North Carolina Department of Insurance
Market Reform Technical Advisory Group In-Person Meeting #6
Monday, April 9, 2012
FINAL Version – Approved by the TAG via email

Meeting Attendees	Organization
TAG Members and NC DOI Project Team	
George Teague	Aetna Health Inc.
Joe Winn (*by phone*)	Aetna Health Inc.
Barbara Morales Burke	Blue Cross Blue Shield of North Carolina
Jeff Tindall	CIGNA Healthcare of North Carolina, Inc.
Tracy Baker	Wellpath/Coventry
Ken Lewis	FirstCarolinaCare Ins. Co. Inc.
Craig Humphrey	FirstCarolinaCare Ins. Co. Inc.
David Contorno	Independent Insurance Agents of NC
Allison Garcimonde	Manatt
Melinda Dutton	Manatt
Sharon Woda	Manatt
Teresa Gutierrez	NC Assoc. of Health Underwriters
Fred Joyner	NC Assoc. of Insurance and Financial Advisors
Mike Kelly	NC Business Group on Health
Vinny Longobardo	NC Business Group on Health
Rebecca Whitaker	NC Community Health Center Association
Allen Feezor	NC Department of Health and Human Services
Ben Popkin	NC Department of Insurance
Carla Obiol	NC Department of Insurance
Jean Holliday	NC Department of Insurance
Julia Lerche	NC Department of Insurance
Lauren Short	NC Department of Insurance
Louis Belo	NC Department of Insurance
Mike Wells	NC Department of Insurance
Rosemary Gillespie	NC Department of Insurance
Ted Hamby	NC Department of Insurance
Walter James	NC Department of Insurance
Yolanda Fonville	NC Department of Insurance
Michael Keough	NC Health Insurance Risk Pool, Inc./dba Inclusive Health
Pam Silberman	NC Institute of Medicine
Adam Linker (*by phone*)	NC Justice Center
Conor Brockett	NC Medical Society
Tammy Tomczyk	Oliver Wyman
Dianna Welch *(by phone)*	Oliver Wyman
Mark Hall *(by phone)*	Wake Forest University
Peter Chauncey	Wellpath/Coventry
Interested Parties	
Andy Landes	H-PACT

Meeting Attendees	Organization
Barbara Foley	Maximus
Ryan Blackledge	NC General Assembly
Amy Jo Johnson	NC General Assembly
Randall Madry *(by phone)*	Schooner Healthcare Services
Flo Stein (*by phone*)	NC DHHS – MH/DD/SAS

Agenda

- Welcome and Introductions
- Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG
- Overview of Essential Health Benefits (EHBs)
  - ACA Statute
  - CCIIO Guidance
  - Stakeholder Perspectives
- Analysis of EHBs in North Carolina
  - Benchmark Plan Comparison
  - Outlier Identification & Analysis
  - TAG Discussion on Analysis
- Discussion of EHBs Selection Process in North Carolina
  - *Should North Carolina define the benchmark package or defer to the federal selection process?*
  - *If North Carolina should define the benchmark package, who should provide input into the decision-making process?*
- Review of TAG #5 Meeting Minutes
- Discussion on Most Favored Nation (MFN) Issue
  - Statement Review and Discussion
- Wrap Up and Next Steps

Please refer to the April 9 "TAG In-Person Meeting #6" Slide Deck.

Welcome and Introductions

Ted Hamby of the North Carolina Department of Insurance ("DOI" or "the Department") convened the meeting at 12:30 PM and welcomed meeting attendees. Mr. Hamby asked attendees, including those participating by phone, to introduce themselves to the group. Mr. Hamby then turned the floor over to Sharon Woda of Manatt for a review of the overall project timeline/objectives of the day's meeting discussion.

Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG

Ms. Woda briefly reviewed the overall project timeline and the work plan for the TAG's first phase of work (*see slide deck for additional details*). Ms. Woda noted that the TAG's first phase of work would be ending in the coming days and that members would be advised of the plan for the second phase of work, tentatively slated to take place from June through the end of the year, during which the TAG will assess remaining issues and prepare for the 2013 session of the North Carolina General Assembly (NCGA).

