INTRODUCTION

THIS PROJECT NARRATIVE IS SUBMITTED IN SUPPORT OF THE WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER (OIC) APPLICATION FOR FUNDING PURSUANT TO THE STATE PLANNING AND ESTABLISHMENT GRANTS for the Affordable Care Act's Exchanges, which have been established by the U.S. Department of Health and Human Services' Office of Consumer Information and Insurance Oversight.

The OIC is responsible for overseeing the development of the West Virginia insurance exchange. The conceptual plans for the West Virginia insurance exchange have progressed more quickly than in many other states due to West Virginia's participation in the State Health Access Program (SHAP) grant, which was issued by the Health Resources and Services Administration in September 2009. West Virginia's exchange planning grant request works in conjunction with the efforts that have already taken place under the SHAP grant and provides the state with necessary funding to perform essential planning activities related to the implementation of the West Virginia health insurance exchange.

The OIC is requesting the maximum grant amount of $1,000,000 and is proposing to use the grant funding to develop a baseline of necessary information so that the state is positioned to make critical policy decisions as stipulated by the Affordable Care Act and as is necessary to best serve the citizens of West Virginia. This grant will enable West Virginia to expand research and development efforts on the health insurance exchange.

This narrative will describe project activities that will take place from the notification of award through twelve months thereafter (October 1, 2010 through September 30, 2011). In accordance with the grant guidance, the narrative is organized with the following section headings: background and research; stakeholder involvement; program integration; resources and capabilities; governance; finance; technical infrastructure; business operations; and regulatory or policy actions. **Grant objectives will be referenced throughout the document and can be cross referenced with the attached work plan and budget detail documents.**

BACKGROUND RESEARCH

Having accurate information on various aspects of the health insurance market is essential for states developing plans for the health insurance exchange. Such information serves as the backbone of any actuarial models; business and operational plans; education and outreach plans; technological assessment plans; and, ultimately, the development of an overall project strategic plan. This data is also essential when educating and discussing policy directions with executive and legislative policymakers; consumer groups; private carriers; producers; and all other interested stakeholder groups.

West Virginia plans to use planning exchange grant funding in two key ways to serve this purpose. The first objective is to assess the West Virginia health insurance consumer market by expanding on previous demographic surveys, studies, and models. This analysis will serve to collect information on both the insured and uninsured. The analysis on the uninsured should include estimates of the total number of people who lack coverage; demographic information as well as geographical variations in the distribution of the uninsured; family income; employment, including a breakdown of the uninsured who are employed based on the size of their employer, and whether they are offered employer sponsored insurance; and eligibility for publicly-subsidized health coverage programs.

Regarding the commercially insured, data will be collected for demographic profiles across each of the major market segments; geographic variations in the coverage rate of the commercially insured; number of carriers operating in each market; breakdown by size of employers that offer insurance; types of insurance provided by employers, including the benefit design; premiums and the percentage paid by employees and employers; employees' take up rate of employer sponsored insurance by size of employer; and the impact of the employer tax credit on the number of employers offering coverage

There will also be a need to collect data as it relates to the number of individuals expected to come into the exchange at specific federal poverty levels; the number of individuals expected to go into Medicaid and at what poverty level; the number of individuals expected to not abide by the mandate; the number of individuals accessing coverage/care within West Virginia that are from out of state; the number of individuals accessing coverage/care outside of West Virginia that live in the state; and surveys on the number of small businesses with interest in purchasing coverage through the SHOP exchange or that may be interested in making a defined contribution that can be aggregated with federal subsidies in the individual exchange.

This work will build upon the detailed series of studies about the uninsured (funded by prior HRSA SPGs). In 2001, the West Virginia University Health Policy Institute (HPI) coordinated the first ***West Virginia Healthcare Survey*** of 16,493 households to learn about West Virginians who did not have health insurance – who they were, what the circumstances of their lives were, and what relationship the lack of insurance had to their health status and their access to healthcare services. The survey was updated in 2003, and the survey was repeated a third time in 2007. The 2003 and 2007 surveys provide valuable statewide measures of change, but were not large enough to provide county-level estimates.

