WV Health Benefit Exchange Stakeholder Conference Call Summary

Group: Carriers, Consumers, Producers, Providers		
Location: Conference Call	**Date:** 12/17/12	**Time**: 1:00 pm- 2:00 pm
Facilitator/Lead: Matt West	**Handouts:**	
Attendees: Attendance was not taken due to large volume of calls. Fifty three participated on the call.		
Next Meeting Date: Conference call January 22, 2013 1:00 PM – 2:00 PM		

Discussion Points

1. Federal Rules and Guidelines

Jeremiah announced that HHS has released a large amount of Rules and Guidelines. He requested that stakeholders review the rules and if they have any questions to please contact the OIC.

- **Data Template Rule** is primarily for Issuers. This rule covers the data that is required in the QHP process.

  This rule requires a large amount of data that issuers will be required to provide. HHS and the NAIC are working on a "How-To" Guide. Some of the required forms are on the SERFF website. (http://www.serff.com/)

- **EHB Rule** comment period ended on 12/26/12. This rule eliminated the issue of state required mandates. The rule states that any state benefit enacted before January 2012 would remain a market-specific EHB. The WV EHB plan is on the Federal Register. The OIC is currently reviewing the pediatric dental piece and is considering submitting the WVCHIP plan as the default. See Appendix A at the following link for current EHB selection: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf

  WV Medicaid is waiting on specific guidance as to what EHB benefits they will need to offer.

- **Market Reform Rule** defines the parameters of the new rating factors for age, tobacco use and region. The states are to provide HHS with their definitions of each parameter.

- **Payment Notice Rule** outlines what fees will be assessed in the Exchange and discusses the premium stabilization programs (reinsurance, risk adjustment, and risk corridors). The fee is defined to be no greater than 3.5% to QHP issuers for plans offered on the Exchange.

There is a very short time frame for comments and questions. Jeremiah encourages everyone to review the rules and provide comments and feedback to HHS. Additionally he requested that stakeholders share their comments and concerns with the OIC.

Q: Do issuers pay a fee for plans not in the Exchange?

A: Not for the Exchange. There are premium stabilization fees on plans not in the Exchange.

Q: Why were a percentage of premiums chosen and not a flat fee?

A: Possibly as a way to normalize across the nation. The fee can be modified and adjusted as information is available to HHS.

Q: Is there a fee on dental?

A: Unknown at this time. Will follow-up when information is made available.

Q: Who determines provider's reimbursement rates?

A: The Exchange does not have any authority to determine reimbursement rates. That will remain an agreement between the issuers and the providers. The Exchange does not directly affect commissions between issuers and agents either.

Q: Has any guidance been released on open enrollment outside the Exchange market?

A: Currently, open enrollment is slated to begin on 10/1/13 and go through 3/31/13. There has been no additional rule or guidance on this. We would encourage that non QHP's and the market outside the Exchange have open enrollment. This would decrease their adverse selection risk.

On December 10th, HHS Secretary Sebelius sent a letter and FAQs to states that included responses to questions related to the ACA. The letter addressed a number of issues. It is located on the OIC website for those who would like to look at it: http:/bewv.wvinsurance.gov/Portals/2/pdf/HHS%20Letter%20and%20FAQs-12-10-2012.pdf

Q: Does the letter address the tax credits for those below 100% of the FPL?

A: There are no tax credits for those below 100% of the FPL.

(http://www.treasury.gov/press-center/press-releases/Pages/tg1587.aspx)

- **Multi State Plan Rule** is surrounded by controversy. Network adequacy and EHB benchmark are discussed in the rule.

Q: Where does CHIP fall?

A: CHIP will be up for reaffirmation in 2019. Either in 2015 or 2016 the program becomes 100% federally funded. Given the MAGI in 2014, we know that some CHIP will move to Medicaid and some Medicaid will move to CHIP. There will be some churning. We are currently working with CHIP on specific strategies and issues. We will provide that information when we can.