Ms. Woda then reviewed the goals for the day's meeting which included:

- Understand the Essential Health Benefit Options for North Carolina
- Validate Analysis Undertaken Related to Essential Health Benefits
- Identify Points of Consensus for Next Steps Related to Essential Health Benefits
- Confirm TAG #5 Meeting Minutes
- Continue Most Favored Nation Discussion and Agree to a Statement

Ms. Woda briefly reviewed the TAG Statement of Values, reminding the group that the statement is meant to guide their deliberations and serve as a lens through which to assess the policy options under consideration, while recognizing that any given policy option will not necessarily be capable of meeting every value listed.

Ms. Woda then turned to provide an overview on Essential Health Benefits (EHBs).

Overview of EHBs

Ms. Woda provided a high-level overview of the statutory and regulatory requirements for EHBs (*see slide deck for additional details*). EHBs include ten benefit categories which must be covered in all non-grandfathered benefit plans in the individual and small group markets starting in 2014, including Qualified Health Plans (QHPs) offered through the Exchange. EHBs serve as the minimum requirements for plan offerings; insurers may offer more benefits than EHBs. Cost sharing requirements are separate and apart from the definition of EHBs. States are required to pay for any state mandated benefits that are not included in EHBs for enrollees of QHPs.

Ms. Woda reviewed relevant federal guidance related to EHBs. The EHB Bulletin, released by HHS in December 2011 to guide implementation in 2014 and 2015, tasked states with defining EHBs for these first two years. States are given up to 10 benchmark plans as options from which to choose, including: small group plans (largest plan by enrollment in each of the three largest small group insurance products); state employee plans (three largest state employee plans by enrollment); federal employee plans (three largest federal employee plans – FEHBPs – by national enrollment); and an HMO (the largest insured commercial – i.e., non-Medicaid – HMO in the state). States must select one benchmark from these options that will apply to both the individual and small group markets, inside and outside of the Exchange. States may also refrain from choosing a benchmark plan and instead defer to the federal default option; the federal default is the largest plan by enrollment in the largest product in the state's small group market.

Ms. Woda next reviewed the EHB selection process as outlined in the EHB Bulletin. If a state elects to choose a benchmark, it must first select a benchmark plan from one of the eligible plans in the state; then supplement the selected plan for any of the ten required EHB categories that are not included in the benchmark; and, finally, oversee insurers' adjustment of benefits for specific services covered and/or any quantitative limits, within and potentially across benefit categories, to ensure that any adjustments are actuarially equivalent to the EHBs.

Ms. Woda concluded the overview by reviewing the timelines and considerations for decision-making related to EHBs, emphasizing the narrow window of time in which states must decide

whether to exercise the benchmark selection option or defer to the federal default option, and noting the diverse stakeholder perspectives related to states' selection of a benchmark plan.

Ms. Woda then asked Melinda Dutton of Manatt to frame the TAG's assessment of the preliminary analysis of EHBs in North Carolina and the group's discussion related to EHBs.

Analysis of EHBs in North Carolina

Ms. Dutton introduced the analysis of EHBs in North Carolina by noting that the TAG is being asked to: weigh in on the analysis conducted to date, including assumptions made during the analysis; make recommendations on additional analysis needed, if any; and discuss any considerations stemming from the analysis. Ms. Dutton emphasized that the TAG is being asked to weigh in on the process for selecting a benchmark plan, and is not being asked to select a benchmark plan or to discuss or advocate for a specific benefit for inclusion/exclusion in the benchmark package. Ms. Dutton then asked Tammy Tomczyk of Oliver Wyman to provide an overview of the analysis of EHBs in North Carolina to date.