According to these surveys on the uninsured, on any given day in West Virginia 236,174 non-elderly adults (aged 19-64) are without health insurance. This represents 21.5% of the non-elderly adult population and over 60% of these uninsured have some connection to work. Many of the working uninsured are employed in seasonal, temporary or part-time jobs that do not afford insurance benefits or full-time jobs that pay low wages without health coverage. Many work in small businesses that cannot afford to offer comprehensive employer-sponsored health insurance. These studies also found that 75%% of uninsured adults in

West Virginia (over 177,000 adults) have been without health insurance for a year or longer. The largest increase between 2001 and 2007 was seen in those without insurance for periods of between one and ten years. The risk of being uninsured is greatest for younger adults (aged 19-34), and this risk has been increasing for this age group over time. In contrast to the earlier survey, males now constitute the majority (50.3% or more than 118,000 individuals) of uninsured adults.

While the report shows, as noted above, that on any given day 236,174 or 21.5% of the adult population was uninsured, the story is quite different for children. In 2007, the overall number of children in the state had dropped by 6 percent (403,092) from the prior survey. Aided by the SCHIP and Medicaid programs, 91.4 % of these children had health insurance and only 3.1% were uninsured all year.

The information reported in the WVU Policy Institute reports is consistent with similar information on those without insurance in West Virginia as reported by sources such as Kaiser Foundation State Health Facts. By using information from these multiple sources, a statistical composite of the challenge presented by this project to cover the uninsured emerges:

Insurance Status of Non-Elderly Adult West Virginians (2007)

Type of Insurance:	**Estimated Number of Adults**	**2007 %**
Private Employer	453,858	41.73%
PEIA	139,096	12.80%
FEHB	41,324	3.80%
VA/CHAMPUS	10,016	0.92%
Medicaid	95,807	8.80%
Self-Purchased Health Insurance	31,126	2.86%
Medicare < 65 yrs	38,092	3.50%
COBRA	12,621	1.16%
UMWA/Railroad Retirement/Other Union	6,047	0.56%
Other	23,347	2.15%
Uninsured	236,174	21.72%
Total	1,087,508	100.00%

Employment Status of the Uninsured in West Virginia (2007)

Employed	109,821	46.50%
Self-Employed	34,481	14.60%
Unemployed	33,064	14%
Homemaker	31,411	13.30%
Disabled	12,990	5.50%
Student	8,975	3.80%
Retired	5,432	2.30%
Total	236,174	100.00%

West Virginia Children's Health Insurance Program (WVCHIP, referred to nationally as SCHIP*)* is a low-cost health care plan for children 18 and younger. West Virginia expanded eligibility for the program in early 2007 to families with incomes

between 200 percent and 220 percent of the federal poverty guidelines. In 2007, average enrollment in WVCHIP was in excess of 25,000 children.

West Virginia Public Employees Insurance Agency (PEIA) is the predominant insurer of public employees in the state of West Virginia and provides coverage to approximately 212,000 individuals. However, this plan is open only to employees of the State or designated governmental units. As noted in other sections of this narrative, from time to time policymakers and lawmakers have used various elements of the PEIA program in coverage expansion efforts.

Medicaid Program: The West Virginia Medicaid program provides health insurance coverage for approximately 22% of the population. West Virginia has a lower percentage of covered adults (due in part by a low FPL threshold) and a higher percentage of disabled than the national averages for the Medicaid-covered population:

Medicaid Enrolled (SFY 2010)

Category	*Enrolled*	*Percent*
Adult	59,035	15%
Aged	30,451	8%
Blind/Disabled	110,870	27%
Child	204,822	51%
Total	405,178	100%

The second objective is to assess the West Virginia health insurance business market by expanding on previous industry surveys, studies, and models. This will include surveys, studies, and models to determine the market share of insurance companies in the individual and small group market; the size and number of lives in the self insured market; the role and scope of the insurance agent in the health insurance market; and the role of public plans in the insurance market. This component of the grant will build off of existing information but will require surveys of carriers; employers; fully insured; self insured; small group; and broker data at both the state and regional level. It is estimated that the cost of this service will be approximately $75,000.

The following information on health insurance regulated by the OIC will apply only to fully-insured health coverage and will not include self-funded coverage. According to the 2008 annual report of the Office of the Insurance Commissioner, comprehensive major medical health insurance (defined as insurance coverage that provides hospitalization, physician services, lab services and medications and referred to in this narrative as “major medical”) resulted in earned premium revenues of $786 million in 2007 and covered approximately 215,166 lives in West Virginia. The OIC reports major medical insurance sold by commercial providers in the State by large groups (*employers with over 50 eligible emp*loyees), representing 53% of the covered lives and

small groups (*employers with 2 to 50 eligible employees*) representing 39% of covered lives (with the balance of 8% representing individual covered lives).

