North Carolina Department of Insurance
Premium Rating Implementation (PRI) Workgroup Meeting
Wednesday, December 12, 2012
FINAL Version – Approved by the Workgroup via email

Meeting Attendees	Organization
Workgroup Members and NC DOI Project Team	
Barbara Morales-Burke	Blue Cross Blue Shield of NC
Brian Tajlili	Blue Cross Blue Shield of NC
Tracy Baker	Coventry Health Care of the Carolinas, Inc.
Peter Chauncey	Coventry Health Care of the Carolinas, Inc.
Craig Humphrey	FirstCarolinaCare Insurance Company, Inc.
Andy Landes	H-PACT
Allison Garcimonde	Manatt
Sharon Woda	Manatt
Joel Ario	Manatt
David Smith	NC Association of Health Underwriters
Yolanda Fonville	NC Department of Insurance
Rosemary Gillepsie	NC Department of Insurance
Ted Hamby	NC Department of Insurance
Jean Holliday	NC Department of Insurance
Walter James	NC Department of Insurance
Julia Lerche	NC Department of Insurance
Ben Popkin	NC Department of Insurance
Lauren Short	NC Department of Insurance
Mike Wells	NC Department of Insurance
Adam Linker	NC Justice Center
Tammy Tomczyk *(by phone)*	Oliver Wyman
Andrea Radford	UNC Rural Health Research & Policy Analysis Center
Robert Keis *(by phone)*	United Healthcare
Liz Crabill *(by phone)*	United Healthcare
Mark Hall	Wake Forest University

Agenda

- Welcome and Introductions
- Goals/Objectives of Workgroup and Today's Discussion
- Items for Discussion in PRI Workgroup
  - *Age Curve*
    - *Should the state accept the default age factors or submit a North Carolina-based age curve? If the latter, how should it be calculated?*
  - *Tobacco Rating*
    - *Should the state impose a standard tobacco rating factor (less than 1.5)? If so, what should the rating factor be?*
    - *If the state does not implement a standardized factor, how should insurers limit the tobacco rating factor to something lower than 1.5?*
    - *How should tobacco use be measured?*
  - *Geographic Rating Areas*
    - *How should geographic rating areas be calculated? Does the methodology change if the state is able to have more than 7 areas?*
- Wrap Up and Next Steps

Please refer to the December 12 "Premium Rating Implementation Workgroup" Slide Deck.

- The PRI Workgroup has been convened as a subgroup of the NC DOI's Technical Advisory Group ("TAG") to bring individuals together with specific technical expertise to help inform the TAG's deliberations around implementation of insurance rating rules in North Carolina.
- The goal of the PRI Workgroup is to set forth policy options and approaches to implementing rating requirements for broader TAG consideration. The TAG, in turn, will recommend preferred options to the NC DOI, who will develop recommendations as applicable to the North Carolina General Assembly ("NCGA").

Issues for Discussion in PRI Workgroup

Age Curve

- The Workgroup briefly reviewed newly-issued proposed rules related to age bands and factors, current North Carolina law around age bands and factors, and considerations for choosing whether to apply the default age rating curve developed by CMS or develop a North Carolina-specific age curve. The Workgroup then discussed the policy options under consideration related to selecting an age curve.

Should the state accept the default age factors or submit a North Carolina-based age curve? If the latter, how should it be calculated?

