid
- Reporting requirements
- Encourage competitive contracts to optimize value

7. Any lessons learned from working with other states that have recently transitioned to a state-based exchange.

Organization Change Management – Understanding working closely with business operations teams

Multifaceted **outreach program** during transition and Open Enrollment periods (e.g., Online, social media, paper mail, news, etc.)

Plan for **data quality and transition management** plan (member information inconsistencies and gaps can cause delays in processing and communications)

Changing **834 files** coming through in consistent manner (all states send through differently)

7. Any lessons learned from working with other states that have recently transitioned to a state-based exchange. (cont'd)

PHE unwinding – making sure that Medicaid determination doesn't conflict with exchange

Open enrollment planning critical to success of enrollment period and processing (i.e. system/plan updates, capacity demands, staffing, notice generation and processing, call center support, etc.)

Error visibility and communication with brokers and members (e.g. backlog updates)

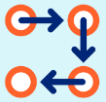
Consistent certifications similar to healthcare.gov – lengthy certifications are a barrier to entry, more streamlined certification

8. Any other important information regarding transitioning to a state-based exchange that is important for us to know.

Cross state agency agreement on SBE eligibility determinations and interfaces with Medicaid solution

Payment processing approach (State vs Carrier) and reconciliation process with carriers

The SBE must **share information with Medicaid** and the Children's Health Insurance Program (CHIP)



Security and Compliance requirements – Annual audit planning needs and overall Authority to Operate (ATO), which is a lengthy process and done every 3 years

Upside to an SBE is being able to **tailor outreach and plans to local communities** and maintaining more control over the solution and programs

Importance of the **call center** functionality and operations, call wait times, and the need for dedicated health exchange representatives available to handled issues

Additional Considerations

- **Stay focused on the goals of transitioning on time/budget and doing so with minimal disruption to customers, partners and stakeholders**
- Require vendors to have proven experience operating exchange technology and customer service solutions in other states
- Close coordination with stakeholder, partners, insurers, brokers and other state agencies throughout the transition
- **Early and continuous engagement with CMS/CCIIO and other federal agencies**
- Broad awareness campaign before the start of Open Enrollment to introduce and educate the public to the transition from Healthcare.gov
- The timeline is tight, so understanding key milestones and communicating progress, or lack thereof,
  is critical to staying on track
- Understanding your partners–assisters, brokers and insurers –are going through a big transition too
- System testing is paramount to minimizing disruption and catching issues before you go live
- **Customers trust their helpers. Make the Brokers and Assisters' onboarding and training an important early investment**
- Plan for managing and communicating issues and workarounds

Thank you! Further Questions & Discussion

Benefits of a state-based exchange

Flexibility to implement policy changes and serve residents in the way that's best for them

Local control of a robust in-person assistance program, education, communications and customer service

Decreased operational costs and an ability to **keep dollars in-state**

Opportunity to implement lower fees than the FFM

Ability to **work more closely with insurers** and foster a competitive marketplace

Better **oversight** and management of the Medicaid churn population

GEORGIA ACCESS

Georgia Access Exchange

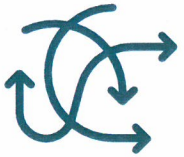
December 2, 2023

The Challenge

~1.3m

As of 2021, an estimated 1.3 million* people in Georgia lacked health insurance, an uninsured rate of 12.7%

Only 3 in 10 Georgians responsible for purchasing insurance independently did so, as of 2021, through the Federally Facilitated Marketplace (healthcare.gov)



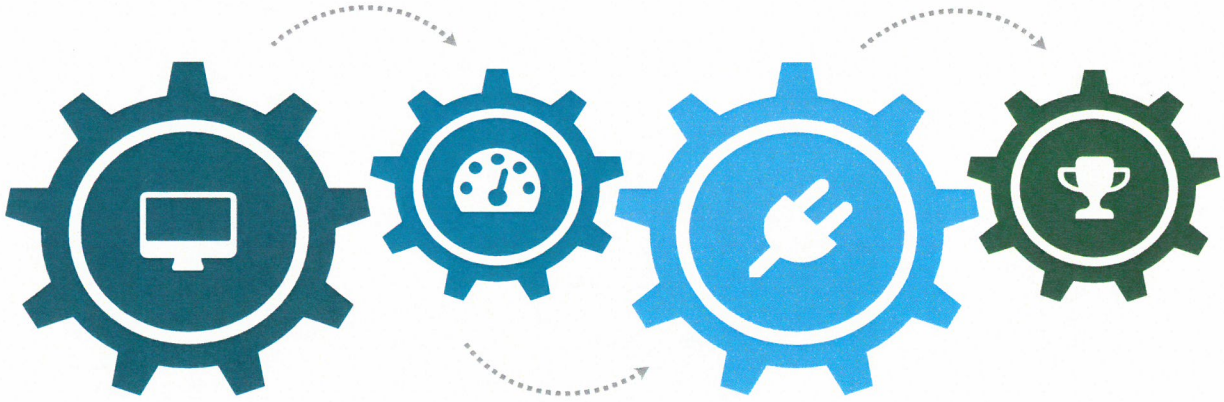
Households between 100% and 400% of the Federal Poverty Level may qualify for subsidies through the Marketplace, yet many go uninsured. Plans for those near 100% are practically free

GEORGIA ACCESS

Turn Back the Clock: Insurance Conditions in 2021-2022 Georgia

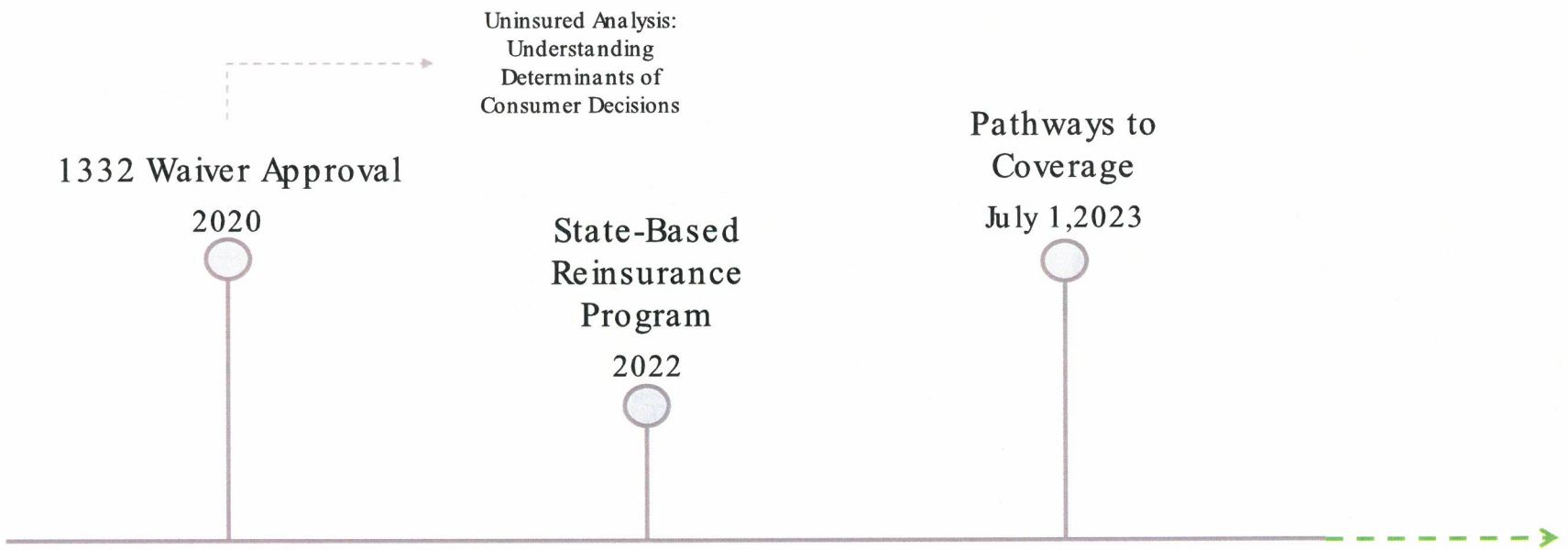
Marketplace enrollment down from 2016 peak