In West Virginia, employer groups account for ninety-two percent of covered lives for major medical products. The OIC reports that "2007 was marked by relative stability in the major medical lines of business. West Virginia's top five companies for large group sales account for about 93 percent of premium earned and nearly 90 percent of covered lives. The number of carriers in this line of business declined to 22 for 2007 from the 26 which were observed in 2006.

Top 10 Carriers of Large Group Major Medical Coverage

Earned Premium ($)	***Company Name***	***Covered Lives***
$171,064,583	*Mountain State BlueCross BlueShield (Highmark)*	41,331
$73,249,668	*The Health Plan of the Upper Ohio Valley*	21,811
$55,823,265	*Carelink Health Plans, Inc.*	13,811
$37,871,408	*Coventry Health & Life Insurance Company*	9,790
$35,685,451	*United Healthcare Insurance Company*	9,647
$6,551,662	*Aetna Life Insurance Company*	2,775
$5,269,384	*Connecticut General Life Insurance Company*	2,786
$3,659,721	*THP Insurance Company*	1,347
$2,653,417	*Consumers Life Insurance Company*	1,233
$2,446,648	*State Farm Mutual Automobile Insurance Co.*	573
$6,958,538	*Others (12)*	2,122
$401,233,745	***Totals (22)***	***107,226***

The OIC reports that "the number of carriers in the small group market decreased from the 2006 total (30) back to the 2005 level of 27. Earned premium volume increased approximately 14 percent over 2006 for the combined sales of large and small group major medical. While at the same time, the number of covered lives decreased by nearly 7% for these group markets."

Top 10 Carriers of Small Group Major Medical Coverage

Earned Premium ($)	***Company Name***	***Covered Lives***
$162,029,170	*Mountain State BlueCross BlueShield (Highmark)*	40,152
$41,868,043	*Coventry Health & Life Insurance Company*	12,878
$25,376,798	*Carelink Health Plans, Inc.*	5,490
$13,814,190	*United Healthcare Insurance Company*	5,083
$9,277,927	*Principal Life Insurance Company*	2,367
$8,929,211	*The Health Plan of the Upper Ohio Valley*	2,227
$5,551,645	*Union Security Insurance Company*	1,106
$5,319,156	*First Health Life & Health Insurance Company*	1,033
$5,096,802	*Consumers Life Insurance Company*	1,530
$5,031,363	*Medical Benefits Mutual Life Insurance Company*	1,445
$14,662,570	*Others (17)*	3,730
296,956,875	***Totals (27)***	***77,041***

The OIC report also notes the challenges facing individuals attempting to purchase individual coverage for major medical. The report notes "the individual buyer is likely to have a job that does not provide healthcare or have no job at all, and the younger and healthier individuals of this market segment often abstain from purchasing healthcare coverage altogether or simply purchase lower levels of coverage. This results in a general *adverse selection* problem in the individual insurance market (i.e. those with

individual insurance are most likely to be individuals who have a medical need and will utilize these products)". This observation is consistent with the findings by the Kaiser Foundation that "non-group insurance premiums vary by age and health status and can be more expensive and less comprehensive than group plans purchased by employers.

Top 10 Carriers of Individual Major Medical Coverage

Earned Premium ($)	***Company Name***	***Covered Lives***
$36,437,253	*Mountain State BlueCross BlueShield (Highmark)*	8,910
$5,664,108	*Time Insurance Company*	2,887
$2,779,807	*John Alden Life Insurance Company*	1,480
$945,894	*The Health Plan of the Upper Ohio Valley*	264
$658,975	*Continental General Insurance Company*	86
$330,659	*Aetna Life Insurance Company*	125
$247,126	*American Republic Insurance Company*	43
$162,771	*Metropolitan Life Insurance Company*	148
$117,562	*American National Insurance Company*	30
$107,794	*Prudential Insurance Company of America*	397
$449,889	*Others (28)*	1,025
47,901,838	***Totals (38)***	***15,395***

Cost of health insurance coverage: The OIC annual report notes the monthly earned premiums per covered life for the listed carriers. From this amount, it is possible to calculate a rough approximation of the cost of individual comprehensive health insurance coverage on a monthly basis:

Average Annual Cost per Insured (Major Medical)

