

# A State-Based Marketplace in North Carolina

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Prepared by: Sonia Sekhar

Master of Public Policy Candidate

The Sanford School of Public Policy

Duke University

Faculty Advisor: Donald H. Taylor, PhD

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## I. Executive Summary

On March 23, 2010, the Affordable Care Act (ACA), the most significant U.S. health policy legislation since Medicare and Medicaid, became law.<sup>1</sup> The law's main objective is to reduce the number of uninsured U.S. residents. Among its most important provisions, is the creation of new health insurance marketplaces, where consumers can choose from a range of health plan options and potentially receive tax credits to pay for coverage. Nationwide, new marketplaces are estimated to reduce the number of uninsured U.S. residents by more than 20 million over ten years.<sup>2</sup>

States have the option of implementing their own marketplace—a state-based marketplace (SBM)—or to defer responsibility to the federal government. North Carolina chose to defer to a Federally Facilitated Marketplace (FFM). FFM states have the option to engage in plan management, which includes premium rating standards, transparency, accreditation, geographic service areas, and premium rating areas. States who currently do not choose to or do not have the capacity to implement their own marketplace have the option to transition to a State-Federal Partnership or SBM, or conduct plan management, in the future.<sup>3</sup>

Given its high rate of uninsurance, increasing health insurance costs, and an apparent demand for health insurance, North Carolina policymakers should consider whether a FFM or SBM would better serve its residents. However, the state also needs to consider what additional responsibilities it would need to take on, and whether the benefits of a SBM exceed its costs from the perspective of North Carolina residents. In particular, North Carolina needs to consider what additional investments it needs to make in outreach and enrollment; how it will setup a viable IT system; impact of regulatory flexibility; and if it can garner the necessary political support to make marketplace implementation successful.

The early experiences of SBM states are also instructive in the challenges and opportunities that come with implementing a SBM. This paper highlights how SBM implementation played out in two states that have gotten a lot of attention, Massachusetts and Kentucky, and key takeaways that will help North Carolina decide its future role in marketplace implementation.

With more than 8 million enrollees in marketplaces across the country, including nearly 360,000 in North Carolina, the state has an important decision to make. Should North Carolina take an active role in shaping its health insurance market, or maintain the status quo? There are arguments to be made on both sides of this issue, but under the assumption that ACA repeal is unlikely, it is important for policymakers in North Carolina to ask themselves whether they want the federal government to continue to manage their health insurance market for the foreseeable future.

## **Recommendations**

I recommend North Carolina take on a more active role in the implementation of the ACA by taking the following steps:

1. Issue an executive order establishing a commission to evaluate the costs and benefits of establishing a SBM and issue a recommendation on whether or not North Carolina should implement an SBM.
2. Pass legislation enabling the North Carolina Department of Insurance to conduct plan management for health plans available on North Carolina's marketplace.

The above recommendations represent a balanced approach the state could take that acknowledge the political contentiousness around the ACA, and the fact that nearly 360,000 North Carolinians have already enrolled in coverage. Indeed, now that approximately 8 million individuals have enrolled in coverage through marketplaces, it would be very difficult for Congress to repeal the ACA. In addition, depending on the draft language of the executive order, the commission North Carolina establishes could still have access to federal funding in 2014 to complete its work.

Politics may continue to drive the direction of ACA implementation in North Carolina, however, by taking a more active role in plan management and establishing a commission to evaluate the costs and benefits of establishing a SBM, North Carolina would avoid the potential political fallout that may result if it immediately implemented a SBM. In addition, it would not be increasing costs to the state, and it would be taking steps to improve the quality of health plans available to residents.

## II. Introduction

On March 23, 2010, the Affordable Care Act (ACA), the most significant U.S. health policy legislation since Medicare and Medicaid, became law.<sup>4</sup> The law's main objective is to reduce the number of uninsured U.S. residents. Among its most important provisions, is the creation of new health insurance marketplaces, where consumers can choose from a range of health plan options and potentially receive tax credits to pay for coverage. Nationwide, new marketplaces are estimated to reduce the number of uninsured U.S. residents by more than 20 million over ten years.<sup>5</sup>

States have the option of implementing their own marketplace—a state-based marketplace (SBM)—or to defer responsibility to the federal government. North Carolina chose to defer to a Federally Facilitated Marketplace (FFM). FFM states have the option to engage in plan management, which includes premium rating standards, transparency, accreditation, geographic service areas, and premium rating areas. States who currently do not choose to or do not have the capacity to implement their own marketplace have the option to transition to a State-Federal Partnership or SBM, or conduct plan management, in the future.<sup>6</sup>

With an rate of uninsurance that exceeds the national average, and more than 1.1 million individuals eligible for marketplace coverage, the design of North Carolina's marketplace plays a significant role in determining how effectively it meets the needs of its residents.<sup>7</sup> Proponents of the ACA argue that SBMs can better serve residents due to its ability to take into account local health insurance market conditions. However, early evidence from the ACA's first open enrollment period show that the results may be more nuanced. North Carolina is the tenth most populous state in the US, but ranks fifth in enrollment nationwide, despite being an SBM.

This paper attempts to compile the best available information on key components of North Carolina's health care system, the progress of new health insurance marketplaces under the ACA, and lessons learned and challenges of selected SBMs (Massachusetts and Kentucky). Based on this information, the paper recommends next steps on ACA implementation to North Carolina.

In addition to think tanks and other academic publications regarding health reform, this paper relies heavily on early data on ACA enrollment, and interviews with state officials, consumer advocates, and policy experts regarding ACA implementation across the country.

