GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Fiscal Note

REVISED

BILL NUMBER: House Bill 115 (Third Edition)

SHORT TITLE: North Carolina Health Benefit Exchange.

SPONSOR(S): Representatives Dockham, Brubaker, Wray, and Murry

FISCAL IMPACT

Yes ( ) **No ( )** **No Estimate Available (X)**

	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
REVENUES	**Undetermined**				
EXPENDITURES	**Undetermined**				
POSITIONS (cumulative):	**Undetermined**				

PRINCIPAL DEPARTMENT(S) &
PROGRAM(S) AFFECTED: Department of Insurance

EFFECTIVE DATE: Upon Enactment

BILL SUMMARY:

SOURCE: BILL DIGEST H.B. 115 (02/16/0201)
TO ESTABLISH THE NORTH CAROLINA HEALTH BENEFIT EXCHANGE.

Enacts new Part 8 in Article 50 of GS Chapter 58, titled the North Carolina Health Benefit Exchange Act, to establish the nonprofit entity of the North Carolina Health Benefit Exchange (Exchange) and provide for its membership, authority, and requirements.

Definitions.
Provides definitions applicable to new Part 8. Defines qualified health plan as a health benefit plan that meets certification criteria described in section 1311(c) of the federal Patient Protection and Affordable Care Act, as amended and criteria in GS 58-50-340 (health benefit plan certification requirements in proposed Part 8). A qualified employer is a small employer that elects to make (1) its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange and (2) at the employer's option, some or all of its employees eligible. The SHOP Exchange is the Small Business Health Options Program established in Part 8. Defines qualified

individual as an individual, including a minor, who (1) is seeking to enroll in a qualified health plan offered to individuals through the Exchange; (2) resides in NC; (3) is not incarcerated at the time of enrollment, other than incarceration pending disposition of charges; and (4) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the U.S. or an alien lawfully present in the U.S.

Exchange.

Provides that the Exchange, established under Part 8, is not an instrumentality of North Carolina and will operate under the Exchange Board of Directors. Requires the Exchange to make only qualified health plans available to qualified individuals and qualified employers beginning with effective dates on January 1, 2014. Permits the Exchange to allow a health carrier to offer limited dental benefits, as indicated, if the plan also provides pediatric dental benefits, as specified. Prohibits the Exchange and any health carrier from charging a fee or penalty for termination of coverage in specified circumstances. Creates a Board of Directors (Board) of the Exchange, consisting of the Commissioner of Insurance (Commissioner) and 11 appointed members, as listed. Details appointment, term, and meeting guidelines. Includes an indemnification provision for the Board and employees of the Exchange and classifies members of the Board as public servants under GS Chapter 138A. Enumerates the general powers and authority of the Exchange, including the power to enter into contracts to carry out the provisions of Part 8. Lists the duties and operational requirements of the Exchange, including the directive to establish a SHOP Exchange (1) through which qualified employers may access coverage for their employees and (2) which will enable any qualified employer to specify a level of coverage so any employee may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage.

Sets forth duties, including reporting requirements, for the Executive Director of the Exchange. Requires the Board to submit a Plan of Operation for the Exchange to the Commissioner containing specified information.

Health Benefit Plan Certification.

Directs the Exchange to certify a health benefit plan as a qualified health plan if the plan meets all of the detailed requirements. Prohibits the Exchange from excluding a health benefit plan by imposing premium price controls. Further prohibits the Exchange from excluding a plan solely because the plan is a fee-for-service plan or because the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange deems inappropriate or too costly. Provides additional requirements applicable to the certification of qualified health plans and includes criteria related to qualified dental plans.

Additional Provisions.