Policy Type	**2005**	*Increase =>*	**2006**	*Increase =>*	**2007**
Large Group	$3,182.12	0.85%	$3,209.46	14.23%	$3,741.94
Small Group	$3,338.51	8.12%	$3,633.60	5.73%	$3,854.53
Individual	$2,715.32	7.71%	$2,942.18	5.44%	$3,111.52

The report states "These costs provide a useful benchmark of health care insurance cost. For a family of four, we could estimate that a total premium may be about $10,852 per year, or about $904 per month under an average major medical policy." The calculations by the OIC are consistent with similar national amounts reported in the Kaiser study, which states: "In 2008, annual employer-sponsored group premiums averaged $4,704 for individual coverage and $12,680 for family coverage. Total family premiums have doubled since 2000. The employee's share of a family premium has also doubled since 2000, averaging $3,354 in 2008. From 2000 to 2007, there were declines in both the percentage of employees offered employer-sponsored insurance and the percentage of those offered coverage that elected to enroll. Both of these trends were most pronounced among workers in low-income families (families below 200% of poverty or $42,406 for a family of four). In 2007, 58% of all low-income employees were offered and eligible for employer-sponsored coverage, leaving more than four in ten without access to this coverage." These low-income uninsured workers are forced to resort to the individual market if not eligible for some other type of public coverage (such as Medicaid).

STAKEHOLDER INVOLVEMENT

The West Virginia OIC has been working diligently to develop the West Virginia health insurance exchange. The OICs efforts in developing the exchange predate the federal reform bill. As a partner in implementing the SHAP grant, which was signed by the current and former Secretary's of the Department of Health and Human Resources (DHHR); the Director of the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP); the Insurance Commissioner; and supported by a written statement from the Governor, the OIC has positioned West Virginia as a leader on insurance exchange.

Furthermore, the OIC is in constant contact with DHHR staff and the GOHELP office, ensuring that exchange efforts are coordinated accordingly with state health reform initiatives. The OIC has also reached out to the West Virginia Child Health Insurance Program (CHIP) and presented to CHIP Board the OIC's efforts. In addition, outreach has been performed with the Health Care Authority, the Bureau for Public Health, the Bureau for Medical Services, and the Health Information Network. The OIC also participated in the annual social worker conference as a means to engage those out in the field about our efforts. Furthermore, the OIC has sat down with the West Virginians for Affordable Health Care and is scheduled to participate in the August health care reform summit being sponsored by a number of community stakeholders in WV.

The OIC has also taken the important step of reaching out to commercial insurance vendors with initial concepts for the exchange. Beyond that, an outreach session with West Virginia insurance agents will have taken place with an independent statewide insurance agent organization by the time this grant has been submitted. Furthermore, the OIC presented exchange plans to the West Virginia Legislature and has had several subsequent conversations with interested legislators, which we feel are critical partners in both developing exchange plans and educating the public. Plans are also being developed to conduct a town hall style meeting on exchanges, which will be posted in the state register. After this meeting, stakeholder groups will be given the choice of self selecting into policy teams to further develop the exchange concept in a manner that reflects the needs of West Virginia's citizens and market.

While there are a number of elements within West Virginia's grant application that are relevant to stakeholder engagement, there are two in particular that have relevance to stakeholder engagement. The ninth objective outlined in our grant application is to develop a facilitation contract for all education and outreach efforts; meetings and report development for stakeholder groups; coordination of regional health insurance exchange discussions with other states; and coordination of contracts, grants, and personnel development. This includes the development of a webpage where public stakeholder groups and citizens can access various pieces of information as it relates to the health insurance exchange. It is estimated that this will cost approximately $100,000.

Also, the sixth objective is to develop an education and outreach strategy for the exchange project. This plan will incorporate information from various community resources as well as the surveys conducted under the grant. It is our hope that by

developing an education and outreach plans with input from citizens at the community level the exchange will be better positioned to effectively engage the public. This objective will result in an education and outreach plan. It is estimated that this will cost approximately $50,000.