Third-highest rate of uninsured residents in the country



GEORGIA ACCESS

Uninsured Analysis: One Step in a Broader State Effort



GEORGIA ACCESS

Georgia Access Exchange

Overview

Georgia's SBE is designed to serve the needs of its residents; it will facilitate a more competitive marketplace with greater consumer choice by engaging Georgia's private-sector entities to provide innovative solutions for plan shopping, enrollment, and support.

Program Goals

- Increase competition, innovation, and private sector investment in Georgia's market.
- Improve the shopping and enrollment experience for consumers.
- Reduce the number of uninsured Georgians.

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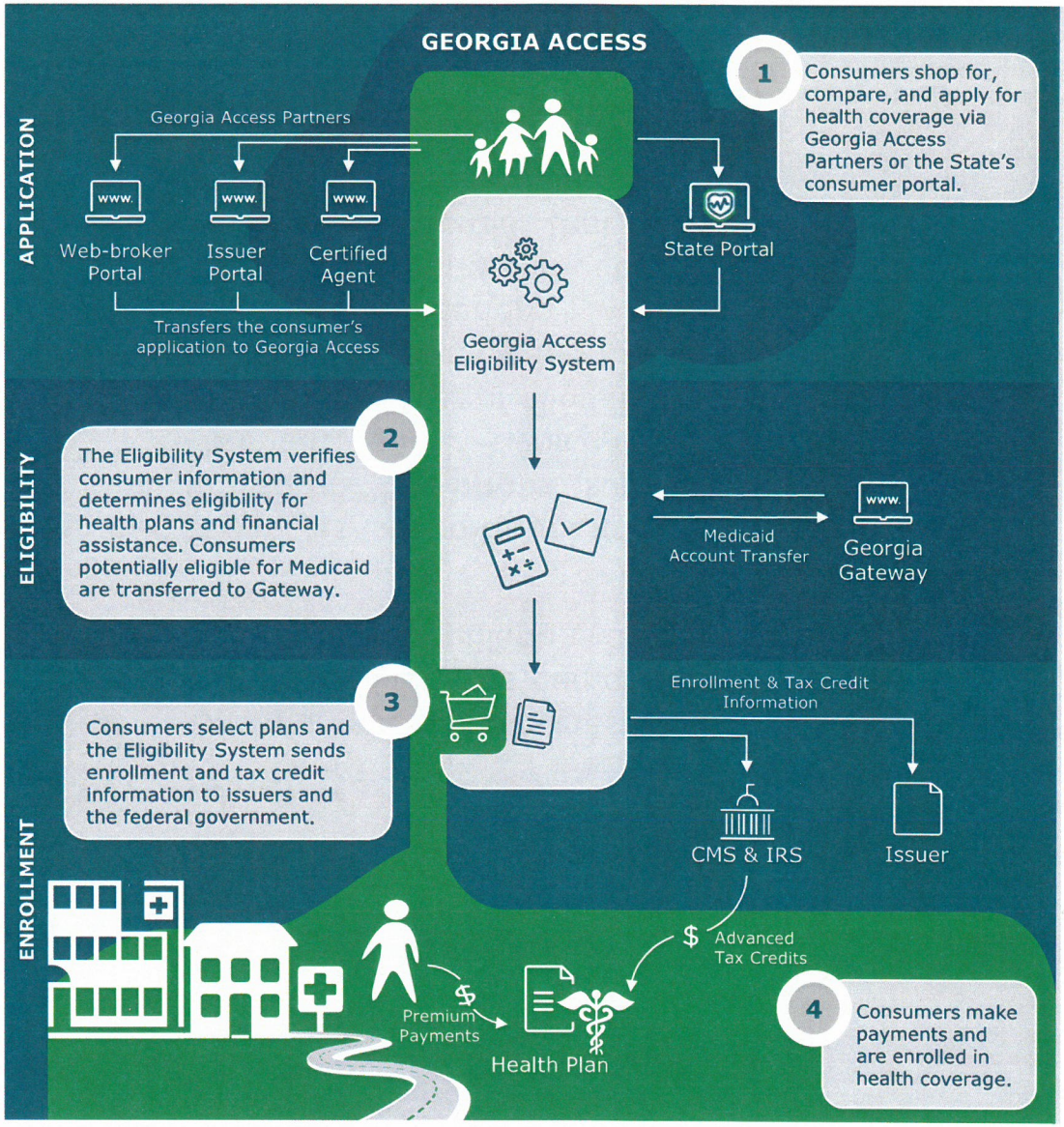


We Know Our Market

Moving to an SBE builds upon the efforts OCI has recently undertaken to understand and improve the market for consumers. Two recent studies will help direct our efforts with Georgia Access.

Network Adequacy Analysis

The study assessed the compliance of plans in the individual market with carrier requirements for availability and accessibility to providers.

With an SBE, OCI has more power to hold carriers accountable for failing to maintain their provider networks to ensure patient access.

Health Market Scan

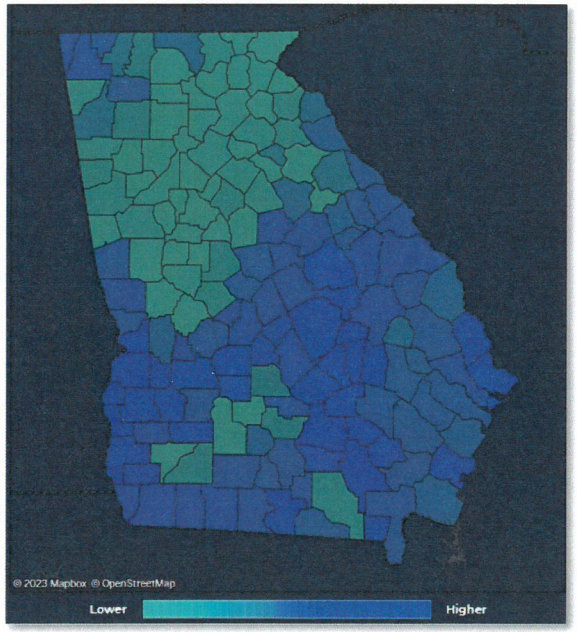
This market scan provides coverage maps to identify the demographics of uninsured populations across the state.

It enables OCI to target known uninsured **"hot spots"** such as Gwinnett County – which has one of the highest rates of eligibility, marketplace participation, and uninsured populations – while limiting marketing and outreach resources in counties that already have high insured populations.