Reserves GS 58-50-341 through GS 58-50-349 for future codification purposes. Diverts the funding stream currently supporting the North Carolina Health Insurance Risk Pool to support the Exchange, beginning in 2014. Requires the Exchange to publish on the internet the average costs of licensing and regulatory fees, administrative costs, monies lost to fraud and waste, and any other payments. States that nothing in the act will be construed to conflict with, preempt, or supersede the Commissioner's authority to regulate the business of insurance. Requires all health carriers offering qualified health plans to comply fully with all applicable laws, unless specifically excepted. Includes a severability clause.

March 30, 2011
H 115. NORTH CAROLINA HEALTH BENEFIT EXCHANGE (NEW).
House committee substitute makes the following changes to 1st edition.

A new section is added, stating that the purpose of the act is to establish the North Carolina Health Benefit Exchange Authority (Exchange Authority) to facilitate the purchase and role of qualified health plans in the individual and small employer market through education, outreach, and technical assistance.

Definitions.
Clarification that the SHOP Exchange is the Small Business Health Options Program established in proposed Part 8 to assist NC Qualified Employers who are small employers to facilitate the enrollment of their employees in Qualified Health Plans. Defines Individual Exchange as the Exchange through which Qualified Individuals purchase coverage. Clarifies the definition for Exchange Authority (was, Exchange in previous edition) and makes a conforming change to all references throughout Part 8. Adds new terms applicable to Part 8 and makes clarifying changes to definitions.

Exchange.
Organizational and clarifying changes are made to the provisions establishing the Exchange Authority, the Exchange Authority Board of Directors (Board), and the powers and duties of each. There is clarification that the Exchange Authority is subject to the supervision of the Commissioner of Insurance (Commissioner). Also clarifies that the purpose of the Exchange Authority is to: (1) create and administer an Individual Exchange and a SHOP Exchange as two separate health benefit exchanges; (2) facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers; and (3) assist Qualified Individuals and Qualified Employers in enrollment in Qualified Health Plans. The Board will consist of the Commissioner and the Director of the Division of Medical Assistance as ex officio nonvoting members, and 11 additional, appointed members. Details the appointing authority as follows: (1) four members appointed by the President Pro Tempore of the Senate for three year terms, with appointments made within 30 days after enactment; (2) four members appointed by the Speaker of the House of Representatives for three year terms, with appointments made within 30 days after enactment; and (3) three members appointed by the Governor for two year terms, within 30 days after enactment. Additional appointee qualifications and requirements are included, along with details on additional powers and duties of the Board.

Requires the Commissioner to review and approve or disapprove the Plan of Operation submitted by the Board within 90 days. Deems the Plan approved if the Commissioner fails to act within 90 days. Allows for resubmission upon disapproval and outlines other procedures related to Plan submission. Clarifies and adds to the list of components included in the Plan of Operation. Clarifies that the Exchange Authority has the authority to contract with an eligible entity, as defined, to perform any functions described in Part 8, take legal action, and enter into information-sharing agreements with federal and State agencies and other State exchanges as specified. The Exchange Authority is authorized to make a Qualified Health Plan available that may require benefits other than the Essential Health Benefits, as specified. Executive Director of the Exchange Authority is to make an annual report by March 1 of each year to listed parties, summarizing the

activities of the Exchange Authority during the preceding calendar year. The Exchange Authority, the Board, and employees, are now subject to Article 33C of GS Chapter 143 (provisions for meetings of public bodies). All information in the possession of the Exchange Authority, regardless of physical form, is now subject to GS Chapter 132 (public records), except protected and confidential information. Clarifies other requirements of the Exchange Authority. New language provides additional duties for the Exchange Authority, including the duty to establish an Individual Exchange, to meet specified financial integrity requirements, and to conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. Additional details on reporting requirements.

Health Benefit Plan Certification.
Clarifies that the Exchange Authority will certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines the plan satisfies the enumerated requirements, unless the Exchange Authority determines the plan is not in the interest of Qualified Individuals and Employers. Directs the Exchange to establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans, as described. Other clarifying changes are made.