PROGRAM INTEGRATION

The West Virginia health insurance exchange will be developed in a coordinated manner with existing State and Federal programs. At the state level this includes programs and agencies such as the GOHELP; the DHHR, which includes the Bureau for Medical Services (BMS), the Bureau for Public Health (BPH), the Bureau for Children and Families (BCF), the West Virginia Health Information Network (WVHIN), and the West Virginia Health Care Authority (HCA); CHIP; the West Virginia Public Employee Insurance Agency (PEIA); and other constituent state agencies and stakeholder groups. Some of the federal programs for which the exchange may need to develop defined programmatic relationships are the U.S. Department of the Treasury, including the Internal Revenue Service; the U.S. Department of Labor; the U.S. Department of Homeland Security; the U.S. Department of Health and Human Services (HHS), including the Center for Medicare and Medicaid Services (CMS), the Office of National Coordinator (ONC), the Office of Consumer Information and Insurance Oversight (OCIIO), and others as necessary.

Given the large number of State and Federal agencies and programs that require some degree of coordination and integration, West Virginia's exchange planning grant has requested funding for a number of objectives directed at assessing technical, financial, and policy integration needs. This includes the fourth objective of the grant, which includes goals of developing plans with other agencies as they relate to the viability of the basic health plan concept; determining the actuarial soundness and financial viability of the regional exchange concept; study of policy integration with BMS, CHIP, and PEIA; and determining the best manner by which to develop exchange efforts with other health reform initiatives, as being coordinated by GOHELP.

There will also be a need to integrate the West Virginia health insurance exchange with education and outreach efforts taking place with a number of programs and health reform initiatives. To assess these needs the grant has set aside funding in the sixth grant objective to develop an education and outreach strategy for the exchange project. This plan will integrate strategies with a number of constituent state agencies and community resources. This will ultimately result in an education and outreach plan, which will be incorporated into both the business plan and the five year strategic plan. It is estimated that the education and outreach plan will cost approximately $50,000.

Another component of West Virginia's program implementation plans will be to develop an assessment of the technical capacity of current state information systems to perform the various technological functions that will be necessary to perform the various

functions of the exchange. Part of this assessment will focus on aligning policy needs with system capacity and technical development. This will be further outlined in the Technical Infrastructure portion of the narrative.

RESOURCES AND CAPABILITIES

West Virginia's grant application has objectives designed to outline what is needed to develop a health insurance exchange. This assessment has already started in West Virginia with resources from the state insurance agency and previously discussed SHAP grant. West Virginia's SHAP grant has dedicated a portion of funding to exchange research and development and will be the primary source of funding for exchange planning personnel. SHAP funding will also be coordinated with future HHS exchange grants in order to procure the necessary contracts to perform exchange duties, ie outreach campaigns and IT systems.

As has been previously mentioned, this grant application anticipates funding to determine what resources will be necessary to properly develop and implement a health insurance exchange. A number of project objectives will be coordinated to address what resources are necessary to this end. The following aspects of West Virginia's grant application serve this purpose- the policy model and planning assessment objective; the development of a business plan; the development of an education and outreach plan; and the development of a technological needs assessment.

GOVERNANCE

West Virginia is currently considering several governance options for the health insurance exchange. A fundamental question must be addressed concerning whether the exchange will be operated by a private non-profit; an existing state agency or agencies; a newly created state agency; or a quasi public-private entity. The state will need to examine several key questions before a final determination can be made concerning the governance of the exchange.

In reviewing the various governance models, West Virginia will consider a number of factors, including public accountability; regulatory function; necessary expertise; market flexibility; procurement issues; personnel issues; and public and private sector integration. Regardless of the governance chosen, the exchange will have to comply with both state and federal laws establishing the exchange. The exchange must work with all of the appropriate stakeholder groups in the decision making process and operate in a transparent manner.

Various components of the exchange planning grant will assist in making the determination as to what governance model is most attractive, including the objectives outlining policy assessment and the objective calling for expert facilitation with stakeholder groups. Ultimately, the final decision on what governance model will work best for the state of West Virginia will rest with the Governor and the Legislature with critical input from the OIC. This decision must also be informed by other constituent state agencies and other important stakeholder groups.

FINANCE

The West Virginia health insurance exchange planning grant will provide the state with the necessary data to develop both a business plan and a five year strategic plan. These documents will serve as key planning and operational guides and address a number of financial components crucial to exchange development and operation. This includes a cost assessment of what is needed to develop and then sustain the exchange, including education and outreach; information technology; navigator or producer services; actuarial services; consumer services; external audit/accounting supports; financial statement reporting for disclosure to the public; an accounting system with a general ledger, payroll, accounts payable, and accounts receivable function; and general staffing needs.