### III. Background

The ACA empowers states to create a health insurance marketplace, where their residents and small businesses can choose health insurance from a range of health plans and depending on household income and other factors, may be eligible for tax credits to pay for their plan. The law provides that the federal government setup health insurance marketplaces for states that choose not to set one up themselves. To date, 24 states, including North Carolina, have deferred to a FFM; 16 states and DC are implementing a SBM; and 10 states are implementing a hybrid, State-Federal Partnership Marketplace, where the state and federal governments share the responsibility of implementing the new marketplaces.<sup>8</sup> In addition, 7 FFM states—not including North Carolina—have taken selecting and conducting ongoing monitoring of health plans sold on the marketplace.<sup>9</sup>

Lawmakers and the Obama Administration did not anticipate the majority of states would defer to a FFM.<sup>10</sup> Some speculate that many of the states deferring to FFMs expected the Supreme Court to rule the entire law unconstitutional or that the law would have otherwise been repealed by 2014. As a result, those states that chose not to or could not put in place the operational requirements of a marketplace in time for the first open enrollment period in October 2013, deferred to a FFM. States who currently do not choose to or do not have the capacity to implement their own marketplace have the option transition to a State-Federal Partnership or SBM, or conduct plan management, in the future.<sup>11</sup>

Under Governor Bev Purdue, North Carolina began to lay the groundwork for establishing its own health insurance marketplace, which included contracting a reputable actuarial consulting firm, Milliman, to produce detailed projections around enrollment and premium rates.<sup>12</sup> However, in 2013 the North Carolina General Assembly passed and Governor Pat McCrory signed into law Senate Bill 4, which essentially bans state entities from implementing a state-based or state-federal partnership marketplace, deferring that responsibility to the federal government.<sup>13</sup>

As a state that narrowly swung to Barack Obama in the 2008 Presidential election and narrowly went to Mitt Romney in 2012, North Carolina remains highly divided on the issue of whether the Affordable Care will improve the health care landscape.<sup>14</sup> Advocates, politicians, and academics have made a range of social, political, and economic arguments in support of and against running a SBM.

Factors, such as uninsurance in North Carolina, the cost of insurance, and the demand for health reform in North Carolina, are important in weighing a SBM versus a FFM. In all three of these arenas, how North Carolina's health insurance

market compares with other states is useful in assessing potential impacts of implementing a SBM.

### **Uninsured in North Carolina**

According to 2012 Census data, 17.5 percent, or 1.6 million North Carolinians were uninsured, which included more than 200,000 children and more than 1.3 million adults ages 18 to 64.<sup>15</sup> North Carolina's uninsurance rate exceeds the national average of 15.4 percent.<sup>16</sup>

The North Carolina Institute of Medicine (NCIOM) found that the majority of uninsured individuals—more than 70 percent—have at least one full-time worker in their family, and the Census reports approximately 36 percent of uninsured non-elderly adults in North Carolina work full-time.<sup>17</sup> Among non-elderly, North Carolinians with health insurance, 64.1 percent have private coverage and 18.4 have public coverage through the state or federal government.<sup>18</sup>

Not having health insurance leaves North Carolina individuals and families vulnerable.<sup>19</sup> Not only are uninsured individuals and families less likely to seek regular check-ups and treatment for needed care, they are also more likely to file for personal bankruptcy because of medical bills.<sup>20</sup>

The NCIOM projects that beginning 2014, approximately 710,000 North Carolinians will purchase coverage through its FFM, including 300,000 previously uninsured individuals.<sup>21</sup> The Kaiser Family Foundation estimates that about one in three uninsured North Carolinians would be eligible for financial assistance to help pay for coverage.<sup>22</sup> FFM enrollment in North Carolina has already exceeded initial, much more modest projections by the US Department of Health and Human Services of 191,000 and currently stands at 357,584.<sup>23</sup> However, we do not yet know how many of those individuals were previously uninsured.

### **Health Insurance Costs and Competition in North Carolina**

Similar to the rest of the nation, health insurance costs in North Carolina are high and continue to rise.<sup>24</sup> In fact, the average cost of employer-sponsored coverage—the type of coverage nearly 60 percent of North Carolinians have—in 2011 was \$5,230 for individuals and \$14,304 for a family of four, figures that have more than doubled over the past decade.<sup>25</sup>

For North Carolina's FFM, the North Carolina Department of Insurance (NCDOI) was responsible for approving the premium rates of participating insurers, however, the federal government ultimately approved the plans being sold on the marketplace.<sup>26</sup> Senate Bill 4 prevents the NCDOI from conducting any additional activity around the shaping of the health plans available on the FFM that was not

already permitted under state law.<sup>27</sup> Two insurers, Blue Cross Blue Shield of North Carolina (BCBS) and Coventry Care of North Carolina, are offering plans on North Carolina’s FFM. BCBS is offering plans in all 100 of North Carolina’s counties, while Coventry Care is only offering coverage in 39 counties.

BSBC published the following monthly premium rate ranges<sup>28</sup>:

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**Monthly Premiums for BCBS of NC’s Individual ACA-Qualified Health Plans**

	<b>25-year-old</b>	<b>40-year-old</b>	<b>60-year-old</b>
<b>Bronze Plan (6 BCBSNC plans available)</b>	\$184.99 - \$219.71	\$235.47 - \$279.66	\$500.05 - \$593.90
<b>Silver Plan (11 BCBSNC plans available)</b>	\$216.91 - \$282.86	\$276.11 - \$360.05	\$586.36 - \$764.62
<b>Gold Plan (5 BCBSNC plans available)</b>	\$283.77 - \$315.05	\$361.21 - \$401.02	\$767.08 - \$851.63
<b>Platinum Plan (2 BCBSNC plans available)</b>	\$318.86 - \$350.40	\$405.88 - \$466.02	\$861.94 - \$947.19
<b>Catastrophic Plan (2 BCBSNC plans available)</b>	\$145.18 - \$159.54	\$184.80 - \$203.07	\$392.44 - \$431.25

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Source: Blue Cross Blue Shield of North Carolina. “BCBSNC Announces Rate Information for Individual ACA Plans.” (September 5, 2013).