Ms. Tomczyk first provided an overview of the plans eligible for benchmark status in North Carolina and summarized the analysis conducted to date on these identified plans (*see slide deck for additional details*). Benefits were compared across the benchmark plans to identify differences across them, including holistic pricing to compare high-level cost differences. Next benefit "outliers" were identified (i.e., benefits that are included in some, but not all, of the eligible plans) as a method for evaluating the various benchmark options; the list of outliers was further narrowed down based on which are of relatively high cost and/or high frequency. Finally, selected benefit outliers were analyzed in terms of the financial, medical and social impact of including/excluding them as part of a state EHB package.

Ms. Tomczyk noted that the comparison of benefits across benchmark plans showed variations in benefits (or levels of coverage) across plans, but preliminary holistic pricing analysis of plans eligible for benchmark status in the state showed minimal differences in total cost across plans. Ms. Tomczyk next provided details on the process of selecting benefit outliers for further analysis.

Ms. Tomczyk identified the following as the assumptions underlying the analysis to date: 1) the state will want to avoid costs associated with covering mandated benefits not in the EHB package (which would result in the exclusion of FEHBP plans for further consideration) and 2) cost and frequency were the primary considerations used to narrow the list of outlier benefits for additional analysis. The TAG was then asked to validate these assumptions (i.e., to answer 1) whether plans that exclude state-mandated benefits should be taken off the table for further consideration as a benchmark plan and 2) whether costs and frequency are the appropriate considerations to narrow the list of outliers).

- Several TAG members representing potential benchmark insurers noted a few instances in which the analysis improperly characterized one of their plans as covering/not covering a service. NC DOI project staff responded that the analysis to date is preliminary and based only on a review of insurer's benefit booklets, and assured members that insurers would be given

the opportunity in the near-term to validate related data before additional analysis is conducted.

- The TAG discussed the assumption that the state (particularly the NCGA) would want to avoid costs associated with covering mandated benefits not in the EHB package (which would have the effect of compelling the state to either choose a benchmark option that contains all state-mandated benefits, or repeal state benefit mandates that are not included in the benchmark option). A few TAG members noted that some members of the NCGA may not be in favor of government mandates and, while recognizing the associated political difficulties of rescinding existent mandates, may use this as an opportunity to justify the elimination of some state-mandated benefits. Others cautioned that it was very difficult to predict how the NCGA would approach the issue, particularly in light of the fact that many of the mandates at issue were put into statute due to the advocacy of special interest groups within the state, organizations which would likely mobilize against rescinding particular benefit mandates. However, members also generally agreed that due to the current budget situation, it is likely that the state would prefer to avoid additional costs associated with mandated benefits not included in the state benchmark plan. The group ultimately agreed that it was not possible to make clear-cut assumptions on how the NCGA would assess and act on the issue of EHBs, and that this may lessen its usefulness as a methodological component of the EHB analysis.
- The TAG discussed whether it was appropriate to exclude FEHBPs as part of the benchmark plan options under consideration, based on the fact that they do not include all state-mandated benefits. Members also noted that the FEHBPs were on average more costly than the other potential benchmark options (even when state-mandated benefits, which were added for the sake of performing the holistic pricing analysis, are removed from the benefit package). While agreeing that lack of coverage of all state mandates in FEHBPs combined with their higher relative pricing make them a less attractive benchmark option, members did not conclude that the FEHBP options should be excluded from future analysis.
- One member asked whether it had been confirmed that the state employee health benefit plans (SEHBPs) in fact include all state mandated benefits, as they are not subject to all of these mandates. Representatives of the NC DOI responded that they were fairly confident that SEHBPs include all state mandated benefits, but would confirm this for the purposes of continued future analysis.

Discussion of EHBs Selection Process in North Carolina

Please note that the "Consensus Points" listed in this section are in DRAFT form only and will be reviewed by the TAG at its next meeting; any modifications to these draft consensus points by the TAG prior to TAG approval will be detailed in a revision to the TAG #6 meeting notes, since another TAG will not be convened until the Summer.

Should North Carolina define the benchmark package or defer to the federal selection process? If North Carolina should define the benchmark package, who should provide input into the decision-making process?

