North Carolina Department of Insurance
Premium Rating Implementation (PRI) Workgroup Meeting
Monday, October 22, 2012-- FINAL

Meeting Attendees	Organization
Workgroup Members and NC DOI Project Team	
Bruce Sobus *(by phone)*	Aetna Health Inc.
George Teague	Aetna Health Inc./CIGNA
Barbara Morales-Burke	Blue Cross Blue Shield of NC
Brian Tajlili	Blue Cross Blue Shield of NC
Anne Malone *(by phone)*	CIGNA
Tracy Baker	Coventry Health Care of the Carolinas, Inc.
Peter Chauncey	Coventry Health Care of the Carolinas, Inc.
Ann Lore	Duke University Health System
Allison Garcimonde	Manatt
Sharon Woda	Manatt
Joel Ario	Manatt
Teresa Gutierrez	NC Association of Health Underwriters
Yolanda Fonville	NC Department of Insurance
Rosemary Gillepsie	NC Department of Insurance
Ted Hamby	NC Department of Insurance
Walter James *(by phone)*	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
Allen Feezor	NC Department of Health & Human- Services
Pam Silberman	NC Institute of Medicine
Tammy Tomczyk	Oliver Wyman
Andrea Radford	UNC Rural Health Research & Policy Analysis Center
Tim Martin *(by phone)*	United Healthcare

Agenda

• Welcome and Introductions
• Goals/Objectives of Workgroup and Today's Discussion
• Items for Discussion in PRI Workgroup
  o *Geographic Rating Areas*
    ▪ *If federal guidance/regulations allow states to set geographic rating areas by county, should North Carolina exercise that option in 2014 and 2015?*
    ▪ *If federal guidance/regulations indicate that geographic rating areas by county are too narrow, or if North Carolina does not prefer the county-level, how should regions be defined for 2014 and 2015?*
  o *Age Bands & Factors – Adults & Children*
    ▪ *Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015? If so, what additional parameters should be considered in North Carolina?*
    ▪ *Should standardized age bands for children be established in the individual market?*
• Wrap Up and Next Steps

Please refer to the October 22 "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").

<u>Issues for Discussion in PRI Workgroup</u>

Geographic Rating Areas

- The Workgroup reviewed relevant federal and state law and regulations related to insurance rating rules, how rating areas are currently defined in North Carolina, initial TAG recommendations on the issue, and approaches to rating areas in other states and programs. The Workgroup then reviewed the policy options under consideration for North Carolina's development of geographic rating areas.

If federal guidance/regulations allow states to set geographic rating areas by county, should North Carolina exercise that option in 2014 and 2015?

- Workgroup members discussed the benefits of setting geographic rating areas by county. Several members representing carriers noted that setting rates at the county level would allow more transparency around the true cost of care to inform rating and isolate variables that account for cost differences. Members also observed that establishing more segmented, rather than less segmented, geographic rating areas would better align with the current practice of most major insurers in the state, thereby minimizing further disruption to the marketplace in 2014.
- Other members countered that one of the overarching goals of the ACA is to move toward increased pooling/spreading of risk rather than segmentation. These members expressed concern that setting rates at the county level could disproportionately impact rural and other high-cost counties, resulting in fewer affordable coverage choices for consumers in those areas. Members representing carriers responded that setting rates at the county level would serve to create a level of transparency and reinforce motivation within delivery systems in all (perhaps especially those with historically high-costs) counties to innovate and take other steps to become as cost-effective as possible in taking care of populations. Some members also expressed concern that establishing highly segmented rating areas could potentially allow carriers to use costs as a proxy for health status (i.e., use geographic areas as a mechanism by which to rate based on health status rather than geographic-specific cost of care). The group agreed that the state should consider the impact on competition and consumer choice in rural areas when setting geographic rating areas, in addition to ensuring that rating factors do not include health proxies.
- The Workgroup discussed whether geographic rating areas might be used as a mechanism to expand coverage options in traditionally high-cost areas where few carriers offer products by grouping less-profitable counties with more-profitable counties to balance out differences between them. Members representing carriers responded that while pooling would reduce costs for some areas, it would also likely result in an overall reduction of coverage options as this cross-subsidization could push marginally profitable counties into unprofitability and result in carriers exiting those counties.
- The group noted that even though carriers currently apply rating factors by county, each county is not necessarily assigned its own unique rate factor; rather, those counties with similar cost characteristics are grouped into a given rate factor or "price bucket." For example, Carrier A might develop 20 rate factors which it applies across several counties with similar cost characteristics in which it does business. However, some members expressed concern that that new restrictions on rating rules in 2014 might drive carriers to further increase segmentation in order to compensate for limitations on ratings in other areas such that the market could shift toward having a rate factor for each county. Accordingly, the group agreed that carriers should be required to maintain current levels of segmentation in 2014 and 2015 with the state reassessing the issue in 2016, once the impact of new rating requirements on the market is better understood, to determine whether it should revise its approach to geographic rating areas in future years.