And Coventry Care of North Carolina, recently acquired by Aetna, released the following monthly premium rates<sup>29</sup>:

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**Monthly Premiums for Coventry of NC’s Individual ACA-Qualified Health Plans**

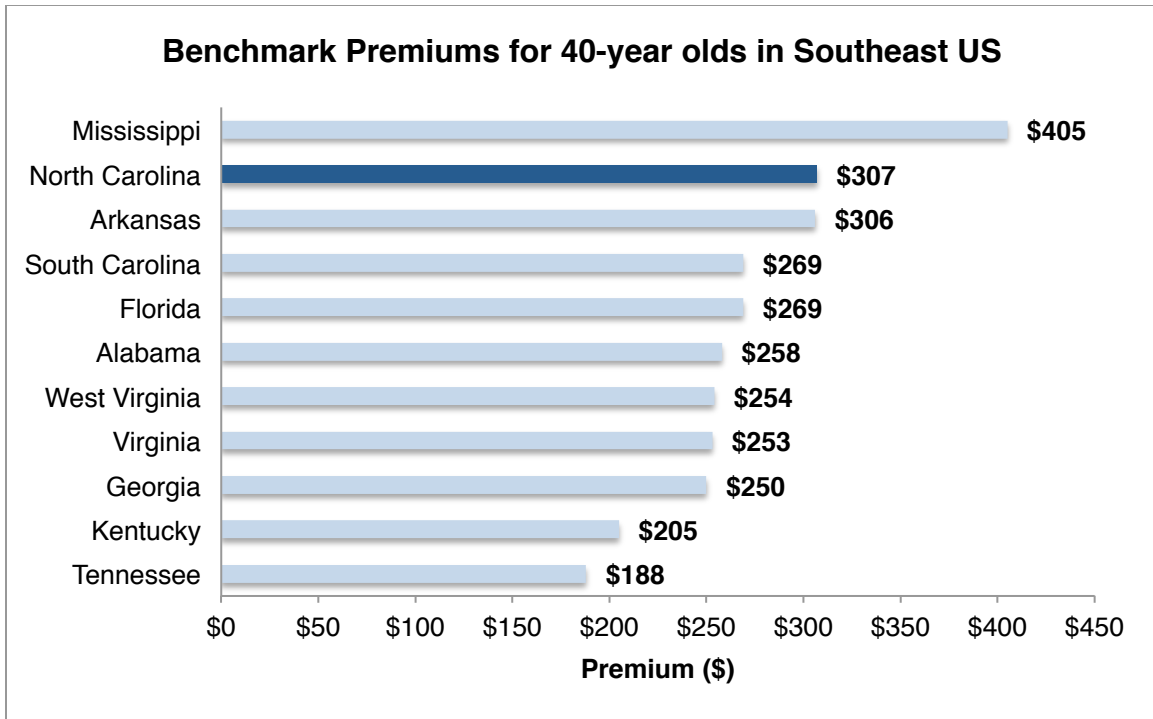
	<b>25-year-old</b>	<b>40-year-old</b>	<b>60-year-old</b>
<b>Bronze Plan</b>	\$240.32	\$305.90	\$649.62
<b>Silver Plan</b>	\$211.80	\$269.60	\$572.53
<b>Gold Plan</b>	\$154.45	\$196.60	\$417.51

Source: deBruyn, Jason. “Coventry to charge lower premiums for exchange plans than Blue Cross.” *Triangle Business Journal* (September 30, 2013).

Rates are based primarily on characteristics of the area in which plans will be sold (rating area), such as the demographics and the price of health care services, but it is also possible that higher rates are due to low insurer participation.<sup>30</sup>

Premiums on the North Carolina marketplace are among the highest in the nation. In fact, premiums of the benchmark, or the second-lowest cost silver, plan for a single 40-year old in a major city in North Carolina are in the 80<sup>th</sup> percentile nationwide.<sup>31</sup> That is, premiums in North Carolina are the tenth most expensive in the nation, and second highest in the southeast US.





Source: Kaiser Family Foundation. “2014 Monthly Premiums for a Single 40-Year-Old at 250 Percent of Poverty in a Major City in Each State” (2013).

One possible reason for why North Carolina’s premiums are noticeably higher than other states is very little competition in health insurance, which is strongly related to insurance market concentration. North Carolina’s health insurance market is dominated by BCBS, which in 2009 had 81 percent of the individual health insurance market share (based on enrollment).<sup>32</sup> All other insurers in the state had less than 5 percent of the market share in 2009.<sup>33</sup>

North Carolina is one of twelve states that have two or fewer insurers participating in its marketplace.<sup>34</sup> Depending on where one lives in the state, there is a strong chance that BCBS is the only option. It is, however, probable that other factors, such as provider market concentration and the regulatory environment, play a role. Only five of the twelve states with two or fewer insurers participating in the marketplace have among the top twelve most expensive premiums.

Similar to other states, like Massachusetts, it is possible that North Carolina’s relatively concentrated provider market contributes to high premiums.<sup>35</sup> For example, the Duke Health System owns 3 hospitals and hundreds of clinics in 7 counties in North Carolina, and UNC Health Care operates 4 hospitals and clinics in all 100 counties of North Carolina.

## **Demand for Health Reform in North Carolina**

Public unpopularity of the ACA is at odds with what is actually happening on the ground. As of the end of the first enrollment period through marketplaces, 8 million individuals have enrolled nationwide, including more than 357,584 people in North Carolina's FFM, about 4 percent of the state's population.<sup>36</sup> North Carolina is the tenth most populous state in the US, but has the fifth highest enrollment. Given high rates of uninsurance in North Carolina this outcome is not entirely surprising, though, it does justify further inquiry into whether a SBM versus an FFM would better serve North Carolina residents.