Network Adequacy Scan | Statewide Snapshot

The following provides a summary of network adequacy for consumers enrolled in the individual market statewide. All findings were calculated based on CMS 2022 drive time requirements, using provider and consumer data submitted by carriers between April 4, 2022, and October 4, 2022.

Coverage Heat Map*



*Darker regions correspond with a higher percentage of uncovered consumers

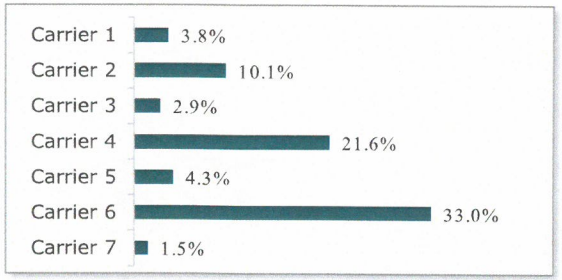
County Summary

N/A	644,815	125,368	19.4%
CMS County Designation	Total Consumers	Uncovered Consumers	of Consumers Uncovered

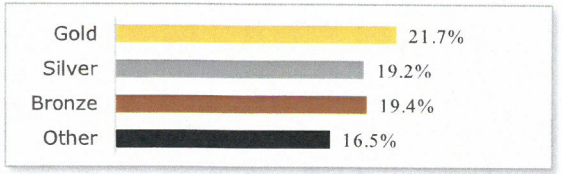
Top Uncovered Criteria

Criteria	Uncovered Consumer Count	Percent Uncovered
Allergy & Immunology	81,584	12.7%
Dermatology	65,092	10.1%
Neurosurgery	49,454	7.7%
Ophthalmology	48,636	7.5%
Rheumatology	42,954	6.7%
Vascular Surgery	36,871	5.7%
Podiatry	35,786	5.5%
Cardiothoracic Surgery	35,380	5.5%
Oncology – Radiation	34,061	5.3%
Chiropractor	27,248	4.2%

Uncovered by Carrier



Uncovered by Plan Level



GEORGIA ACCESS

Health Market Scan | Gwinnett County Snapshot

Gwinnett County has a large volume of consumers buying on Exchange, but it also has a large volume of uninsured who would be eligible. Taking a closer look at census tracts helps to inform marketing efforts.

TRACT #13135050526

BORDERS PLEASANT HILL

Rural (non-core) | **Medium** metro | **Urban** (Large central metro)

INSURANCE METRICS

2,836 Total population

9.4% FFM

19.3% Uninsured & Eligible

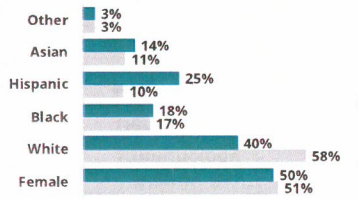
285% Average FPL

DISCUSSION

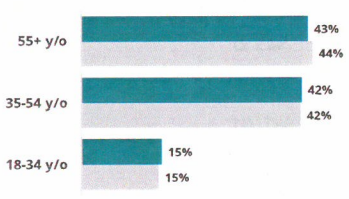
The Gwinnett County tract with the highest rate of uninsured has many Hispanic residents and low homeownership, income, and marriage rates.

DEMOGRAPHICS

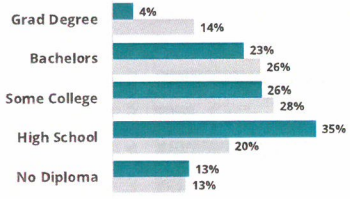
Key: Census Tract | Gwinnett County (GC)



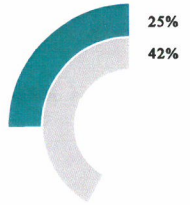
Race Distribution



Age Distribution



Education Level



Percent Married

ACCESS AND HEALTH

$159 estimated **AVERAGE PREMIUM** per eligible individual

Self-Care
37% ***(vs. 33%)*** maintain regular healthy habits

Homeowner Status
62% ***(vs. 77%)*** are homeowners

Debt
96% ***(vs. 98%)*** have debt

Employment
96% ***(vs.97%)*** employed

Technology Disposition
81% ***(vs. 79%)*** able to operate basic technology

Health Literacy
41% ***(vs. 35%)*** low health literacy

Polymorbidity
34% ***(vs. 27%)*** have 2 or more chronic health problems

GEORGIA ACCESS

Georgia Access Open Enrollment 2023 Campaign Impact

To understand the impact of the campaign, the State measured key Awareness and Traffic metrics* from marketing channels and on the GeorgiaAccess.gov site.

UNINSURED POPULATION

1.5M

Uninsured Residents

MARKETING RESULTS

$5M
Total Spend

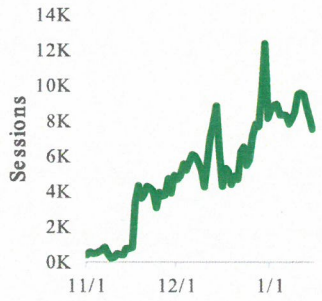
236M
Total Digital Impressions

396K
Total Link Clicks

GEORGIA ACCESS SITE

385K
Total Sessions

334K
Total Unique Users



FIND A HEALTHCARE PARTNER PAGE

99,079
Total Page Views

29s
Avg. Engagement Time

31,814
Total Clicks on Healthcare Partners*

HEALTHCARE PROVIDERS AND BROKERS HIGHEST SHARE OF CLICKS**

PROVIDERS	BROKERS
Anthem	WELL
aetna	health markets
United Healthcare	HealthSherpa

+178K (+25.4%) *Open enrollment plan selections compared to OE22*

879K *Total open enrollment plan selections in OE23*

*The open enrollment plan selection growth in Georgia was **double the national growth rate average** of +12.5%*

**Awareness is the measure of the reach of GeorgiaAccess.gov messaging across marketing channels, and traffic measures level of link clicks and engagement on the website*
***Clicks on Healthcare Partners include clicks to the partner's website and phone number*

GEORGIA ACCESS

FFM Exchange User Fee Summary by Year

	Actual						Projected	
	2018	2019	2020	2021	2022	2023	2024	2025
User Fee %	3.50%	3.50%	3.00%	3.00%	2.75%	2.75%	2.20%	1.50%
% Prem ON Exchange	90.1%	90.6%	89.9%	89.7%	93.5%	94.6%	94.4%	92.9%
Total Dollar Fees	**$139,293,737**	**$130,591,193**	**$107,421,101**	**$119,328,579**	**$131,104,461**	**$156,476,696**	**$127,376,876**	**$71,101,741**
Exchange Fee PMPM	$24.58	$23.40	$18.20	$17.67	$16.36	$16.72	$10.60	$5.85
Total Premium	$4,415,131,106	$4,119,753,031	$3,984,390,250	$4,435,638,213	$5,096,717,847	$6,017,303,497	$6,136,022,905	$5,104,773,635
Member Months	5,666,897	5,580,765	5,902,198	6,752,728	8,014,340	9,358,170	12,011,668	12,161,539
With Medicaid Expansion							9,924,913	7,988,030
Cumulative Reduction							-2,086,755	-4,173,509
Avg Premium PMPM	$779.11	$738.21	$675.07	$656.87	$635.95	$643.00	$618.24	$639.05
As % of Premium	3.15%	3.17%	2.70%	2.69%	2.57%	2.60%	1.72%	0.91%

The seven consideration items in Section 30.9.(a):

(1) Stabilization strategies aimed at addressing risk associated with individuals with high healthcare costs.