- The Workgroup discussed whether the North Carolina market is significantly different from the national market to merit the development of a North Carolina-specific age curve. To inform the discussion, the group reviewed an age curve developed by Blue Cross Blue Shield North Carolina (BCBSNC) based on North Carolina experience data and compared it to the proposed national curve. A member representing BCBSNC discussed differences between the two curves, noting that the differences in child costs were the most marked and material, with the proposed national curve setting the rating factor for children low compared to North Carolina experience. Members observed that there are also notable differences between the two curves for older adults, particularly between the ages of 50-63, with the proposed national curve again set rating factors low for this group.
- The group discussed the adequacy of the proposed national rating factor for children (0.635) and the extent to which the state has flexibility in modifying the 0-20 age band and/or related rating factor, with the group positing that establishing a separate age band for 0-2 year olds would help bring the proposed child rating factor more in line with North Carolina experience. Manatt meeting facilitators and NC DOI representatives responded that newly proposed federal guidance requires states to adopt a single age band and standard rating factor covering children 0 to 20 years of age (i.e., North Carolina does not have the flexibility to establish a separate 0-2 age band), but that the state is able to propose a NC-specific alternative to the proposed rating factor for children ages 0-20. The group agreed that differences between the proposed national age curve and North Carolina experience with regard to child costs merit further analysis to assess whether the proposed child rating factor of 0.635 is appropriate for use in the state.
- Members also expressed concern that the proposed national curve will lead to rates for older adults being set too low relative to North Carolina experience, particularly between the ages of 50-63. These members noted that the ACA already significantly subsidizes coverage for older adults through the 3:1 age factor ratio requirement. The group noted that setting factors to not hit the "3.0" mark until age 64+ (as set in the federal curve) means that the premium costs will be even higher for younger adults, increasing the potential for adverse selection if younger adults consequently opt out of purchasing coverage.
- The group agreed on the importance of understanding the extent of these differences and the resulting impact on the market when assessing whether a NC-specific age curve is worth pursuing, particularly in light of the tight timelines for doing so and the many competing reform-related priorities. Several members representing insurers stated that if the analysis shows that implementing the proposed national curve will result in significant disruption, then an NC-specific curve would be desirable. One member observed that it may be worth pursuing a state-based curve even if the differences between the national curve and North Carolina experience are relatively small, as this is one of the few areas where states are given the opportunity to customize rating factors to suit state needs and there are many other areas where flexibility is limited and disruption will be significant (e.g., elimination of gender rating, 3:1 age bands).
- Members agreed that a disruption analysis is needed to understand the extent of disruption that would occur in each age category across all issuers as a result of implementing the proposed national age curve versus the BCBS-developed North Carolina experience-based age curve, including the resultant impact on premiums. The group agreed that NC DOI should use

the BCBS-developed curve as a starting point/proxy for a North Carolina-specific age curve to be used in the disruption analysis. The disruption analysis will include an assessment of the impact of the proposed national age curve and the BCBS-developed NC-based age curve, and will also assess whether the proposed rating factor for children (0.635) is appropriate for and aligned with the North Carolina experience. The group agreed that the disruption analysis should be carried out by the NC DOI in the coming weeks so that results can be shared with the group in advance of a January meeting of the Workgroup to continue assessing the possible development of a NC-specific age curve.

Points of Consensus:

- Workgroup members **reached consensus** that there was sufficient justification to further assess development of a North Carolina-specific age curve, including significant differences in child costs between the proposed national age curve and curve presented by BCBS based on NC experience, as well as relatively heavy subsidization of costs for ages 50-63 inherent in the proposed national curve.
- Accordingly, the Workgroup agreed that NC DOI should conduct in the near-term a disruption analysis that will include an assessment, from both an actuarial soundness perspective and a market disruption perspective, of the impact of moving from the current market to the 1) proposed national age curve and 2) BCBS-developed North Carolina experience-based age curve. The analysis should also consider whether the HHS proposed rating factor for children 0-20 years old (0.635) is appropriate for North Carolina.

Tobacco Rating

- The Workgroup briefly reviewed newly-issued proposed rules related to tobacco rating factors, data on current tobacco use in North Carolina, previous TAG deliberations on the subject and considerations for setting a tobacco rating factor, including affordability implications for low-income individuals. The Workgroup then discussed the policy options under consideration related to tobacco rating.