David Smith, an expert on health policy issues in North Carolina and currently VP of Health and Welfare Benefits at Ebenconcepts, attributes high enrollment in North Carolina to the commissions insurers participating in the FFM are paying agents and brokers to sign people up.<sup>37</sup> Well-organized consumer advocates, and the allowance of navigators in North Carolina county health sites to help people sign up for coverage, are also likely to have played a role in North Carolina's high enrollment figures.<sup>38</sup>

## **Should North Carolina Implement its Own Marketplace?**

Given its high rate of uninsurance, increasing health insurance costs, and an apparent demand for health insurance, North Carolina policymakers should consider whether a FFM or SBM would better serve its residents. Answering this question now is important for a number of reasons.

First, 2014 is the last year, under current law, for North Carolina to request federal funding to implement a marketplace.<sup>39</sup> If North Carolina decides to implement its own marketplace in future years, it seems unlikely that it will have access to a comparable amount of federal funds that it has now.

In addition, the high rates of enrollment in North Carolina's FFM despite major glitches in the FFM's rollout on healthcare.gov suggest that the state may be able to better connect even more residents with health insurance than the federal government is able to now. For example, the state could leverage its internal databases, and other services it provides to residents, such the Supplemental Nutritional Assistance Program (SNAP), Unemployment Insurance (UI), and State Earned Income Tax Credit (EITC), to sign eligible individuals up for coverage. In addition, a recent Urban Institute report found that SBM states receive approximately \$20.97 per uninsured person for outreach, education, and enrollment assistance compared to \$5.90 in FFM states.<sup>40</sup>

By playing a passive role in the implementation of its marketplace, North Carolina runs the risk of making it more difficult for their residents to purchase health insurance through the new marketplace. Based on the information the state has, it is better positioned than the federal government to target eligible residents and engage relevant stakeholders to help enroll more people for coverage and drive down the number of uninsured residents. A recent Gallup poll found that the rate of uninsured has decreased by approximately 2.5 percent in states that have embraced the ACA, versus only a 0.8 percent decrease in states that have not.<sup>41</sup>

As of now, 18.7 percent of the potential marketplace plan enrollees in North Carolina have enrolled, which is above the national average of 14.8 percent.<sup>42</sup> It is, however, highly plausible that participation could exceed these levels if North Carolina ran a SBM. SBMs with a participation rate of at least 25 percent of those eligible, such as Connecticut, California, and Rhode Island, have similar participation rates as North Carolina in health programs, like the Children's Health Insurance Program (CHIP), suggesting that North Carolina could also have higher participation rates.<sup>43</sup> North Carolina's nationally recognized Medicaid program also provides some indication of the state's capacity to successfully manage a SBM.<sup>44</sup>

In short, North Carolina residents could see significant, meaningful improvements in the quality and affordability of health insurance they buy if the state runs its own marketplace.

On the other hand, a poorly implemented SBM could represent an even greater liability than a FFM. Oregon's marketplace, for example, has gained notoriety for failing to deliver a functional IT system and enrolling only 11.5 percent of eligible individuals.<sup>45</sup> The next section discusses some of the opportunities and challenges North Carolina may face if it implements a SBM, and the potential costs and benefits of that decision.

## IV. Implementation Opportunities and Challenges

When considering whether or not to implement its own SBM, North Carolina needs to assess what additional responsibilities it would need to take on, and whether the benefits of a SBM exceed its costs. In particular, North Carolina needs to consider what additional investments it needs to make in outreach and enrollment; how it will setup a viable IT system; regulatory flexibility; and if it can garner the necessary political support to make marketplace implementation successful.

### **Outreach and enrollment of uninsured residents**

Consumers have difficulty understanding their benefits and rights when it comes to health insurance and health care products, and generally, do not have the information they need to make rational decisions.<sup>46</sup> Language and other cultural barriers exacerbate the problem. In response to these issues, the ACA provides multiple layers of outreach and enrollment to educate consumers about the changes taking place in the health care system, and to encourage participation in the new health insurance marketplaces.

Forms of direct consumer assistance that are available through North Carolina's FFM include: Navigators and Certified Application Counselors. Navigator programs are primarily charged with informing consumers about qualified health plan options and potential tax credit eligibility to pay for coverage through public education activities and direct assistance to consumers.<sup>47</sup> Certified Application Counselors are generally volunteers or employees at organizations that provide information and help individuals apply for and renew coverage in the new marketplaces. In-person assistance programs, which are intended to help people sign-up and enroll for coverage, are optional for SBMs, required for State-Federal partnership markets, and will be available in FFM states, which will be administered by the federal government.<sup>48</sup>

North Carolina had navigators and certified application counselors for the 2014 open enrollment period (October 1, 2013-March 31, 2014). But because North Carolina is a FFM state, it has had to return some of the consumer assistance-related funding it received from the federal government.<sup>49</sup> The federal government granted four groups in North Carolina \$3 million to train navigators.<sup>50</sup> North Carolina Community Care Networks, a consortium of 100 legal rights, faith-based, agricultural, and aging-focused organizations, received the largest Navigator grant in North Carolina.<sup>51</sup>

If North Carolina takes an active roll in outreach and enrollment by implementing a SBM that has a navigator program, it is likely that the state will be able to connect an even greater number of the approximately 710,000 marketplace-

eligible residents than those that have enrolled today.<sup>52</sup> Unlike the federal government, North Carolina could leverage its existing interfaces with potentially eligible residents, such as the Supplemental Nutritional Assistance Program (SNAP), Unemployment Insurance (UI), and State Earned Income Tax Credit (EITC), to boost enrollment and reduce overall administrative costs.<sup>53</sup>

## **IT System**

Under the ACA, individual and family eligibility for marketplace coverage will use consistent standards and systems to seamlessly and efficiently meet consumers' needs, improve quality, and lower costs. A well-functioning IT system is central to implementing eligibility and enrollment. Federal rules require real-time eligibility determinations, a streamlined application process, and a "no wrong door" policy.