Comments:

1. Individuals with high claim costs are well covered and protected under the existing plans:
    a. Catastrophic claims are managed by the issuer's case management.
    b. Issuers are protected from extremely large claims through the risk adjustment transfer mechanism with high-cost risk pool implemented in PY2018.
    c. State Reinsurance program through the Section 1332 waiver would provide another layer of protection to the individuals covered and the issuers.
    d. Lower premium rates under a state reinsurance program would lower uninsured rate.
    e. State-based Exchange would reduce number of uninsured through:
        i. Robust marketing and outreach to increase enrollment.
        ii. Lower rates resulting from lower exchange fee reflected in the premium.
        iii. Longer open enrollment period.
        iv. More streamlined enrollment process for easier enrollment.
2. Individuals with high out-of-pocket cost-sharing concern can be addressed with the following options under a state-based Exchange:
    a. State cost-sharing subsidy on the top of federal cost-sharing subsidy.
    b. State specific Standardized plans with lower deductible and/or lower OOPM.

(2) Individual coverage Health Reimbursement Arrangements (HRAs) for employees of large and small businesses within the State.

Comments:

1. Background:
    a. A Qualified Small Employer Health Reimbursement Arrangement(QSEHRA) allows small employers(less than 50 full-time employees) who don't offer group health insurance benefits to reimburse employees – tax-free – for some or all of the premiums they pay for coverage purchased in the individual market, on or off-exchange.
    b. The maximum amount that an employer can reimburse through a QSEHRA in 2022 is $5,450 for a single employee's coverage ($454.16 per month), and $11,050 for family coverage ($920.83 per month). These amounts are indexed annually by the IRS.
    c. Unlike ICHRAs, it is possible to have both a QSEHRA benefit and a premium tax credit in the marketplace.
    d. QSEHRA became available in 2017.
    e. ICHRAs were created under regulations issues by the Trump administration in 2019; and became available as of 2020.
2. It is already available under the regulations whether a state-based exchange and/or Section 1332 Waiver are implemented or not.

(3) Financial assistance for various types of health insurance plans, including nonqualified health plans, for individuals purchasing coverage on the State-based exchange.

Comments:

1. Federal financial assistance for either qualified or nonqualified health plans are outside scope of what the current (post 2018 guidance) Section 1332 Waiver can deliver.
2. State provided premium and cost-sharing subsidies for qualified and nonqualified health plans can be considered with implementation of the SBE; source of funding needs to be identified.

(4) A new, State-administered subsidy program for (i) individuals and families and (ii) small businesses purchasing coverage for employees through the State-based exchange.

Comments:

1. The current Section 1332 Waiver does not impact the state administered subsidies.
2. No approval for the waiver application means no pass-through funding from federal.
3. State provided premium and cost-sharing subsidies for qualified and nonqualified health plans can be considered with implementation of the SBE; source of funding needs to be allocated.

(5) The establishment of account-based premium credits for individuals and families enrolled in healthcare coverage through the State-based exchange.

Comments:

1. Given rescinding of the 2018 Empowerment Waivers that has sought to increase flexibility of how the premium subsidy is applied, it is unlikely the account-based premium credit is feasible without solely state-provided funding.
2. It is expected that it would not be allowed under the current 1332 Waiver.
3. Establishment of state-based exchange would not help with needed funding.

(6) The use of any available federal funding or grants for the creation of the State-based exchange, or necessary information technology to support the exchange, or both.

Comments:

1. Section 1332 Waiver is not needed for establishing a state-based exchange.
2. Federal grants were available through November 2014 to establish SBE.
3. No grant may be awarded after January 1, 2015(Source: Congressional Research Service report, October 29, 2014)

(7) The establishment of a reinsurance program that seeks to maximize federal funding for the program and stabilize the rates and premiums for health insurance policies offered in this State.

Comments:

1. To date states have used Section 1332 Waiver mostly to establish state-provided reinsurance program.
2. Given the delivery date in section (b), we need to set an internal timeline to meet the deadline:
    a. Need to set a target premium reduction.
    b. Reinsurance plan design: a straight-forward design with attachment points and coinsurance percentage (ex. 70% between $50,000 and $300,000 large claims).
    c. Find funding sources to meet the revenue needed over the federal pass-through funding.
        i. Assessments on health insurance premium.
        ii. Fees charged on providers and PBM.
    d. The final product would be a compromise of the above three items.
        i. Use other states' experience as reference points.
    e. Preparation of the submission data with the application.
        i. Assess data need to complete required projection to demonstrate that the statutory guardrails are met.
        ii. Reliance on consulting services to develop the submission package and after services.
            1. Do we have a funding allocated for the consulting work?
            2. If not, need to assess internal capacity, data needs, and timeline to meet the target date.

Below is a table summarizing how the State Based Exchange (SBE) and the Section 1322 Waiver may impact each of the seven consideration items in Section 30.9.(a):

Items to consider in Section 30.9.(a)	State Based Exchange	Section 1332 Waiver	Notes
Individuals with risk of high healthcare costs	Improves	Improves	High claims are well covered under the existing plans. SBE and the Waiver add another layer of protection from high claim costs.
Individual coverage Health Reimbursement Arrangements	Not required	Not required	It is already available under the existing regulations regardless of establishment of the SBE or the 1332 Waiver.
Financial assistance for nonqualified health plans	Required; Enable administration of state provided financial assistance	Likely not be approved under the current rules	Discarding the 2018 State Relief and Empowerment Waiver guidance by the current administration signals no federal financial assistance for nonqualified health plans. State provided financial assistance is possible under the SBE but funding needs to be appropriated.
State-administered subsidy programs	Required; Enable administration of state provided financial assistance	Not required	State can provide both premium and cost-sharing subsidy in addition to the federal subsidies available under the SBE but funding needs to be secured.
Account-based premium credits	Required; Enable administration of state provided premium credits	Likely not be approved under the current rules	Discarding the 2018 State Relief and Empowerment Waiver guidance by the current administration signals no federal funding for account-based premium credits. State provided premium credits is possible under the SBE but funding needs to be appropriated.
Federal funding or grants for the creation of the SBE	Enable, but no funding is available currently	Not required	Initial federal grants were available through November of 2014; ARP of 2021 provided $20 million to 21 SBEs to modernize and update.
Establishment of a reinsurance program	Not required	Required	The pass-through funding provides a large portion of the revenue needed; likely needs assessments and other fee sources to fund the revenue gap.

STATE OF NORTH CAROLINA
1332 STATE INNOVATION WAIVER APPLICATION TO ESTABLISH A STATE REINSURANCE PROGRAM

NORTH CAROLINA DEPARTMENT OF INSURANCE
Commissioner Mike Causey
[date to be determined]

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I. Executive Summary

Request

Mike Causey, North Carolina Insurance Commissioner, on behalf of the State of North Carolina, is submitting this application to the Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS), and to the United States Department of the Treasury, for a waiver of certain provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, together referred to as the Affordable Care Act (ACA), as authorized by Section 1332 of that Act.