Additional Provisions.
Permits a Qualified Employer to either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange. Permits a Qualified Individual enrolled in any Qualified Health Plan to pay any applicable premium owed to the Health Insurer issuing the plan. Establishes the Individual Exchange and the SHOP Exchange risk pools, as detailed. Provides that the statute does not: prohibit a Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or Employer; prohibit a Qualified Individual from enrolling in, or a Qualified Employer from selecting, a health plan outside of the Exchange Authority; limit the operation of any State law for any policy or plan outside the Exchange Authority; or otherwise restrict the choice of any individual to enroll or not enroll. Details circumstances under which a Qualified Individual may enroll in a catastrophic plan. Allows Agents and Brokers to enroll and assist Qualified Individuals and Employers, as described. Requires that the compensation for an Agent and Broker are to be determined by the insurer.

The utilization of the NC Health Insurance Risk Pool as a funding stream to support the Exchange Authority is codified. Adds that, beginning in 2015, the funding stream supporting the NC Health Insurance Risk Pool will support those operations of the Exchange Authority that serve individuals with incomes less than or equal to 400% of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance under federal law. Other costs of the Exchange Authority are to be funded by an annual user fee paid by the individual or employer to the Exchange Authority, as specified. Requires the Exchange Authority to examine its potential operating costs and propose any additional funding stream changes before the 2013 General Assembly commences. The Exchange Authority is to be self-sustaining by January 1, 2015, as required by federal law. Details additional funding criteria and exempts the Exchange Authority from all State taxes. The Commissioner is to promulgate the necessary regulations. Requires an annual audit of the Exchange Authority. Makes additional clarifying changes.

Changes the title of the act to AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

May 10, 2011,
House Committee Substitute makes the following changes to the 2nd edition

1. The Board of Directors is increased from 11 members to 12. In the event of a tie vote within the Commission, the Director of the Division of Medical Assistance will cast the deciding vote.

2. Health insurance carriers who offer high deductible health insurance plans outside the Health Benefit Exchange are required to offer them within the Exchange.

ASSUMPTIONS AND METHODOLOGY:

Since January 2011, the North Carolina General Assembly and the Department of Insurance have each been pursuing the necessary research and analysis required for legislative action to establish a Health Benefit Exchange in North Carolina. The purpose of an Exchange would be to facilitate the purchase of health care coverage by certain individuals and to determine the role of qualified health plans under an Exchange in the individual and small employer health insurance market. Also, an Exchange can provide an information role through education, outreach, and technical assistance.

The following analysis tracks the Executive and Legislative efforts separately, while assuming the combined efforts will become one strategy with the potential enactment of HB 115 on or before July 1, 2011; and that the Department of Insurance will continue to seek Federal funding through December 31, 2014 to establish and initially operate the Health Benefit Exchange Authority. Beginning January 1, 2015, the Exchange's operations are to be self-sufficient.

North Carolina General Assembly

Upon enactment of HB 115, Section 2 amends Article 58-50-310(c) and calls for the Commissioner of Insurance to direct the Health Benefit Exchange Authority (HBE Authority) to develop a Plan of Operation within 90 days, presumably by September 30, 2011. The Plan is to be reviewed, evaluated, amended as necessary and adopted within 180 days—presumably by December 31, 2011.

The proposed legislation calls for the HBE Authority's Plan of Operation to address its responsibility for the following:

a. Setting policies and establishing bylaws;
b. Certifying Qualified Health Plans;
c. Determining the need for and selection of eligible entities to assist Exchange Authority in performing its functions or operations;

d. Conducting the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority;
e. Acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority;
f. Evaluating the effectiveness of the overall operations of the Exchange Authority.
g. Providing for conflict of interest rules and recusal procedures;
h. Coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid;
i. Providing for other matters as may be necessary; and
j. Developing appeals processes authorized by this Part pursuant to G.S. 58-50-340 and G.S. 58-50-350. 11