Should the state impose a standard tobacco rating factor (less than 1.5)? If so, what should the rating factor be? If not, how should insurers limit the tobacco rating factor to something lower than 1.5? How should "tobacco use" be measured?

- At its October 2012 meeting, the NC DOI TAG came to consensus that the tobacco rating factor should be limited to less than 1.5, though the group did not reach consensus regarding what the appropriate rating factor would be. Accordingly, the Workgroup discussed the relative advantages and disadvantages of imposing a standard tobacco rating factor set at less than 1.5 (including imposing a rating factor of 1, thereby eliminating insurers' ability to rate for tobacco use).
- Some members felt strongly that issuers should rate for tobacco use, positing that tobacco rating offers an opportunity to send an anti-smoking public health message and to incentivize

individuals to adopt healthier behaviors. These members also noted that rating for tobacco use ensures that the costs associated with this behavior are borne by tobacco users.

- Conversely, others felt strongly that the tobacco rating factor should be eliminated altogether, positing that increasing costs for tobacco users has little effect on changing their behavior and, counter to the goals of the ACA, may result in low-income tobacco users opting out of purchasing coverage. One member opposed to tobacco rating factors stated that such factors are fundamentally regressive, as the related cost represents a larger percentage of a low-income person's income. Another member expressed concern about the impact a tobacco rating factor (that includes forms of tobacco use beyond smoking) would have on individual market uptake rates in rural communities.
- One member suggested allowing insurers flexibility to set a tobacco rating factor less than 1.5 and letting the market run its course, noting that there will be new coverage options available post-2014 such that individuals can switch to an insurer who offers them lower-cost coverage if their coverage becomes unaffordable. A few members expressed concern with this approach, particularly for rural areas in which consumers may only have one or two insurers from which to choose.
- A proposal was made to allow insurers the flexibility to set a tobacco rating factor in the individual market (including the flexibility to refrain from rating for tobacco use), subject to a cap. Members agreed that this approach would allow for insurer flexibility while accounting for concerns related to ensuring the affordability of coverage for low-income individuals.
- The group subsequently discussed where the rating factor cap should be set. Members suggested 1.3 as a potential option, citing past TAG deliberations in which insurer representatives reported that individual policies currently underwrite based on smoking/non-smoking status and that the addition of smoking typically results in premiums that are 20-30% higher for smokers than non-smokers. The group additionally noted that 30% is the average increase in premiums for Inclusive Health members who self-attest to tobacco use, and also aligns with the proposed incentive cap for wellness programs put forth in recent federal guidance.
- However, others expressed concern that while the 1.3 rating factor may be actuarially justified, choosing this rate would not address the group's concerns related to affordability and access. Members also observed that 1.3 would likely become the de facto tobacco rating factor for most insurers due to actuarial justification. These members suggested setting the rating factor cap slightly lower than what is actuarially justified to account for distributive concerns (e.g., 1.2). Several members asked whether the NC DOI could develop a more illustrative analysis to demonstrate how the use of various tobacco rating factors would impact the market, including an assessment of the impact each would have on affordability and access for low-income populations, particularly if the state decides to not expand Medicaid eligibility. Members agreed that this analysis would be helpful to determining the appropriate tobacco rating factor at which to set the cap.
- Members briefly discussed how to operationalize rating for tobacco use, specifically how to measure tobacco use. Insurer representatives stated that issuers primarily rely on self-attestation to monitor tobacco use. The group noted that the proposed rule seeks public

comment on how to define and measure tobacco use and agreed to wait for the final rule to further assess potential implementation options.

Points of Consensus

- Workgroup members **reached consensus** that North Carolina should not impose a standard tobacco rating factor in the individual market. Instead, the state should set a cap on the tobacco rating factor and allow insurers the flexibility to set a rate below that cap.
- There was consensus that the cap should not be higher than 1.3, however, there was not consensus on if the cap should be set lower. Several members of the group felt strongly that the cap should be set lower than 1.3 to address public policy concerns related to accessibility and affordability of insurance coverage for low-income populations.
- Workgroup members agreed to await further federal guidance regarding the definition of and how to measure tobacco use.