North Carolina's Section 1332 Waiver application seeks to waive Section 1312(c)(1) of the ACA for the purpose of establishing a state-based and state-administered reinsurance program. If approved, the Section 1332 Waiver, as proposed, is targeted to be effective January 1, [2027] for an initial period of five years.
.
This waiver would not affect any other provision of the ACA but is expected to result in a lower market-wide index rate, thereby lowering premiums and reducing the Federal cost of Premium Tax Credits (PTCs). With this Section 1332 Waiver application, North Carolina requests that the Department of the Treasury "pass-through" net savings to help fund its reinsurance program.

Basis for Request and Goal of Reinsurance Program

North Carolina believes that the introduction of a state-based reinsurance program to fund high-cost claims would lower premiums, making it possible for more individuals to stay in the market and making the market more attractive to existing and possible future issuers. Both of these outcomes would help to maintain stability in the market.

Operation, Funding and Impact of the North Carolina Reinsurance Program

As outlined in further detail below, [enabling legislation], signed into law on [date], authorizes the State's Section 1332 Waiver application and requires Federal approval of the waiver application for the reinsurance program to be implemented. Under [enabling legislation], the program would be administered by [NCDOI or another entity to be determined].

The proposed reinsurance program would be modeled after the former Federal Transitional Reinsurance Program and would reimburse issuers who offer comprehensive coverage in North Carolina's single risk pool individual market via an attachment point model reinsurance program. The proposed reinsurance

program is expected to lower issuer costs in North Carolina's individual market by approximately [21 percent] on average.

The sources of funding for the proposed reinsurance program are expected to be as follows:

1) A premium assessment, authorized by [enabling legislation], which is described in more detail below.

2) Federal pass-through funding provided in response to this waiver application; estimates of the amount of which are detailed below.

Compliance with Section 1332

North Carolina's Section 1332 Waiver satisfies all of the waiver guardrails provided for under the ACA:

- The waiver does not make alterations to the required scope of benefits offered in the individual health insurance market in North Carolina and, therefore, would provide access to coverage that is as comprehensive as absent the waiver. Further, the waiver would result in an increase in the number of individuals with coverage that meets the ACA's Essential Health Benefits requirements.

- The waiver would reduce premiums and not impact cost sharing, thereby increasing the affordability of comprehensive coverage.

- The waiver would cover more individuals in North Carolina than would be covered absent the waiver.

- The waiver would not result in increased spending or administrative or other expenses to the Federal government.

As detailed below, North Carolina's waiver would also advance the Federal principles for Section 1332 Waivers.

State Contact

[To be determined] will serve as the State's point of contact for the Section 1332 Waiver application and is responsible for ensuring compliance with all Section 1332 Waiver provisions, submitting required reports and serving as the primary contact for all waiver-related issues and concerns.

Name: [TBD]
Title: [TBD]
Telephone Number: [TBD]

Email address: [TBD]

II. North Carolina Section 1332 Waiver Request and Goals

North Carolina believes that a state-based reinsurance program would be an effective way to help stabilize the individual market. By establishing a reinsurance program to reimburse issuers based on their liability for high cost claims, North Carolina's Section 1332 Waiver would reduce premiums, making private individual health insurance coverage more accessible, particularly for those North Carolina residents who may not receive enhanced advance PTCs if the Inflation Reduction Act(IRA) is not renewed after 2025. More stable membership in the individual market would, in turn, stabilize issuer participation, reducing the risk of erosion of issuer participation and supporting the potential for increased competition among issuers in future years and, as a result, increased consumer choice.

In order to implement a reinsurance program, North Carolina is seeking to waive Section 1312(c)(1) of the ACA to the extent that it impacts market-wide index rate development effective January 1, [2027] and for an initial period of five years. Waiver of Section 1312(c)(1) is necessary to allow issuers to include expected reinsurance payments as they develop their market-wide index rates – which is a condition of participation in the reinsurance program and necessary for rate savings to be realized.

III. Description of Section 1332 Waiver Proposal

The proposed North Carolina reinsurance program has been modeled largely on the Federal Transitional Reinsurance Program that operated in the individual market from 2014 through 2016 under Section 1341 of the ACA. Like the Federal program, North Carolina's reinsurance program would operate under an attachment-point based model.

Authorizing Legislation

North Carolina [enabling legislation] was signed into law by Governor [Roy Cooper on [DATE]], directs the [NCDOI or another agency to be determined] to establish a market stabilization program, such as a reinsurance program, for the State's individual market if doing so is supported by actuarial experts retained by [NCDOI]. Under the statute, the program would be administered by [NCDOI or another agency to be determined].

[Enabling legislation], also authorizes the State to apply for a Section 1332 Waiver and specifically directs the NCDOI to do so if such action is supported by the recommendations of actuarial experts. As outlined in a report issued to the NCDOI and attached as Appendix B, [Actuarial consultant's report] found that

implementing a reinsurance program would result in both premium savings and increased enrollment. [Enabling legislation] provides that the reinsurance program may be implemented *if* such waiver is approved by the Federal government. As such, the reinsurance program will only be implemented if the Section 1332 Waiver is granted.

[Enabling legislation] provides that [NCDOI or another agency to be determined] may develop a plan of operation to support the affordability and accessibility of health insurance in North Carolina's individual health insurance market. As a result, [NCDOI or another agency to be determined] has developed a Reinsurance Risk Mechanism Plan of Operations that includes the Section 1332 Waiver program within the individual health insurance market.

Based on the findings that a Section 1332 Waiver is necessary to draw down Federal pass-through funding to support the reinsurance program, North Carolina has developed this waiver application as required by State law and as outlined above.

The State funding to support the reinsurance mechanism would be derived from an insurance assessment for which [NCDOI or another agency to be determined] has authority pursuant to [enabling legislation], which provides [NCDOI or another agency to be determined] with those powers and duties. The [enabling legislation] specifically directs [NCDOI or another agency to be determined] to assess issuers who offer comprehensive, major medical plans in North Carolina's individual market that are part of the single-risk pool, to fund the State share to support the reinsurance program. Assessments for the reinsurance program would begin accruing January 1, [2027].

See Appendix A for a complete copy of the legislation discussed above.

Reinsurance Program Structure

The North Carolina reinsurance program, if the Section 1332 Waiver is approved, would be administered by [NCDOI or another agency to be determined].

Like the Federal Transitional Reinsurance Program, North Carolina's reinsurance program would function as an invisible reinsurance program, in that enrollees would remain in their current health insurance plan in the single risk pool individual market. Issuers would receive reimbursement from the reinsurance program based on their liability for high-cost claims with funding allocations determined based on attachment-point reinsurance parameters. Enrollees would not be aware that claims were being reimbursed by the reinsurance pool as the reimbursement would be completed on the backend of the process without coverage being ceded or consequences otherwise to the enrollee.

The program would reimburse issuers who offer comprehensive, major medical plans in North Carolina's individual market that are part of the single-risk pool. Grandfathered and transitional plan claims would be excluded, but reinsurance would be available for both on and off Exchange single risk pool claims. Payments to issuers would be calculated based on a percentage (coinsurance percentage) of the annual claims that issuers incur for coverage under such plans between a specified lower threshold (attachment point) and upper threshold (reinsurance cap). The reinsurance parameters would be determined each year by NCDOI by February 1 of the prior year.