While not addressed in the legislation, it has been assumed that the Department of Insurance will use current grant funds from Centers for Medicare and Medicaid at the Federal Department of Health and Humans Services to fund the HBE Authority. Also, the Department of Insurance would be expected to seek future grants to fund these activities. Enactment of HB 115 during the 2011 Session of the General Assembly will ensure the Department of Insurance's opportunity to apply for Federal grants within the established deadlines. If the legislation is not enacted during the 2011 Session of the General Assembly, North Carolina is in jeopardy of missing the deadline for applying for Level II Establishment funding. The last deadline for applying for a Level II grant is June 30, 2012. Because the North Carolina General Assembly does not convene in 2012 until May 9, 2012, the General Assembly and the Department of Insurance would have no more than six weeks to enact HB 115 and apply for a Level II Establishment Grant. (See section on Federal Level Two Grants)

Department of Insurance

In August 2010, the Federal Government announced several grant opportunities to allow States to plan and implement State Health Benefit Exchanges, such as that proposed by HB 115.

The first set of Health Benefit Exchange grants were awarded to States, including North Carolina, on September 30, 2010. North Carolina's Department of Insurance received a grant to support its planning efforts to determine how the State's exchange will be operated and governed. With these grant funds the Department of Insurance contracted with Milliman, Inc. to develop operational projections and guidance related to establishing a health benefit exchange in North Carolina.

On April 1, 2011, Milliman presented its most current draft of the "The North Carolina Benefit Exchange Study" to the Health Benefit Exchange Task Panel of the North Carolina Institute of Medicine. Representatives from Milliman stated there is tremendous uncertainty surrounding many of the projections in the report. Milliman noted that "The uncertainty stems from imperfect data, evolving legislation and regulations, changing economic conditions, interdependence of variables, and the impossibility of predicting the reactions of employers and consumers to decisions that they have not faced in the past."

The draft report addressed the fact that the HBE Authority will be responsible for providing a mechanism for the distribution of health insurance products to individual and small group

consumers and have several major functions as defined in guidance provided by the Center for Consumer Information & Insurance Oversight (CCIIO), a part of the Centers for Medicare and Medicaid Services (CMS). These activities and functions are consistent with the provisions of HB 115, but are far more extensive in identifying and enumerating the activities the HBE Authority may assume and develop in the Plan of Operation referenced in Section 58-50-310(c) of HB 115. These include:

a. Certification, recertification, and decertification of plans;
b. Operation of a toll-free hotline;
c. Maintenance of a website for providing information on plans to current and prospective enrollees;
d. Assignment of a price and quality rating to plans;
e. Presentation of plan benefit options in a standardized format;
f. Provision of Information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs;
g. Certification of individuals exempt from the individual responsibility requirement;
h. Provision of information on certain individuals to the Treasury Department and to
i. employers; and
j. Establishment of a Navigator program that provides grants to entities assisting consumers.
k. Ensuring information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers;
l. Consideration of plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases;
m. Public disclosure of plan data, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information;
n. Providing timely information for
    1) consumers requesting their amount of cost sharing for specific services from specified providers;
    2) participants in group health plans; and
    3) plan quality improvement activities.
o. Presentation of enrollee satisfaction survey results;
p. Provision for open enrollment periods;
q. Consultation with stakeholders, including tribes; and
r. Publication of data on the Health Benefit Authority administrative costs.

This substantial list of potential functions and activities is based on data Milliman gathered from the Massachusetts Health Benefit Exchange, called the “Connector”, and from health insurance companies, combined with the expected functions that the North Carolina Exchange would provide. Currently, the Massachusetts entity is the only comparable Health Benefit Exchange from which States can draw upon as a model.

It will be incumbent on North Carolina’s HBE Authority to decide exactly what services the HBE will provide to North Carolinians, and a detailed projection of administrative responsibilities and expenses in its Plan of Operation. The following is one potential operational structure for the HBE Authority. The actual structure will depend upon duties provided to the Exchange, decisions made by the HBE Board relating to contracting services to outside vendors, DOI or other state agencies.