- The TAG discussed the relative advantages and disadvantages of the state defining the benchmark package. Several members noted that, as mentioned in prior TAG meetings, the

North Carolina market is unique and therefore merits state control over defining the benchmark package in order to ensure that it is tailored as much as possible to meet North Carolina's specific needs. The group identified various advantages associated with North Carolina defining its own benchmark, including the state's ability to make decisions/facilitate a state-based process for choosing benefit supplements to the EHB package (as the federal default option would otherwise impose a process for these supplements which may be different than the process North Carolina would undertake), and to monitor adjustments among plans based on the relative value of specific benefits.

- The TAG also considered the implications of deferring to the federal default option, with some members noting that because the federal default is defined as the largest plan (by enrollment) in the largest product in the state's small group market, it may in fact be a viable option for the state. These members posited that due to political reasons and issues related to cost/inclusion of state-mandated benefits addressed earlier by the group, the FEHBPs and SEHBP were less viable options to serve as the state benchmark (so that the truly viable options are really the top three small group plans in the state, which do not differ dramatically from one another). Accordingly, the primary reason to continue with additional analysis of the remaining benchmark options would be if there were serious concerns with Small Group Plan #1 (e.g., higher relative cost or the exclusion of benefits which the group feels are critical to include in the benchmark plan). However, other members noted that it was impossible to know whether there were concerns with Small Group Plan #1 without a more detailed assessment of its relative merits, noting that enrollment volume alone was an inadequate measure of plan quality and value.
- While recognizing that this may ultimately boil down to the state exercising its choice only to end up choosing the federal default option, members were still reluctant to defer to the federal default in the absence of further analysis of all the possible benchmark options (both for practical reasons – a desire to ensure the benchmark plan truly meets the state's needs – and political reasons – a concern over sending inaccurate signals to the NCGA that the group prefers deferring ACA policy decisions to the federal level).
- The TAG discussed what next steps would be required if the group recommends that the state define its own benchmark plan, including who in the state would have the authority to select the benchmark (e.g., the executive branch, the NCGA, the NC DOI). The group noted that if the preferred benchmark plan would result in additional costs to the state (because it does not include all state-mandated benefits), the NCGA may want to be involved. However, the group also noted that due to the very short window of time in which the state must decide whether to define the benchmark or defer to the federal default, it may be challenging to address the issue through legislation.

Consensus Point:

- The TAG **reached consensus** that North Carolina should further investigate the relative advantages of defining the benchmark package at the state-level, including through the TAG's continued analysis of the several plan options eligible for benchmark status in the state.

Ms. Dutton then turned to Ms. Woda for the TAG's review and approval of the TAG Meeting #5 meeting minutes.

Review of TAG #5 Meeting Minutes

Ms. Woda asked members to review the minutes from TAG Meeting #5, specifically calling the group's attention to each of the draft points of consensus related to risk adjustment and reinsurance programs in the state included in the notes. The group approved the meeting minutes, including all included points of consensus, as drafted.