For the [2027] Plan Year, the State is anticipating a reinsurance program with an attachment point of [$50,000 and a target reinsurance cap of $250,000]. The target coinsurance percentage for [2027] would be [80 percent]. However, the coinsurance amount and the cap would not be finalized until all funding and requests for reimbursement have been reviewed. The State has committed that all funding collected for the reinsurance program would be paid out (for payments to issuers and for program administration) for the year for which it is collected, and no additional State funds would be provided. The State understands that actual values of revenue, funding, and amounts eligible for reimbursement may differ from projected amounts. Therefore, after the total funding available (inclusive of State and Federal funding) is confirmed and the total amount of payments due based on eligible claims has been determined, the coinsurance rate would be finalized in order to ensure reinsurance reimbursements and administrative costs do not exceed the funding available for the applicable plan year based on the static funding parameters outlined below. Similarly, the target coinsurance rate may be increased as necessary to ensure that all funds collected are expended. If, for any year, the coinsurance rate is adjusted to 100% and available funding continues to exceed coinsurance payment amounts, the State would adjust the reinsurance cap.

Final payments to issuers would be based on all claims incurred in the applicable program year and adjudicated and paid by June 30th of the following year. [NCDOI or another agency to be determined] would calculate an initial, partial payment allocation due to each issuer based on information received in EDGE Server summary reports for which [NCDOI or another agency to be determined] intends to contract with CMS. [NCDOI or another agency to be determined] would also collect summary claims information from issuers following the close of the applicable program year (claims incurred in the applicable year and paid by June 30 of the following year). This summary claims data would be used to determine the final payment allocation percentages due to each issuer. These final payment allocation percentages would be authenticated based on a comparison to the EDGE Server summary reports, and issuers may be asked to submit additional claims information to substantiate their data if there are discrepancies. Again, as detailed above, if total payments based on the target reinsurance amount exceed funding

available or vice versa, the coinsurance rate – and possibly the cap – would be adjusted to ensure the two amounts match.

The State would revisit reinsurance parameters on an annual basis based on modeling of the assessment adequacy and annual projections of claims for the following program year. It is estimated that [NCDOI or another agency to be determined] would announce the parameters to be used for the future plan years to issuers and members of the public by no later than February of the prior year.

It is estimated that the reinsurance program would lower premiums in the individual market by an average of approximately [21 percent] compared to if no program were in effect.

While issuers with plans in the individual single-risk pool market would not be held to a specific rate decrease relative to the reinsurance program, they would be required to reflect the fact that there is a mechanism in place from which they would receive reimbursement and to factor their estimate of rate impact into rates in order to participate in the program.

In utilizing the parameters described, as with the federal Transitional Reinsurance Program, it is expected that issuers would continue to have incentives to apply their care management practices across all claims. This is because it is intentionally expected that issuers would be reimbursed for only a portion of a given member's claim costs and only for those claims between the attachment point and reinsurance cap. However, with the goal of ensuring cost-effectiveness and being prudent with public funds, as a condition of participation in the reinsurance program, issuers would be required to have care management programs in place and to submit descriptions of their care management programs initially and to provide timely updates (no less than annually) to [NCDOI or another agency to be determined].

The State reserves the right to make program changes within the parameters of the waiver approval and will do so by August 1st of the year prior to when those changes would be effective.

Reinsurance Program Funding

The sources of funding for the proposed reinsurance program would be as follows:

1) A premium assessment to be applied to issuers across the health insurance market.

As noted above, [NCDOI or another agency to be determined] would impose a per exposure (per member per month) assessment that applies to all licensed issuers

across the State's health insurance markets. This State funding would fund the costs of the program which are not financed by the federal pass-through funding.

[The calculation of the State assessment would be fixed at 60 basis points (0.6 percent) of the prior year's Second Lowest Cost Silver Plan (SLCSP) without-waiver rate. As such, the assessment is expected to change each year, and the assessment for a given year can be calculated as soon as the SLCSP premium for the prior year is known (at this point, by November of two years prior to the applicable year). NCDOI expects the assessment base to be relatively stable and assumes that the assessment rate will increase in proportion to the assumed increases in State funding projected.]

[Based on the SLSCP rate for [TBD] the assessment would be [TBD] per member per month. Based on an assessment base of approximately [TBD] lives, the assessment is estimated to raise $[TBD] to fund claims cost.]

2) Federal pass-through funding provided in response to this waiver application.

Through this Section 1332 Waiver application, North Carolina is requesting that the Treasury "pass-through" to the reinsurance program the cost savings from reduced federal outlays for PTCs as provided for under 1332(a)(3) of the ACA. PTCs are calculated based on the premium for the SLCSP. Therefore, the reduction of the premiums for the SLCSP that will result from the reinsurance program will directly reduce the cost of PTCs. The pass-through funding amount would be reduced by the decrease in Exchange use fees resulting from premium reductions. [The State estimates that it will be eligible for [pass-through amounts to be determined], as outlined in Appendix B. This funding would be used jointly with the State funding to reimburse eligible claims under the reinsurance program.]

IV. Compliance with Section 1332 Guardrails

The NCDOI retained [Actuarial consultant] to address the actuarial analysis, actuarial certifications, economic analysis and data and assumptions requirements for the North Carolina Section 1332 Waiver. [Actuarial consultant] collected data from all issuers offering individual coverage in North Carolina's Marketplace to develop the analysis.

As detailed in [Actuarial consultant's report] in Appendix B, North Carolina's proposed waiver program was designed to comply with the required "guardrails" for Section 1332 Waivers outlined in the ACA. Specifically, and as addressed below, North Carolina's proposed reinsurance program would satisfy the requirements relative to ensuring that health care coverage remains comprehensive, affordable and accessible to North Carolinians and that the waiver would not increase the federal deficit.

Comprehensiveness of Coverage (1332(b)(1)(A))

ACA Section 1332(b)(1)(A) requires that coverage available after implementation of the waiver must be at least as comprehensive in regard to covered benefits (measured by the extent to which that they satisfy ACA Essential Health Benefit (EHB) requirements) as would be available without the implementation of the Section 1332 Waiver. The proposed waiver cannot make alterations that diminish the scope of benefits offered and cannot result in a decrease in the number of individuals with access to affordable coverage that meets the EHB requirements.

North Carolina's Section 1332 Waiver would not alter the required scope of benefits offered in the individual insurance market, including relative to the ACA EHB requirement under section 2707 of the Public Health Service Act as well as state mandated benefits. As such, the comprehensiveness of coverage guardrail is satisfied. Furthermore, the waiver would increase the number of individuals that enroll in coverage (as outlined below) that meets both the existing State and Federal requirements. The waiver would have no material impact on comprehensiveness of group coverage or public programs.

Affordability of Coverage (1332(b)(1)(B))

ACA Section 1332(b)(1)(B) requires that the cost of comprehensive (EHB-compliant) coverage and access to cost-sharing protections against excessive out-of-pocket spending must be at least affordable as would be available without the implementation of the Section 1332 Waiver. The proposed waiver cannot decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending or otherwise result in a decrease in affordability for individuals. For the purposes of this guardrail, "affordability" is based on state residents' net out-of-pocket spending, including relative to premium contributions, cost sharing and spending on non-covered services.

North Carolina's Section 1332 Waiver would not require or encourage issuers to alter their plans' cost-sharing designs or network coverage. Furthermore, North Carolina's Section 1332 Waiver is designed and expected to reduce premium rates in the individual market. As outlined in Appendix B, in the first year of the waiver, premiums are projected to be approximately [21] percent less expensive than they would be without the waiver. As a result, if approved, North Carolina's Section 1332 Waiver is expected to make coverage more affordable for those who pay the full cost of comprehensive (EHB-compliant) insurance in the individual market and would not raise the cost of coverage for those receiving PTCs. The waiver would have no material impact on premiums, cost sharing and other costs relative to group coverage or public programs.