Geographic Rating Areas

- The Workgroup briefly reviewed newly-issued proposed rules related to geographic rating areas, previous Rating Workgroup and TAG deliberations on the subject and a high-level analysis of current geographic rating areas in North Carolina. The Workgroup then discussed the policy options under consideration related to establishing geographic rating areas.

How should geographic rating areas be calculated? Does the methodology change if the state is able to have more than 7 areas?

- A number of members expressed strong support for the state submitting an exception to CCIIO that would allow North Carolina to use counties as geographic rating areas. These members identified the benefits of setting geographic rating areas by county, including increased transparency around the factors driving cost differences across communities, which in turn provides increased incentives for delivery systems and providers to compete based on innovation and the delivery of cost-effective care. These members noted that not allowing county-based geographic rating areas could also result in an overall reduction of coverage options as insurers will have an incentive to exit high-cost counties to reduce costs in a rating area. Members also observed that the great majority of insurers in the state currently use county-based geographic rating areas and that the practice has not resulted in a distinct rating factor for each county but, to the contrary, most insurers use only a handful of unique factors which they apply across multiple counties that have similar cost characteristics. Members agreed that for these reasons, the state should seek approval to use counties as geographic rating areas in North Carolina.
- The group discussed the relative likelihood of receiving approval from CCIIO to use the county-based approach, noting that North Carolina's has a significantly larger number of counties (100) than the maximum number of geographic rating areas (7) proposed in the rating rule. Representatives from the NC DOI reported that recent discussions with CCIIO have indicated

that it would consider the request to use 100 counties but only with justification as to why the use of counties is necessary. The group agreed that North Carolina would need to ready its proposal in advance of the deadline for submitting rating areas to CMS in order to allow time to incorporate CCIIO's feedback and potentially work through iterations of a proposed approach.

- Recognizing that CCIIO could potentially deny the state's request to use counties as geographic rating areas due to the complexity it would introduce in the state's risk adjustment model, the group considered other possible approaches to calculating rating areas in the state. Though the group was not sure what the ideal number of rating areas would be, several members agreed that it is generally preferable to have a larger number of rating areas rather than a smaller number, and that ideally North Carolina would have more than the seven rating areas maximum put forth in the proposed rule.
- The group agreed that further analysis was needed to determine a methodology for grouping counties into rating areas in a way that minimizes disruption as much as possible which could serve as an alternate approach if the state is not permitted to use counties. Members agreed that the NC DOI should conduct an analysis that starts with the 100 counties and groups them in a way that allows for no more than a specified maximum level of cost variation within a grouping for any given insurer (e.g., 5%, 10% cost variation). The resulting groupings would have actuarial justification and could be submitted to CCIIO as the geographic rating areas for the state only if CCIIO did not approve the 100 county-level approach.

Points of Consensus

- Workgroup members **reached consensus** that the state should seek CCIIO approval for using counties as geographic rating areas, based on a desire to enable efficient pricing, facilitate price transparency to drive delivery system competition and innovation, and ensure the availability of coverage options throughout the state.
- If not approved for the 100 counties approach, NC should seek as much flexibility as possible to group counties in a way that seeks to minimize market disruption as much as possible.
- The NC DOI should conduct analysis in coming weeks to assess potential groupings that will minimize disruption.

Next Steps

- The PRI Workgroup is asked to review meeting notes, once made available, to ensure accurate representation of the group's Points of Consensus.
- NCDOI will work with consultants to perform additional analysis of age factors and geographic rating areas to share with workgroup and TAG members prior to the next in-person meeting.
- Workgroup members are encouraged to send any additional feedback to Allison Garcimonde (agarcimonde@manatt.com) or Lauren Short (lauren.short@ncdoi.gov) of the NC DOI.