Discussion of Most Favored Nation Issue

- TAG members reiterated their substantive concerns with Most Favored Nation clauses in provider contracts, noting their belief that in a post- ACA environment, MFN will severely limit: competition among carriers; consumer choice; the ability to implement innovations in benefit design, payment and care delivery; and could impact the long-term success and sustainability of the Exchange. Members also reiterated their belief that MFN clauses can negatively impact network expansion and produce an unlevel playing field, while prohibiting these types of contract clauses would encourage new competitors to enter the marketplace, aid consumers by promoting competition and lower rates, and help providers diversify their insurer mix and enjoy increased autonomy.
- The TAG reviewed the draft statement addressing MFN clauses *(see slide deck for additional details)*. Members debated the extent to which the MFN statement should be tied to implementation of the Affordable Care Act (ACA). Some members expressed concern that the statement was too tightly coupled with the ACA, which implies that the negative impact of MFN clauses would be eliminated in the absence of federal health reform law (i.e., if the ACA is repealed). Since the NCGA is currently considering a bill addressing MFN clauses separate and apart from the ACA, these two issues do not necessarily need to be grouped together. Other members countered that the reason for tying the MFN issue to the ACA in the statement was because the impact of MFN clauses becomes more of an imperative in a post-ACA environment, per the group's discussion at TAG Meeting #5. Some also noted that tying the statement to ACA-related considerations tied the issue to the TAG's scope and may provide a better opportunity for the statement to be reviewed by the NCGA.
- The group discussed how "consensus" was being defined in the context of the statement. Some members pointed out that only a very small number of TAG members had opposed the group's addressing the issue of MFN clauses. These members argued that while there was not unanimous agreement, it was fair to say that the group had reached consensus since the significant majority of members were in agreement. However, other members disagreed, and pointed to past TAG deliberations in which an inability to reach unanimous consent on an issue was characterized in TAG discussions and related meeting notes as a lack of consensus.
- A minority of members were opposed to the TAG's draft statement on the issue of MFN clauses. One member's primary reason for opposing the TAG issuing a statement on the MFN issue was based on concerns that the substance was outside of the TAG's purview and that development of the statement deviates from the TAG process to date (e.g., in past deliberations the group was presented with detailed, data-based analysis on both sides of an

issue to inform consideration rather than anecdotal evidence, lack of unanimous approval by members has to date meant lack of consensus, etc.). Another member echoed these procedural concerns, and also pointed out substantive concerns with the analysis of MFN clauses on which the statement is based. These concerns include: the impact of MFN clauses requires comprehensive, market-specific analysis and should not be based on speculation regarding what could potentially happen in the market after 2014; available evidence of MFN's impact on competition and price is limited and contradictory; MFNs may have positive impact by reducing costs for consumers; MFN-type clauses are common in other industries and existing federal and state law provide protection from their improper use. This member advocated for the inclusion of the minority's perspective to be captured in the meeting minutes and in the issue brief that will contain the TAG's statement on MFN clauses, in line with the TAG's past approach to other issues under the group's consideration.

- Several TAG members representing the provider community expressed concern over the last clause of the statement ("and other health care provider contract clauses which inhibit insurers' ability to negotiate service rates with health care providers"), which they deemed overly vague and therefore problematic. Members who had participated in developing the draft statement noted that the intent of the clause was to ensure that the full range of MFN-type clauses/contracting mechanisms were addressed by the statement. The group agreed that this part of the sentence was not critical to the statement and agreed to strike it from the statement.

Points of Consensus:

- There was consensus among a significant majority of TAG members to approve the statement on MFN clauses, pending the removal of the sentence on "other health care provider contract clauses" as described above.
- The group also agreed that the minority perspective (both with regard to the substantive and procedural concerns outlined above) should be noted in the meeting minutes and the related issue brief.

Wrap Up and Next Steps

Ms. Woda reviewed next steps as follows:

- TAG review of meeting minutes. Ms Woda reiterated that the minutes reflect points of consensus and considerations discussed during the meeting which will be used for developing related issue briefs, and that accordingly it is important that members carefully review the meeting notes. Ms. Woda also noted that the group would need to approve the minutes via email since it will not be meeting in-person again before the next phase of work begins.
- Review Issue Briefs. Ms. Woda stated that the group would be asked to specifically review: the new section in Issue Brief #1 on employer participation rate requirements in the SHOP; a new section in Issue Brief #2 on the MFN issue; and Issue Brief #3 in its entirety (as it will include all new material on Reinsurance and Risk Adjustment for the TAG's review).
- Review Essential Health Benefits output, once available. Ms. Woda stated that NC DOI project staff will assess next steps on EHBs coming out of today's meeting and circle back with the TAG with additional information.

TAG members are encouraged to send any additional feedback or suggestions to Allison Garcimonde (agarcimonde@manatt.com) or Lauren Short (lauren.short@ncdoi.gov) of the NC DOI.

The meeting was adjourned at 3:20 pm.