There may also be economies of scale and resource sharing that can be created with other states' Exchange Authorities.

Possible Organizational and Staffing Structure For North Carolina Health Benefit Authority			
Executive Office—11.0			
Operations		**Marketing**	
Function	FTEs	Function	FTEs
Plan Administration	7.0	Exchange Marketing	3.0
Call Center	15.0	Navigator Program	5.0
Eligibility Processing	5.0	Materials & Fulfillment	5.0
Plan Performance & Quality	4.0	Gov't & Public Relations	4.0
Enrollment Reporting	3.0		
Information Systems		**Finance**	
Actuarial Analysis	14.0	Accounting	5.0
		Human Resources	7.0
Total FTEs—89			

The HBE Authority must take into account the projected growth in the number of North Carolinians who will have access to either public or private health insurance.

In 2014, it is estimated that an additional 458,000 people will be eligible to participate and enroll in either Medicaid or North Carolina's Health Choice programs. In addition, it is estimated that approximately 578,000 people will purchase health insurance through the Health Benefit Exchange, through both the small employer and individual markets. This number is expected to grow to 731,000 by 2016.

The enrollment figures above lend support to the organizational and staffing structure suggested in the Milliman study. It's expected that any administrative cost projections would be offset by premium tax assessments currently collected to fund the North Carolina State High Risk Pool, Inclusive Health. That program will cease to exist effective January 1, 2014, with the implementation of the Patient Protection and Affordable Care Act (PPACA).

Health Benefit Exchange Authority—Operations and Financing Prior to January 1, 2014

Federal Level One Grants
This past January, CMS announced the availability of grants to enable States to initiate and implement activities that are critical to Health Benefit Exchange operations, such as those enumerated in HB 115 and expanded on in the Milliman draft report, and to meet Federal requirements for establishing and operating Exchanges. These grants provide up to one year of funding to States that have made some progress under the Exchange Planning grant, but are not yet

able to meet the eligibility requirements of the Level Two Establishment grants. On or before June 30, 2011 the Department of Insurance plans on applying for a Level One grant.

It is important to point out, for the sake of this fiscal analysis, that the Federal government has not required State matching funds to qualify or access Federal funds for the Planning, Level One, or Level Two grants. While the funds under these grants are targeted for States' Health Benefit Exchanges, and not Medicaid, the guidance from the Federal government reinforces the statutory requirement to ensure that Exchange functions and activities related to eligibility and enrollment are fully integrated with a State's Medicaid and Children's Health Insurance Plan, in the instance of North Carolina its Medicaid and Health Choice programs. This integration between the Exchange and Medicaid is necessary because as an individual's income increases above 138% of the Federal Poverty Line or decreases below it they will alternately become eligible to participate in the Health Benefit Exchange or enroll in Medicaid.

Federal Level Two Grants

Assuming the enactment of HB 115 during the 2011 Session of the General Assembly and the required development of the Plan of Operation required by HB 115, the Department of Insurance would, on or before December 31, 2011, expect to be in a position to apply for Level Two Grants. To do so it will have to demonstrate the following:

- The necessary legal authority to establish and operate an Exchange that complies with Federal requirements available at the time of the application;
- An established governance structure for the Exchange;
- A fully developed budget through 2014;
- An initial plan discussing financial sustainability by 2015;
- A plan outlining steps to prevent fraud, waste and abuse; and
- A plan describing how capacity for providing assistance to individuals and small businesses in the State will be created, continued, and/or expanded, including provision for a call center.