Though, it now works well, the flawed rollout of HealthCare.gov, the website for all FFMs, shined a bright light on how important well-functioning IT systems are in the implementation of the ACA. While the federal government gave SBMs flexibility on the type and complexity of IT systems they use, some have been more successful than others. For example, Connecticut and Kentucky's IT systems are highlighted as success stories, while Oregon and Maryland's are largely viewed as failures.<sup>54</sup>

One additional complexity FFMs faced was HealthCare.gov's real-time electronic account transfer to state Medicaid/CHIP agencies for individuals deemed eligible was delayed. Instead, state agencies received a "flat file" which often only contained partial information about individuals who applied and were very difficult to use.<sup>55</sup> While improving, this process is still a work in progress.

Some of the marketplaces that have had relative success with their IT systems focused on simplicity, provided preliminary screening tools for consumers, and had a shared eligibility rules engine with Medicaid. Systems that are struggling tried to accomplish much more than just core functionality, and had poorly written software. Problems ranged from long wait times to frozen screens, lost information, error messages and mistaken identities.<sup>56</sup> Most states that encountered these problems had manual workarounds so they could continue to process applications.

If North Carolina implemented a SBM, it could draw from the early experience of other states and the federal government, to implement a better, more consumer-friendly IT system than is available to North Carolinians today. Connecticut, which has been receiving a lot of positive attention for its well-functioning IT system, for example, is starting to help other states, such as Iowa, Maryland, and Arkansas, build and operate IT systems for their marketplaces.<sup>57</sup> By creating a unique portal for North Carolina, residents would no longer be subject to some of

the difficulties still faced by HealthCare.gov, such as delays due to high volume of traffic. To the extent possible, North Carolina could leverage existing systems it uses for screening for and administering Medicaid and human services, like food and nutrition services.

The information and new resources that have come out of the initial rollout of HealthCare.gov and SBM IT systems, will give North Carolina a head start on implementing an IT system that is tailored to the needs of its residents. In addition, it will be much easier for the state to process Medicaid applications as a SBM, given the current problems with electronic account transfers through HealthCare.gov.

### **Regulatory Flexibility**

While prescriptive in some ways, the ACA give states flexibility on marketplace implementation in a number of key areas. Regulatory flexibility enables states to tailor their marketplace and available health plan options to local insurance market conditions. Some notable areas of regulatory flexibility include:

1. **Incentives to attract insurer participation.** Ten states and the District of Columbia are limiting insurer participation in their marketplace in future plan years if they do not participate this year.<sup>58</sup> FFMs do not restrict insurer participation. In addition, some states took steps to align existing state insurance market rules with new SBM policies in order to prevent insurers from facing significantly different, and potentially more advantageous, regulatory conditions outside the marketplace.
2. **Eligibility and enrollment functions.** Federal regulation is fairly specific about the eligibility and enrollment processes being seamless and there should be “no wrong door” for a consumer to apply for coverage, but SBMs still retain flexibility around how to conduct actual eligibility determinations, the structure of IT systems, application forms, and the collection of premiums.<sup>59</sup>
3. **Standardized plan options within the marketplace.** Nine states and the District of Columbia have taken advantage of the option to restrict the number of plans and/or require insurers to offer standardized plans on their marketplace.<sup>60</sup> No such standardization is taking place on FFMs.
4. **Defining benchmark essential health benefits (EHB).** In establishing the health benefits all qualified health plans would have to cover, the federal government gave FFM states four options of an EHB benchmark plan, and if the states do not choose an option, the federal government

chooses the largest plan by enrollment in the state's small group market.<sup>61</sup> North Carolina deferred the choice of a benchmark plan to the federal government.<sup>62</sup>

5. **Consumer assistance.** SBMs run their own navigator programs that fund local entities and organizations to help customers sign-up for coverage. The federal government conducted the funding process for FFM states. In addition, FFM states cannot run their own in-person assister programs (IPA), and rely on the federal government's call center capacity. With 33 FFM states, the federal government's capacity for promoting adequate consumer assistance has been stretched.<sup>63</sup> SBMs also have the option of permitting and paying agents and brokers to help people sign-up for coverage. FFMs do not have that option, though, insurers selling health plans on FFMs can still pay agents and brokers commissions for selling marketplace coverage.
6. **Advanced implementation of quality rating systems.** FFMs will only enforce quality requirements in 2016, however, many SBMs have already provided consumers with quality data to help inform their decisions.<sup>64</sup>
7. **Plan management.** Federal guidance permits both SBM and FFM states to engage in plan management, which includes premium rating standards, transparency, accreditation, geographic service areas, and premium rating areas.

## **Political Support**

Because the ACA has been a polarizing issue, policymakers continue to debate whether government should take steps to reduce the number of uninsured. But policies to address the rate of uninsurance are not a new concept for either party. In fact, they have been featured as central tenets in prominent health reform proposals across the political spectrum in the past decade.<sup>65</sup> In short, since both political parties agree that having health insurance is important, North Carolina should consider taking a more active role to facilitating getting covered.

Gaining the necessary political support from the public, members of the North Carolina General Assembly, insurance companies, and health care providers is important in ensuring the success of implementing a SBM. Right now a majority of members of the General Assembly have shown a strong aversion to implementing any part of the ACA. However, a SBM's relative advantage in tailoring health insurance options to local insurance market conditions may be worth revisiting if evidence shows a significant number of people are falling through the cracks.

## **Benefits and Costs of Implementing a SBM**

If North Carolina decides to reevaluate running its own SBM, there are important benefits and costs to consider.