Q: How will Carriers receive payment for premiums?

A: That will vary. In the individual markets, the consumers have options as to how payments will be made. Consumers can designate the U.S. Treasury to make the monthly payments to the carriers, or they can have the tax credits applied to their tax returns. It is thought that most will have the payment sent directly to the carrier by the Treasury. In the SHOP market there will be a third-party administrator (TPA) that will remit the payments to the carriers.

2. Status Updates

- **West Virginia Legislature** – The OIC presented to the West Virginia Legislature on the options for the Exchange. There has been no final decision. The state is working with HHS on two MOUs for Plan Management and Consumer Assistance. The final date for the decision is 2/15/13. The major issues are cost and sustainability. If we were to go with a fully-federal Exchange, there would be a significant regulatory burden placed on the carriers and agents. The presentation is located on the OIC web site if you would like to review the information. (http://bewv.wvinsurance.gov/Portals/2/pdf/LEG%20PRES%20DRAFT%20(Final).pdf)
- **Provider Quality** – Work continues with the WVSOM. Currently reviewing CAPS data. The latest update from HHS is that they are looking at 2016 to implement the Provider Quality Standards.
- **Marshall University Health Insurance Literacy** – Work continues and we expect a final report in late January. This is important research and will provide us with a level of consumer understanding as it relates to health insurance.
- **Oral Health Study** – This project has been finalized and the reports can be located on the bewv.com website at: http://bewv.wvinsurance.gov/ResearchProjects/OralHealthProject.aspx
- **WVU Performance Measurement Study** – Continues the service delivery and impact on the economy and population health. They are establishing a baseline to evaluate issues.
- **Consumer Assistance** – Guidance was released on 1/3/2013. It can be located here: http://bewv.wvinsurance.gov/Portals/2/partnership-guidance-01-03-2013%20pdf.pdf
- **Plan Management** – There are timeline delays. SERFF is waiting on rules to be released. There is a very short timeline and number of questions that HHS needs to provide.
- **Grant Application Process** – Currently we are looking at a possible addition to our Level 1 Grant. We may submit that sometime in February 2013. This would be to cover the cost of the Partnership.
- **CCRC** – Reported that they are in the process of data collection and they expect that to wrap up soon. They will then move to the micro-simulation phase. Current time line is that a draft should be available in February 2013. As soon as we can release it we will.
- **Network Adequacy** – If an issuer is current, they may attest that they are adequate. Issues would be addressed as they arise. If an issuer is not accredited, they must submit a plan on how they will become adequate.

3. Medicaid

Commissioner Atkins from Medicaid provided additional updates. She noted that they are awaiting guidance on the EHB.

Q: Will Medicaid be having any public participation on EHB development?

A: There will be stakeholder meetings to determine where the current Medicaid populations will fit in.

Q: Perry Bryant asked if there will be cost sharing for those above 100% of the FPL?A: Medicaid is waiting on guidance on what will be permitted. Commissioner Atkins then asked if there was anything specific being suggested. Perry then stated that he was not opposed to co-pays.

Q: Are there additional details on the EHB rule?

A: Jeremiah stated that we are continuing to review the rule. As details are available the OIC will share them.

Discussion then centered on the January meeting. Jeremiah asked if there were any objections to holding another conference call. The consensus was that was good with those on the call. The face-to-face meetings will return in February.

Phil Shimer asked for an update on the sustainability model. Jeremiah stated that the office was working on an update and that once it was available the OIC would provide it.

Phil Shimer asked about the new fee of $63 that employers are to pay when they provide insurance.

Jeremiah stated that he was unfamiliar with that regulation but he would look into in.

Next Meeting Conference Call January 22 1:00 PM

Action Register

What/Task	Who	When
1. Prepare notes from meeting	OIC	
2. Send SERFF link to stakeholders.	OIC	
3. Research the “$63” fee.	OIC	

Session Plus/Delta

A Plus/Delta was not done for this meeting.