Scope of Coverage (1332(b)(1)(C))

ACA Section 1332(b)(1)(C) requires that, under a Section 1332 Waiver, coverage must be available to at least a comparable number of the State's residents as would have been covered absent the waiver.

North Carolina's Section 1332 Waiver does not alter the scope of available coverage and will not alter its availability. [Actuarial consultant] estimates that reduced premiums will result in more individuals retaining coverage, rather than dropping coverage due to unaffordable premium rates. The waiver would have no material impact on enrollment in group coverage or public programs.

Deficit Neutrality (1332(b)(1)(D))

ACA Section 1332(b)(1)(D) requires that a Section 1332 Waiver must not increase the Federal deficit in each year of the waiver and over a 10-year budget period. The proposed waiver cannot result in increased spending or administrative or other expenses to the Federal government. All changes in Federal revenues and outlays resulting from an approved Section 1332 Waiver must be considered.

North Carolina's Section 1332 Waiver would not increase Federal spending or administrative or expenses and, as such, would not increase the Federal deficit. The reinsurance program proposed in North Carolina's Section 1332 Waiver would seek pass-through funding that is equal to, and not greater than, the amount of additional money in PTCs that the Treasury would otherwise pay without a reinsurance program under a Section 1332 Waiver. The funding would result from savings to PTCs due to lower premium amounts, offset by the corresponding reduction in projected revenue from Exchange User Fees. As a result, Federal expenditures would not be expected to change as a result of the waiver.

V. Advancement of Section 1332 Principles

North Carolina's proposed Section 1332 Waiver would advance the Federal principles for Section 1332 Waivers: providing increased access to affordable private market coverage; encouraging sustainable spending growth; fostering state innovation, supporting and empowering those in need; and promoting consumer-driven healthcare.

Provide Increased Access to Affordable Private Market Coverage

As noted above, the reinsurance program established under North Carolina's Section 1332 Waiver would reduce premium rates and the contributions made by a number of North Carolinian, specifically those individuals who purchase insurance on the individual market without subsidy. As such, private health insurance would

be both more affordable and, in turn, more accessible to those individuals. By stabilizing the individual insurance market, the reinsurance program is also geared toward maintaining issuer participation and competition in the market which benefits all enrollees.

Encourage Sustainable Spending Growth

The proposed reinsurance program would reduce individual market premiums and would encourage healthier people to participate in the pool. This would result in lower cost coverage which would in turn result in more sustainable federal spending (PTCs and waiver funds).

Foster State Innovation

With input from stakeholders and the North Carolina legislature and based on the findings outlined by [Actuarial consultant], [NCDOI or another agency to be determined] has determined that a state-based, attachment point reinsurance program meets the State's needs for stabilizing the individual insurance market, lowering premium rates and increasing enrollment. [In particular, the State heard from issuers that this model, as compared to others considered, would have the largest impact on rates with the least need from conservatism in factoring program impact into their rate development]. Through that exercise and this waiver, North Carolina has designed a program with unique features specifically geared to the State's conditions and needs.

Support and Empower Those in Need

North Carolina's proposed Section 1332 Waiver is expected to support and empower those in need by supporting and expanding access to health insurance. While premium rates and enrollment may not be impacted for the most vulnerable North Carolina residents, they would be impacted for a group that is vulnerable when it comes to health insurance coverage – those residents that neither have access to group coverage nor premium assistance. Additionally, by stabilizing the individual market, as outlined above, the State would help to ensure that all North Carolina residents that purchase private coverage through the individual market – including those with PTCs – have multiple options from which they can choose for coverage.

Promote Consumer-Driven Healthcare

As noted above, by increasing the affordability of health insurance premiums in the individual market and supporting the stability of that market, North Carolina's Section 1332 Waiver supports the continued opportunity for Granite Staters to not only purchase insurance but to also have the ability to choose between multiple insurance options to find the plan that best meets their individual needs.

VI. Draft Waiver Implementation Timeline

With the proposed waiver, the State is not seeking any new services or potential changes to the current roles and responsibilities of the State or Federal government and would continue to utilize a FFM model with Qualified Health Plans (QHPs) being sold on the Federally-facilitated Marketplace.

North Carolina would seek to achieve the following timeline and key milestone dates in order to effectuate a Section 1332 Waiver program:

DATE	DESCRIPTION
June 16, 2025	State Public Waiver Notice released, and 30-day State Public Comment Period opens
June 30, 2025	First Public Hearing held
July 2, 2025	Second Public Hearing held
July 15, 2025	State Public Comment Period closes
July 30, 2025	North Carolina Section 1332 Waiver application submitted to the Federal government
July/August 2025	Federal government determines waiver application is complete; Federal Approval and 30-day Public Comment Period open
August/September 2025	Federal Public Comment Period closes
August/September 2025	Anticipated Federal approval date
August 15, 2025	Anticipated deadline for Individual QHP rate filings for 2026 Plan Year
August 20, 2025	Expected date for NCDOI to finalize 2026 rates
September 15, 2025	Expected date by which CMS sends certification notices to issuers for 2026 Plan Year
November 1, 2025	Expected start date for Open Enrollment
January 1, 2026	2026 Plan Year begins
August 15, 2026	Individual QHP rate filing deadline for 2027 plan year
August 20, 2026	Expected date for NCDOI to finalize 2027 rates
September 15, 2026	Anticipated date by which CMS sends certification notices to issuers for 2027 Plan Year

September 15, 2026	NCDOI sends pass-through report to Federal government for 2027 Plan Year
November 1, 2026	Expected start date for Open Enrollment
November 1, 2026	Assessment amounts for upcoming plan year would be released by NCHP
January 1, 2027	2027 Plan Year begins
April 2027	Federal government makes pass-through funding for program year 1 available to State
April 15, 2027	State submits first quarterly report to Federal government
May 2027	First assessment payment made from issuers to the State (to continue quarterly)
June 15, 2027	State holds required six-month public forum post implementation of the Section 1332 Waiver per 45 CFR 155.1230(c)
July 15, 2027	State submits second quarterly report to Federal government
August 15, 2027	Individual QHP rate filing deadline for 2028 plan year
August 20, 2027	Expected date for NCDOI to finalize 2028 rates
September 15, 2027	Anticipated date by which CMS sends certification notices to issuers for 2028 Plan Year
September 15, 2027	NCDOI sends pass-through report to Federal government for 2028 Plan Year
Fall 2027	State begins to receive monthly EDGE reports from CMS
October 15, 2027	State sends third quarterly report to Federal government
November 1, 2027	Expected start date for Open Enrollment
November 1, 2027	Assessment amounts for upcoming plan year would be released by NCHP
January 1, 2028	2028 Plan Year begins
March 15, 2028	State submits first annual report to Federal government

April 2028	Federal government makes pass-through funding for program year 1 available to State & State receives final EDGE report from CMS for 2027 payment year
June 2028	Issuer submission deadline for NC claim template
June - October 2028	Anticipated calculation and State review period for claims incurred in the 2027 Plan Year
June 30, 2028	Anticipated date for initial, partial payment to issuers for claims incurred in the 2027 Plan Year
October 31, 2028	Anticipated date for 2nd and final payment to issuers for claims incurred in the 2027 Plan Year

VII. Other Requirements

Administrative Burden

North Carolina's Section 1332 Waiver would cause no additional administrative burden to employers or individual consumers because the reinsurance program proposed by North Carolina does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Consumers would experience no changes related to this waiver and would continue to purchase and receive premium tax credits in accordance with current Federal eligibility standards.