The state must also gather information and develop a strategy as it relates to developing and regulating the exchange market. This is perhaps the most important component of the exchange in that it will drive the structure of plans and regulate cost sharing for consumers. To this end, a number of key questions must be answered, including requirements for plans to be certified, whether or not to combine the small group and individual markets, redetermination of the state's mandatory benefits, fees that will be charged in the exchange, etc.

The level of upfront investment depends on the types of services that will be provided in the market and the extent to which the existing services can be leveraged and utilized by the exchange. Administrative cost issues must be solved so that exchange plans are no more costly than plans outside of the exchange market. A number of strategies will be explored to help assess the most efficient manner by which to operate the exchange, including exploration of the regional exchange concept for both the purpose of increasing the size of the risk pool and/or sharing back end administrative functions across state lines for the purpose of leveraging down vendor costs through an economy of scale. Such administrative efficiencies will also be explored with the federal government. Also, steps must be taken so that the administrative costs of the exchange are made clear to the public. Transparency of administrative costs will be a key factor in earning the public's trust.

A majority of the objectives outlined in the exchange planning grant narrative are designed to address finance issues. This includes both the first and second objectives, which are designed to gather market information on consumers and industry respectively.

The third objective will be to develop an actuarial and economic assessment of the West Virginia health insurance market and determine who will be in the exchange and at what cost. This actuarial assessment will have to take into account those that choose to take the penalty or are forced to get an exemption from the mandate due to inability to make premium payments.

Cost sensitivity is an important consideration for exchange take up rates and includes not only the monthly cost of coverage, but also co-pays and deductibles which can preclude access to care even for those with some coverage. One example of the interplay of pricing and enrollment can be found in Vermont's health reform efforts. Dr. Thorpe, who provided guidance on many of the West Virginia efforts, devised a "take-up rate" formula for Vermont's health reform to assess how many uninsured would enroll. Dr. Thorpe used a measure of price elasticity based upon economic theory, including the formula used by the Congressional Budget Office to estimate enrollment in public programs. "Price elasticity" is the measure of how individuals respond to price changes for a particular good. Dr. Thorpe estimates price elasticity for health insurance at -0.5. This means for every 10 percent decline in the price of insurance, 5 percent of the uninsured will enroll. In addition to the price sensitivity of enrollment, Dr. Thorpe takes into account the share of the health premium as part of household income, and the amount of the public subsidy. (Overview of Catamount Health. Kenneth E. Thorpe. February 23, 2006)

Dr. Thorpe's Take-up Formula

Percent FPL	Monthly Premium, *Most* Enroll	Premium as % income	Monthly Premium, *Nearly All* Enroll	Premium as % income
150% FPL	$27	2.2%	$15	1.2%
301% FPL	$175	6.8%	$83	3.4%
500% FPL	$288	6.9%	$138	3.4%

The fourth objective will be to take the market surveys, studies, and models and assess the pros and cons of various public policy questions. This would include an analysis for combining the small group and individual markets; incorporating the large group market into the exchange; assessing plans for the purpose of developing actuarial tiers; viability of the basic health plan; determining the actuarial soundness of the regional exchange concept; the process by which the exchange becomes sustainable via fees and charges; and comparing the cost of federally mandatory benefits and state mandatory benefits.

The fifth objective will be to develop a business plan based on the information gathered as part of this grant and other exchange concept designs undertaken by the state of West Virginia. This business plan must outline how actuarial tiers will be developed, projections for the exchange budget, and the financial impact of the exchange on the health insurance market.

The sixth objective is to develop an education and outreach strategy for the exchange project. This plan will incorporate information from various community resources as well as the surveys conducted under the grant. This will result in an education and outreach plan, which will be incorporated into both the business plan and the five year strategic plan. This strategy will include an assessment of projected expenditures on education, outreach, and marketing.

The seventh objective is to perform an assessment of the technical capacity of current West Virginia systems to perform the technological functions that the state will need in order to perform the various functions of the West Virginia exchange. This will

result in the development of a WV Exchange Technology Plan and is intended to provide a projected cost of information technology contracts and the interfaces that must be developed with state and federal systems.

Lastly, the ninth objective is designed to develop a facilitation contract. Part of the duties outlined in this contract will be to coordinate efforts in development of exchange component plans and the five year strategic plan, as well as facilitation of financially oriented discussions with stakeholder groups.