To qualify for a Level Two Establishment Grant HB 115 will need to be enacted. If the legislation is not enacted during the 2011 Session of the General Assembly, North Carolina is in jeopardy of missing the deadline for applying for this grant and the funding. The last deadline for applying for a Level II grant is June 30, 2012. The North Carolina General Assembly does not convene in 2012 until May 9, 2012. This would mean that the General Assembly and the Department of Insurance would have no more than six weeks to enact HB 115 and apply for a Level II Establishment Grant. The Level Two Establishment Grant will provide North Carolina's Health Benefit Exchange Authority with funding through December 31, 2014.

Federal Funding for Complementary Medicaid Efforts

The Federal government has proposed to make enhanced federal matching funds (FMAP) for State IT development of Medicaid eligibility systems that will integrate with those of the Health Benefit Exchanges. In November 2010, the Federal government issued a proposed rule that, if approved, would make this enhanced rate available.

A 90 percent Federal matching rate would be available to States for:

- Design, Development and Installation (DDI) of modernized systems through December 31, 2015, e.g. SFY 2015-16

A 75 percent Federal matching rate would be to States for:

- Maintenance and operation of the upgraded system, so long as specified conditions are met.

This is a significant increase from the current 50 percent matching rate for such activities. Therefore, it will be in North Carolina's interest to pursue Medicaid planning and development funds as soon as possible to maximize the opportunity to draw down 90 percent federal matching funds.

January 2013

As required by section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act (PPACA), the Health Benefit Exchange Authority is to be self-sustaining by January 1, 2015.

HB 115 states that prior to the commencement of 2013 session of the North Carolina General Assembly, the Health Benefit Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to ensure its solvency.

Concurrently, no later than January 1, 2013 North Carolina must receive certification from Federal Department of Health and Human Services that it is making adequate progress toward establishing an Exchange compliant with Section 1321 of the Affordable Care Act, or otherwise the federal government will step in to establish the Exchange.

Solvency

The HBE Authority will have significant administrative expenses given the activities, functions, and administrative structure outlined in the "North Carolina Benefit Exchange Study." While the HBE Authority's initial Plan of Operation and subsequent analysis may scale back this model, the PPACA requires that it be self-sustaining.

Beginning in 2014, the funding stream that supported the North Carolina Health Insurance Risk Pool is to be used to support the operations of the Health Benefit Exchange Authority.

The administrative expenses could be funded through premium taxes, carrier assessments per covered life, provider assessments, or other methods. Some combination of these mechanisms may produce an allocation of costs that is the most broadly accepted among stakeholders.

The following table highlights two potential scenarios to raising the required revenue for the Exchange and the base upon which those two scenarios would derive their receipts.

Potential Assessment Scenarios for the HBE Authority to Achieve Solvency	
	Base for distribution of Costs
Expenses Per Member Per Month	
	Health Benefit Exchange Members
	Total Commercially Fully-Insured Members
Expenses as a Percent of Unsubsidized Premium	
	Total Health Benefit Exchange Premiums
	Total Commercially Fully-Insured Premiums

As stated above there is uncertainty surrounding the necessary cost projections in the establishment of a Health Benefit Exchange and the required Authority to operate it prospectively. Those uncertainties may remain as North Carolina and other States move into uncharted territory in establishing an Exchange. However, the development of a Plan of Operation, as proposed in HB 115, along with the future development of better data, evolving State legislation and federal regulations should bring some clarity to these evolving issues.

SOURCES OF DATA:

1. "North Carolina Health Benefit Exchange Study;" March 31, 2011; Draft Report #4, Milliman, Inc.
2. "Medicaid's Role in the Health Benefits Exchange: A Road Map for States; March 2011, Deborah Bachrach, Patricia Boozang, Melinda Dutton; Manatt Health Solutions
3. North Carolina, Department of Insurance
4. Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges; Funding Opportunity, January 20, 2011, Office of Consumer Information and Insurance Oversight, DHHS

TECHNICAL CONSIDERATIONS: None

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DATE: May 12, 2011

Signed Copy Located in the NCGA Principal Clerk's Offices