Points of Consensus:

- Workgroup members **reached consensus** in agreeing that, if possible, under federal regulation that North Carolina should elect to use counties as geographic rating areas in 2014 and 2015. The group further agreed that NC DOI should reassess the issue in 2016, once the impact of new rating requirements on the market is better understood, to determine whether it should revise its approach to geographic rating areas in future years. The workgroup also discussed prohibiting insurers from further segmenting geographic rating areas in 2014 and 2015; though several members expressed support for this approach, the group had concerns over potential unintended consequences and ultimately did not reach consensus on this point.
- The group recognized the tension between the desire for more segmented geographic rating areas as a mechanism to increase cost transparency and efficiency and, conversely, the desire for increased pooling to spread risk, particularly in rural areas.
- The Department should, when reviewing rating areas and rating factors, ensure that rating areas are not used as a proxy for health status, and that rating factors do not include health status differences.

If federal guidance/regulations indicate that geographic rating areas by county are too narrow, or if North Carolina does not prefer the county-level, how should regions be defined for 2014 and 2015?

- Members then turned to discuss what approach the state should adopt if federal regulations preclude setting geographic rating areas at the county level and instead require grouping of counties into a given number of regions, including whether North Carolina should establish a new grouping methodology based on studies/analysis, rely on existing groupings, or rely on federal minimums once established.
- The Workgroup agreed that the accelerated timeline for implementation would make it very difficult to conduct sufficient analysis to develop a new grouping methodology for the state. Members also agreed that it was not desirable to opt to defer to federal minimums in advance of related guidance that will specify what those minimums are.
- Accordingly, the group discussed the remaining option of potentially relying upon existing groupings to develop geographic rating areas (e.g., Metropolitan Statistical Areas, CCNC Regions, CMS Network Adequacy Standards). Some members also suggested hospital referral clusters as an additional potential group that might be considered, as this aligns with the approach being adopted in the creation of Accountable Care Organizations.
- NC DOI discussed a strategy deployed in California, which was to group carriers' existing county-specific rating factors into contiguous regions. Regions were established based on the variances in factors, whereby similar factors were grouped together as a proxy for similar medical costs.
- Members agreed that uncertainty around what forthcoming federal regulations will require for the development of geographical rating areas makes it difficult to choose an existing approach that might serve as a new baseline for grouping (e.g., how many rating areas will be required, whether they must be contiguous, etc.).

Points of Consensus:

- Workgroup members **reached consensus** that if federal guidance indicates that geographic rating areas by county are too narrow, North Carolina should attempt to minimize disruption by maintaining as much of its current approach as possible while meeting federal minimums. The group agreed that the approach in California should be considered as a process by which this could occur.
- The group also agreed to revisit the topic once federal rules have been released.

Age Bands & Factors

- The Workgroup reviewed relevant federal and state law and regulations related to age bands and factors, how age bands and factors are currently defined in North Carolina, and approaches to age bands/factors implementation in other states. The Workgroup then reviewed the policy options under consideration for changing age bands/factors in North Carolina.

Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015? If so, what additional parameters should be considered in North Carolina?

- The Workgroup discussed the current average factor spread in the individual and small group markets and noted that nearly all insurers will need to make adjustments to comply with the 3:1 ACA-mandated requirement for age factors such that significant market disruption is likely to occur in the short term. Several members agreed that additional parameters around age bands and factors would result in considerable market disruption and rate increases beyond that which will result from the new 3:1 ACA-mandated requirement. These members thought that carriers should be granted flexibility to manage this disruption in the near-term while maintaining the option of re-evaluating the need for additional standardization in the future.
- One member observed that with guaranteed issue in the individual market, carriers would likely see a greater range of claim costs within a given age band, and the potential for steeper claims cost slopes in age bands for older individuals, than is currently the case. Another member noted that it would be helpful to have concrete examples of the impact that the new 3:1 requirement will have on per member per month (PMPM) rates to inform the assessment of age bands and factors.
- Other members posited that while market disruption may occur in the near-term, setting additional parameters around age bands could help stabilize the market in the long-term, particularly by minimizing rating differences across consumers and helping to smooth premium increases over time that would otherwise result solely from a consumer aging. Some of these members also expressed concern that carriers could potentially use flexibility around age bands to game the system, which might result in "rate cliffs" across bands (e.g., a carrier could

group all individuals under 40 into one age band and apply rate factors above 1 only to older age bands). The group discussed potentially allowing for single year age bands to allow for segmentation that would mitigate gaming based on bands. The group also discussed potentially setting maximum allowable rate increases between age bands to mitigate the potential for "rate cliffs."

- Members briefly discussed establishing standardized age bands for children in the individual market and agreed that doing so raises similar concerns to those discussed in the context of adult age bands.

Points of Consensus

- Workgroup members generally agreed that complying with new 3:1 ACA-mandated requirements in 2014 will already result in significant market disruption, such that the state should refrain from imposing additional parameters on age bands in the small group and rating factors in both the individual and small group market until the impact of reforms is better understood.
    - Members expressed an interest in further considering the use of single-year age bands in the individual market to mitigate the potential for rate cliffs across bands, since many insurers in the individual market already use highly segmented age bands.
    - Members did not want to consider a change to standardized age bands in the small group market or standardized age factors in either the individual or small group markets at this time.
- Members agreed that an assessment of the issue of age bands and factors would be better informed by the forthcoming release of federal market reform regulations.

Next Steps

- The PRI Workgroup is asked to review federal market reform regulations, once released, to inform its future deliberations on implementation of premium rating rules. The Workgroup will gather again to revisit options with a focus on reacting to the regulations and revising Workgroup feedback as necessary in order to further develop policy options for TAG consideration.
- 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.