TECHNICAL INFRASTRUCTURE

Developing the technical infrastructure of the health insurance exchange will be one of the most difficult and complicated undertakings for any state. The technical capacity of the exchange is crucial for all parties that will have contact with the exchange. Consumers will need a seamless interface for eligibility, premium aggregation, consumer information, plan menu selection, and enrollment. Carriers will need an efficient mechanism to have their plans approved, graded, and uploaded into the exchange; have their plans fairly listed in the carrier menu market; have consumers efficiently enrolled; and have consumer premiums aggregated, collected, and remitted to the carrier's account. Navigators, consultants, and producers will need access to the exchange so as to review, manage, or assist with a consumer's account; have their work in the exchange recorded for quality assessment; and have their work compensated by some mechanism of payment.

Regulators and/or exchange staff have a number of interactions with the information technology components of the exchange. First, the exchange must determine how to structure the technical infrastructure of the exchange- technical functions the exchange must perform; technical functions the exchange can share with state or federal agencies; technical interfaces with technology systems outside of the exchange; evaluation of system performance for all stakeholders; tracking of exchange utilization for purposes of developing public policy; etc.

The seventh objective of West Virginia's exchange planning grant will result in the development assessment and strategic plan for information technology infrastructure. This includes assessment of current eligibility systems; assessment of linkages with small group employers; assessment of linkages with various West Virginia agencies; assessment of linkages with the federal government; assessment of linkages with carriers; assessment of linkages with producers, navigators, and consultants; assessment of technical needs to track individuals across various coverage options; technical capacity to collect and remit premiums; technical capacity to link consumers with carrier plans; the technical capacity to store and save exchange related data; and other technical infrastructure needs as determined necessary in the plan. Regarding eligibility, once the federal standards and data bases for eligibility determination are clear, the project will focus on how best to connect West Virginia's exchange with HHS for purposes of eligibility determination and subsidy calculation. These decisions will be made with state partners in DHHR and

CHIP and will require more budget resources in subsequent exchange grant requests. Ultimately, the technology assessment will result in the development of a strategic plan for technology needs and be fused with the exchange business plan and five year strategic plan.

BUSINESS OPERATIONS

There are a number of business operations that health insurance exchanges will have to perform. The state must first decide on the scope of the exchange before actually developing these components. There are at least two areas where business operations will have to be developed. First, functions dictating the exchange's role and interaction in the market will have to be developed. These areas include the number, type, and standardization of plans; risk adjustment; and interaction with brokers, carriers, employers, state and federal agencies, and individual consumers. Second, operational functions performed by the exchange, including information systems, customer service functions, and management of payments and subsidies.

Concerning how to make determinations as it relates to the exchange's interactions in the market, an important responsibility of the exchange is how it interacts with carriers who offer benefit plans. One consideration is how many and the type of plans that will be offered through the exchange. Another operation is how these plans will be managed with the market outside of the exchange if one exists. Finally, an exchange must determine what tiers each plan falls in, the level of standardization between the plans, and how plans will be graded.

The state will also have to develop a mechanism by which to regulate risk between plans. The ACA calls for states to develop a risk adjustment program, which is to cover plans both in and out of the exchange but will not be able to address self insured plans or grandfathered plans. In this program the state will assess plans and insurers with low risk enrollees and make payments to plans and insurers with high risk enrollees. This will be coupled with the transitional reinsurance program to be implemented in 2014 by the states in conjunction with reinsurers and the development of a risk corridor program that will be available for qualified health plans in the individual and small group market. The development of a risk adjuster and coordinating this component with others aimed at guarding against adverse risk will be key components to preventing adverse risk and will be comprehensively addressed in the studies and research performed as part of West Virginia's exchange planning grant.

The exchange will have a number of responsibilities that will require it to interact with a number of actors in the insurance market. These relationships must be cultivated in a manner that emphasizes a good working relationship in order for the exchange to develop an efficient operational model.

Concerning systematic, customer service, and payment management operations of the exchange, West Virginia will expand on research that has already taken place. The following exchange concepts, currently being researched as part of the SHAP grant, represent a sample of what is being considered. The exchange concepts being considered:

Eligibility Portal: Portal could give consumer ability to input relevant personal information, which will allow electronic assessment of public plan and federal subsidy eligibility. Portal could also give consumer option to input employer or other account code, giving exchange the ability to pull from various accounts set up on consumer's behalf. Eligibility portal will connect to all available health insurance coverage opportunities in the state of West Virginia, including linking consumer to commercial insurance plans for individuals, small groups, and associations via a carrier menu. If consumer is eligible for public plan, consumer will be directly linked to eligibility/enrollment portal for specified public plan.