The administrative burden to health insurance issuers associated with submitting limited data to North Carolina would be minimal. It is anticipated the reporting and compliance burden for issuers would be minimal as the State would utilize existing data reporting templates submitted through the EDGE Server, which issuers are currently utilizing for Federal risk adjustment purposes. However, issuers would incur a cost for the financing of the reinsurance program under North Carolina's Section 1332 Waiver in the form of the previously-described premium assessment.

The waiver is expected to cause minimal administrative burden and expense to the State and Federal governments.

The State of North Carolina would have the resources to conduct the administrative tasks required for a reinsurance program under a Section 1332 Waiver:

1) Administration of the reinsurance program;
2) Collection and application for pass-through funding;
3) Monitoring of compliance with State and Federal law;
4) Collection and analyses of data related to the Section 1332 Waiver;
5) Performing reviews and implementation of the Section 1332 Waiver; and
6) Submitting any annual, quarterly, or other required reports to the NCDOI, State legislature, [state-based exchange], CMS, and/or Treasury.

The Section 1332 Waiver would require the Federal government to perform the following administrative tasks, which are minimal in comparison to duties currently performed by the Federal government:

1) Review documented complaints, if any, related to the Section 1332 Waiver;
2) Review State reporting;
3) Evaluate the State's Section 1332 Waiver and reinsurance program;
4) Calculate and facilitate the transfer of pass-through funds; and
5) [Allow the use of the EDGE Server to calculate reinsurance payments. If allowed, the [NCDOI or another agency to be determined] would provide the Federal government, through written communication, with the applicable reinsurance parameters for each plan year to be used for calculating issuer reimbursements under the reinsurance program and would compensate the Federal government for that service.]

[There are no changes proposed to the current roles and functions of the Federally-facilitated Marketplace on behalf of North Carolina.]

Impact on Other ACA Provisions

The proposed reinsurance program to be implemented if North Carolina's Section 1332 Waiver is granted would have no impact on other provisions of the ACA.

Impact on Access to Out-of-State Services

Granting this waiver request would not have an impact on issuer networks or service areas when coverage is provided for services performed by out-of-state providers.

Compliance, Fraud, Waste, and Abuse

NCDOI is responsible for monitoring and requiring issuer compliance with all applicable market conduct standards and for ensuring the solvency of all issuers through continual monitoring and analysis of issuer reporting. This includes the performance of market conduct analysis, exams and investigations. NCDOI also

provides consumer outreach and protection through response to consumer inquiries and complaints.

Under the proposed waiver structure, [NCDOI or another agency to be determined] would administer the reinsurance program in accordance with its existing compliance and auditing procedures. In addition, [NCDOI or another agency to be determined] would be responsible for establishing procedures for the handling and accounting of program assets and monies, as well as for an annual fiscal reporting. An appeals process will be made available to issuers.

The Federal government would be responsible for calculating the savings from this waiver and for ensuring that the waiver does not increase Federal spending.

Provision of Information Necessary to Administer Waiver at Federal Level

[In addition to providing the required reporting information (discussed in Section VIII which follows), if allowed to use the EDGE Server to calculate reinsurance payments, NCHP would provide the Federal government with the applicable reinsurance parameters to be used for calculating issuer reimbursements under the reinsurance program for each plan year through written communication and by no later than February 1st of the year following the applicable plan year.]

VIII. State Reporting Requirements and Targets

The State would be responsible for the reporting requirements of 45 CFR 155.1324,9F10 including the following:

1) Quarterly reports: [NCDOI or another agency to be determined] would be responsible for submitting quarterly reports, including reports of operational challenges, if any, and plans for and results of associated corrective actions, as applicable. As outlined in the implementation timeline, it is expected that the first quarterly report would be submitted in April 2027.

2) Annual reports: [NCDOI or another agency to be determined] would be responsible for submitting annual reports, including the following:

a. The progress of the Section 1332 Waiver;
b. Data on compliance with 1332(b)(1)(A) through (D) (i.e., the four Section 1332 guardrails) of the ACA, consistent with the data being used to support this application's finding as required under 45 CFR 155.1308(f)(4);10F11
c. A summary of the annual post-award public forum (anticipated to be held in June [2027]), in accordance with 45 CFR 155.1320(c),11F12

including all public comments received on the progress of the waiver and action taken in response to such concerns or comments;

d. Other information consistent with the State's approved terms and conditions; and

e. Any modifications from Federal or State law (given there is no change to the provision of the ten Essential Health Benefits).

45 CFR 155.1324(c)12F13 indicates that a draft annual report must be submitted to the Secretary no later than 90 days after the end of each waiver year or as specified in the waiver's terms and conditions. [NCDOI or another agency to be determined] is expected to submit the first annual report on or about March 15, [2028].

3) Second Lowest Cost Silver Premium: NCDOI would provide the actual SLCSP premium under the waiver and an estimate of the premium as it would have been without the waiver, for a representative consumer in each rating area, on an annual basis. As outlined in the timeline, this information is expected to be provided for the first time on September 15, [2026], and in accordance with the waiver's terms and conditions, for all subsequent years of waiver operations.

IX. Public Comment Period

Public Comments

On [June 16, 2025], the NCDOI commenced a public comment period on this waiver request. On that date, the NCDOI posted notice of the opportunity to comment and access to the State's draft waiver application on its website [link]. The NCDOI also issued notices to three major, local newspapers ([TBD]) and via NCDOI's email distribution list which includes stakeholders and members of the public across the state. All notices are provided in Appendix C.

On [June 30, 2025], the NCDOI held the first webinar public hearing regarding the waiver. In attendance were [TBD]. The full attendee list is included in Appendix D. The full list of questions and state responses from the hearing are included in Appendix F. The hearing was recorded, and the recording can be accessed on the NCDOI website.

On [July 2, 2025], the NCDOI held a second webinar public hearing regarding the waiver. In attendance were [TBD]. The full attendee list is included in Appendix E. None of the attendees shared comments at the hearing, however, two questions were asked regarding rate development and expected rate reductions. The full list of questions and state responses are included in Appendix F.

During the public comment period, the NCDOI also received [TBD] written comments from members of the public. All comments are included in Appendix G

and also summarized with the state's response below. The public comment period remained open for 30 days and closed at the end of the day on [July 15, 2025].

Summary of Comments Received and State Response:

[to be determined]

Tribal Consultation

[to be determined]

Other Stakeholder Input

As part of the required State process, the State began consulting key stakeholders ahead of the public input process in the early phases of developing the waiver. As required under state statute, NCDOI consulted the [to be determined]

Appendix

Appendix A: Enabling Legislation
Appendix B: Actuarial Consultant's Report
Appendix C: Notice of Public Comment Period, Waiver Informational Presentation
Appendix D: Registration Report: [June 16, 2025] Public Hearing
Appendix E: Registration Report: [June 30, 2025] Public Hearing
Appendix F: Public Comments and Questions from the Public Hearings
Appendix G: Written Public Comments Received