Running a SBM would give North Carolina direct resources to boost outreach and engagement, increasing enrollment in private health insurance plans, and driving down the state's uninsurance rate. Learning from the early experience of other states and the federal government, North Carolina would also be able to create a streamlined IT system that communicates effectively with existing systems in the state and improves the user-experience of residents. And by either taking a more active role in plan management or running a SBM, North Carolina could exercise a number of the regulatory flexibilities in the ACA to tailor plans available to local insurance market conditions.

On the other hand, if North Carolina decided to run its own marketplace after 2014, it would have to fund that effort without significant support from the federal government. In addition, if its SBM does not heed the lessons from marketplaces that are already operational—especially on its IT system—North Carolina risks wasting hundreds of millions of dollars that it could have spent elsewhere on an inadequate marketplace.

The federal government's heavy involvement in North Carolina's health insurance market might motivate the General Assembly and the Governor to reconsider what is at stake by not taking a more active role in marketplace implementation.



## V. Case Study Examples: Kentucky & Massachusetts

Two states that have gotten a lot of attention for their SBMs are Massachusetts and Kentucky. The following section reviews some of the key features of Kentucky and Massachusetts' SBMs and some lessons learned based on their experiences.

### **Kentucky Health Reform in 2013**

Kentucky Governor Steve Beshear signed executive orders (EO) that established its SBM in July 2012, and in June 2013.<sup>66</sup> The Governor needed to issue the second EO because Kentucky state law requires EOs to be approved by the legislature, and the first one he issued failed to pass in 2012. The 2013 EO will be considered during the next legislative session.

Three insurers are participating in Kynect's individual market, and more than 80,000 individuals have signed up for marketplace coverage and more than 357,000 have signed up for Medicaid, as of March 1.<sup>67</sup> Kentucky has gained national attention because its consumers faced fewer problems using Kynect's website to sign up for coverage, and also because it is one of the more conservative states to implement the core provisions of the ACA.<sup>68</sup>

***Structure of KY marketplace:*** The EO creates the marketplace, Kynect, within the Cabinet for Health and Family Services. The EO requires Kynect to consult an advisory board that includes government and health industry representative on key policy and operational issues. Kynect worked with its Department of Insurance to certify health plans available on the marketplace.

### **Table 1. Lessons learned & challenges remaining in KY**

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## **Lessons learned**

- 1. Create an integrated Medicaid-Marketplace eligibility system.**  
Because Kentucky chose to expand Medicaid and implement a SBM under the ACA, it would have to coordinate with its Medicaid agency when issuing marketplace eligibility determinations. In the first year of implementation states could have separate eligibility systems for marketplace and Medicaid, but many states that chose that approach experienced more technical problems at the beginning of open enrollment.

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2. **Conduct an extensive outreach campaign.** Kentucky has been advertising marketplace enrollment through a variety of media, including television, radio, newspapers, billboards, hospital kiosks, and bus advertisements.<sup>69</sup> In addition, Kynect formed partnerships with local health agencies to conduct outreach and education.<sup>70</sup>

3. **Keep the IT system simple.** A number of states tried to integrate a number of complex features in their IT systems. Kentucky and a few others focused on delivering the core functions of the marketplace and were much more successful in their efforts.

4. **Enable preliminary determinations.** Unlike a number of other marketplace websites, Kentucky allowed consumers to receive a preliminary determination to browse potential options, without having to fill out an entire application. This feature was much more consumer-friendly than the alternative, and encouraged more people to sign-up.

5. **CO-OP Plans can bring greater competition to the market.** Prior to the ACA, Anthem had 80 percent of Kentucky's health insurance market share, but Kentucky's CO-OP plan has 60 percent of the new market because of its lower rates.<sup>71</sup>

## Challenges remaining

1. **Lack of resources to assist consumers.** Despite resources available through the federal government, the consumer assistance functions of the marketplace still cannot meet demand. For example, Kynect staff suspect they could use double the number of navigators they have now.

2. **SHOP website not user-friendly.** Unlike the individual market application and enrollment process, small businesses face a much more complex process, with more steps. Kynect plans to simplify this process in time for the next open enrollment period.

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**Lessons for North Carolina.** The Kentucky experience demonstrates how state regulators can leverage flexibility in federal rules to tailor their SBM to local conditions. In addition, the Kentucky experience shows that even in a state that is not supportive of the ACA and President Obama, people are benefitting from their SBM. And in just one year, Kentucky introduced a lot more competition to its insurance market.

## **Massachusetts Health Reform in 2006**

In 2006, Massachusetts passed a major overhaul of its health care system, Chapter 58 of the Acts of 2006, that took steps to reduce the number of uninsured, and today, Massachusetts has the lowest rate of uninsurance in the U.S.<sup>72</sup> The following description focuses on Massachusetts' SBM prior to the implementation of the ACA.

**Structure of MA marketplace:** Like the ACA, a centerpiece of Massachusetts' health reform is a health insurance marketplace. An unsubsidized marketplace, Commonwealth Choice, offers consumers a choice from a range of health plans with varying levels of coverage, and a subsidized marketplace, Commonwealth Care, that has health plans offering a standardized benefits package to lower-income residents that pay little or nothing for coverage.<sup>73</sup> And also similar to the ACA, Massachusetts' health reform provided a streamlined application process for insurance, removing some of the complex verification and renewal rules that often deter individuals and families with lower-incomes from signing-up for and staying enrolled in available health insurance plans.<sup>74</sup>

## **Table 2. Lessons learned & challenges remaining in MA**

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### **Lessons learned**

**1. Use existing eligibility systems.** Massachusetts used existing eligibility systems for their expansion of Medicaid coverage and for residents who qualified for Commonwealth Care plans, which drove a significant share of enrollment.

**2. Build a diverse coalition of supporters.** Employers, faith-based organizations, health insurers, and even the Red Sox, among others, supported health reform in Massachusetts and invested resources in educating the public about their new health insurance options.

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3. **Target eligible populations.** The state sent mailers to individuals part of its free care pool, which noticeably reduced the administrative costs of enrollment. In fact, more than 100,000 individuals enrolled as a result from this targeting effort.<sup>75</sup>

4. **Consumers prefer standard plan options.** Initially, the Commonwealth Health Insurance Connector Authority, which runs Commonwealth Choice, gave insurers significant flexibility around plan design, and as a result it was difficult to understand the copayments, deductibles, and coinsurance associated with each plan, especially among lower actuarial value, but higher out-of-pocket “bronze plans.”<sup>76</sup> Subsequently, in 2010, the Connector Authority limited the number of plans insurers could offer on the marketplace and each tier of plan they could offer had to have the same level of copayments, deductibles and coinsurance.<sup>77</sup> This response to the increasingly complex health plans being offered on the marketplace, encouraged the standardization of products, which may have ultimately steered consumers towards higher value plans with lower deductibles.

5. **Create feedback loops with state regulators.** Connector officials were in regular contact with Health Care for All MA, which runs a consumer helpline, and other consumer advocates on problems consumers encountered. These feedback loops enabled the Connector to resolve problems in a timely manner.

## Challenges remaining

1. **High costs and price variation in health care.** One problem that persists in Massachusetts is wide price variation among the plans available on Commonwealth Care. Economists argue that imperfect competition in the insurance market is partly to blame for health plans that are able to charge more than marginal cost for their product, and that certain regulatory levers, such as pricing restrictions, may be able to reduce the discrepancy.<sup>78</sup> As a result, Massachusetts continues to evaluate options to drive down costs in their health insurance marketplaces.

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2. **Lack of resources to assist consumers.** Consumer advocacy groups in Massachusetts, such as a Health Care for All, continue to field inquiries about how to choose a health plan, but find existing resources in adequate.<sup>79</sup>

3. **Broken IT system.** When Massachusetts first implemented health reform in 2007, most individuals seeking financial assistance applied manually. However, Massachusetts' new IT system for plan year 2014 has encountered numerous problems which have most prevented individuals applying for financial assistance from using their website.

***Lessons for North Carolina.*** Similar to Kentucky, the Massachusetts experience demonstrates the key role state regulators can play in improving the quality of products available to consumers, as well as how the marketplace and key stakeholders' ongoing, active engagement in outreach were likely critical in driving enrollment rates up. North Carolina faces a very different political environment than Massachusetts, which passed their health reform under a republican governor with bipartisan support from their legislature. In addition, Massachusetts' uninsurance rate among nonelderly adults prior to reform in 2006 was 13 percent, below the national average of 15.8 percent.<sup>80</sup> However, like North Carolina, Blue Cross Blue Shield dominated half of the individual market in Massachusetts prior to reform, and the hospital/physician market is highly concentrated.<sup>81</sup> So, there may still be lessons that can be applied to North Carolina even though the states are different in many ways.

## VI. North Carolina's Options

Based on the analysis provided in this paper, North Carolina's options on implementing a SBM are:

- Pass legislation to establish a SBM within North Carolina's Department of Health and Human Services (NCDHHS).
- Issue an executive order establishing a commission to evaluate the costs and benefits of establishing an SBM and issue a recommendation on whether or not North Carolina should implement a SBM.
- Conduct plan management for its FFM.
- Maintain the status quo on its FFM.

While the North Carolina Department of Insurance (NCDOI) has previously been proposed as a logical home for a SBM, the advantages of coordinating SBM and Medicaid efforts, which have been a key feature of successful SBMs, justify basing it in NCDHHS.

The key criteria in determining which alternatives are best for North Carolina are political feasibility and impact on the state's budget.

### **Recommendations**

I recommend North Carolina take on a more active role in the implementation of the ACA by taking the following steps:

3. Issue an executive order establishing a commission to evaluate the costs and benefits of establishing a SBM and issue a recommendation on whether or not North Carolina should implement an SBM.
4. Pass legislation enabling the NCDOI to conduct plan management for health plans available on North Carolina's marketplace.

The above recommendations represent a balanced approach the state could take that acknowledge the political contentiousness around the ACA, and the fact that nearly 360,000 North Carolinians have already enrolled in coverage. Indeed, now that approximately 8 million individuals have enrolled in coverage through marketplaces, it would be very difficult for Congress to repeal the ACA. In addition, depending on the draft language of the executive order, the commission North Carolina establishes could still have access to federal funding in 2014 to complete its work.

## VI. Conclusion

With nearly 360,000 of its residents already covered under the ACA's new marketplaces, North Carolina needs to decide its future role in its health insurance market. Above average uninsurance, a highly concentrated health insurance market, and high demand for health insurance among residents suggest that there may be a strong impetus for the state to take a more active role in marketplace implementation instead of deferring its responsibilities to the federal government.

In order to make this decision, the state must assess whether it can take on the additional responsibilities required, and whether the benefits of taking those on exceed their costs. The early experiences of other states have shown some of the implementation risks involved, especially around IT system adoption, but in a number of cases, the risks they took bore tremendous rewards, like significantly lower rates of uninsurance in Massachusetts, and increased insurance market competition in Kentucky.

Leveraging the resources available through the federal government, and existing systems in the state, North Carolina could improve the quality of health insurance options available and further decrease the number of uninsured, if it took a more active role in ACA implementation. HealthCare.gov's flawed rollout, and the polarizing rhetoric around the ACA have not stopped people from signing up for coverage in North Carolina's marketplace. By taking a more active role in plan management and establishing a commission to evaluate the costs and benefits of establishing an SBM, North Carolina would avoid the potential political fallout that may result if it immediately implemented a SBM. In addition, it would not be increasing costs to the state, and it would be taking steps to improve the quality of health plans available to residents.

## VII. Appendix 1: Premiums

### 2014 Monthly Premiums for a Single 40-Year Old in Each State

Location	Major City	Second-Lowest Cost Silver Plan Before Subsidies (Benchmark Plan)
<b>Vermont</b>	Burlington	413
<b>Mississippi</b>	Jackson	405
<b>Wyoming</b>	Cheyenne	395
<b>New York</b>	New York City	390
<b>Alaska</b>	Anchorage	381
<b>Indiana</b>	Indianapolis	341
<b>Connecticut</b>	Hartford	328
<b>New Jersey</b>	Newark	318
<b>Wisconsin</b>	Milwaukee	315
<b>North Carolina</b>	<b>Charlotte</b>	<b>307</b>
<b>Arkansas</b>	Little Rock	306
<b>Pennsylvania</b>	Philadelphia	300
<b>Louisiana</b>	New Orleans	295
<b>Maine</b>	Portland	295
<b>Rhode Island</b>	Providence	293
<b>Delaware</b>	Wilmington	289
<b>New Hampshire</b>	Manchester	289
<b>Washington</b>	Seattle	283
<b>Massachusetts</b>	Boston	278
<b>Nebraska</b>	Omaha	271
<b>North Dakota</b>	Fargo	271
<b>Florida</b>	Miami	269
<b>South Carolina</b>	Columbia	269
<b>South Dakota</b>	Sioux Falls	264
<b>Missouri</b>	St. Louis	263
<b>Alabama</b>	Birmingham	258
<b>Montana</b>	Billings	258
<b>California</b>	Los Angeles	255
<b>West Virginia</b>	Huntington	254
<b>Virginia</b>	Richmond	253
<b>Colorado</b>	Denver	250
<b>Georgia</b>	Atlanta	250



<b>Ohio</b>	Cleveland	249
<b>District of Columbia</b>	Washington, DC	242
<b>Nevada</b>	Las Vegas	238
<b>Kansas</b>	Wichita	235
<b>Idaho</b>	Boise	231
<b>Iowa</b>	Cedar Rapids	230
<b>Texas</b>	Houston	230
<b>Maryland</b>	Baltimore	228
<b>Michigan</b>	Detroit	224
<b>Illinois</b>	Chicago	212
<b>Utah</b>	Salt Lake City	209
<b>Kentucky</b>	Louisville	205
<b>Oklahoma</b>	Oklahoma City	201
<b>Oregon</b>	Portland	201
<b>Arizona</b>	Phoenix	197
<b>New Mexico</b>	Albuquerque	194
<b>Tennessee</b>	Nashville	188
<b>Hawaii</b>	Honolulu	183
<b>Minnesota</b>	Minneapolis	154

VIII. Appendix 2: Insurance Market Competition in NC

<b>Carrier Name</b>	<b># of Lives Covered by Non-Employer Based Coverage in 2009</b>	<b>Market Shared Based on Covered Lives in 2009</b>	<b>Cumulative Market Share</b>
<b>Blue Cross Blue Shield of NC</b>	336,699	81.1%	81.1%
<b>WellPath, Inc</b>	19,927	4.8%	85.9%
<b>Time Ins Co</b>	11,624	2.8%	88.7%
<b>Golden Rule Ins Co</b>	10,967	2.6%	91.4%
<b>Humana Ins Co</b>	5,729	1.4%	92.8%
<b>Celtic Ins Co</b>	4,872	1.2%	93.9%
<b>MEGA Life and Health Ins Co</b>	4,284	1.0%	95.0%
<b>Aetna Life Insurance Co</b>	4,067	1.0%	96.0%
<b>Mid-West National Life Ins Co of TN</b>	3,635	0.9%	96.8%
<b>American Republic Ins Co</b>	2,925	0.7%	97.5%
<b>World Ins Co</b>	2,561	0.6%	98.2%
<b>Inclusive Health (NC Health Insurance Risk Pool)</b>	2,506	0.6%	98.8%
<b>John Alden Life Ins Co</b>	2,026	0.5%	99.2%
<b>Reserve National Ins Co</b>	1,817	0.4%	99.7%
<b>American National Life Ins Co of TX</b>	972	0.2%	99.9%
<b>Standard Life &amp; Accident Ins Co</b>	157	0.0%	100.0%
<b>CT General Life Ins Co</b>	130	0.0%	100.0%
<b>American National Insurance Co</b>	40	0.0%	100.0%
<b>Guarantee Trust Life</b>	9	0.0%	100.0%
<b>FirstCarolinaCare</b>	0	0.0%	100.0%
<b>National Foundation Life Insurance Co</b>	NR	N/A	N/A
<b>United American Insurance Co</b>	NR	N/A	N/A
<b>Total</b>	<b>414,947</b>	<b>100.0%</b>	

Source: Milliman, Inc. "North Carolina Health Benefit Exchange Study." (March 31, 2011).

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<sup>1</sup> Public Law 111-148.

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<sup>3</sup> Kaiser Family Foundation. "Establishing Health Insurance Marketplaces: An Overview of State Efforts" (2013). <http://kff.org/health-reform/issue-brief/establishing-health-insurance-exchanges-an-overview-of/>

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§1311 - Eliminates federal funding for Exchanges beginning January 1, 2015. Requires states to make certain that Exchanges are self-sustaining. Allows Exchanges to charge assessments or user fees or employ other methods to generate revenue. Prohibits the Exchange from using administrative or operational funds for giveaways, retreats or excessive compensation.

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Relevant provision:

"Creating Affordable and Accessible Health Insurance Options

"Our health care system should be easier to navigate and provide integrated care in a more equitable manner. A vibrant market for health insurance that is consistent and fair will allow all Americans access to health coverage."

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