Premium Aggregator: Upon inputting specific income and employer information, consumer will have all premium contributions aggregated. As consumer compares and contrasts plans in the carrier menu, they will know the aggregated contribution to their coverage from other entities, thus giving them a better tool by which to budget for and purchase the plan that best serves their needs.

Coverage Decision Making Assistance Tool: As consumer navigates the exchange, they could be given option to respond to questions in a guided decision-making tree that would direct consumer to plans that best serve their health care needs. Such a tool would be voluntary and include a disclaimer that consumer should take time to fully research coverage options available to them.

Carrier Menu: Exchange provides access to a carrier plan menu for consumers looking to purchase commercial insurance. This menu will allow consumers to compare and contrast critical insurance metrics with more detailed plan descriptions also being available. Carrier menu will be linked to any available federal subsidies and other account contributions set up for consumer. Menu will be structured in five actuarially determined tiers per federal guidelines, with one being available to only young adults.

Standardized Enrollment Portal: Upon selection of a carrier plan, exchange will facilitate the consumer's purchase of coverage by collecting relevant information and linking to carrier or by directly linking consumer, with input selected plan and eligibility information, into carrier enrollment system.

Premium Collection and Remittance: The Exchange could perform accounting functions to remit premiums and prepaid amounts to the various insurers and brokers or participating health care organizations, including payroll deduction for premium or prepayment for coverage. Through economy of scale, the exchange could potentially perform these functions more efficiently.

Employer Exchange Kits: Small and eventually large employers can utilize the functions of the exchange to streamline the administrative burden that providing coverage to their employees results. To effectively utilize the exchange, an employer kit could be developed that systematically outlines all of the steps that an employer needs to take to use the exchange.

Portability of Coverage: It is contemplated that Exchange will facilitate portability of coverage as employee transitions from employer to employer. This concept faces obstacle of different employers choosing different tiers of coverage for their employees.

Link to Regional Exchange: WV has considered two potential benefits of regional exchanges. The first option would be to provide coverage to consumers from multiple states/regions in a single exchange or give a consumer access to multiple exchanges. This would benefit consumers by either increasing the number of participants in plans from which they choose. It could also provide them with regionally attractive options, especially for consumers living in border counties. State mandatorily covered services and variations in state regulations make this concept difficult to realize. The second option would be to share administrative functions with other state exchanges. For example, having one vendor that would be able to collect and remit premiums in more than one exchange could potentially see savings through an economy of scale.

Insurance Consultant/ Counselor Assistance: A web portal is only one means by which consumers will access exchange. Given computer/ internet access and literacy issues, insurance counselors have been designated in the SHAP budget for consumers to access via phone or web chat. The Call Center/Live Chat for health insurance questions and assistance, is conceptually modeled after and incorporating elements of the State Health Insurance Assistance Program for Medicare.

Multiple Exchange Access Points: WV Consumers need multiple access points into the exchange so that they are assured to receive appropriate subsidies and other services as provided by the exchange. Given literacy levels, lack of computer access, and poor broadband linkages, it is absolutely essential that the exchange is not just a web portal. Beyond the required call center, plans are being developed to utilize a number of organizations already established in communities, including Family Resource Networks; DHHR case workers; volunteers; and other community groups to serve as insurance exchange facilitators and counselors.

All Payer Claims Database: Through an executive order by the Governor, DHHR is leading a task force to establish an APCD. This tool could function to provide consumers with both provider charges within a carrier network and quality assessments of those providers in carrier networks. This tool will also be essential in developing a risk adjustment policy.

Master Client Index: In that state client service and consumer health coverage systems do not communicate with one another, the state is unable to ascertain exactly how many clients are being served at any one time because some of these

services overlap. The state is also unable to track individuals across state systems, meaning that the state is unable to determine continuity of care for vulnerable populations. In that some public health programs will continue to overlay various types of coverage for the underinsured, it is in the state's best interest to coordinate these overlays and track coverage trends as much as possible for resource allocation and case management purposes.

Health Coverage Matrix: An overview will be made available of all health coverage available in state of West Virginia. While consumer will be able to access these programs via the eligibility portal, consumer also will have option of reviewing the universe of available services in a matrix document on the exchange website.

Agent/Broker Access: Agents and brokers are key stakeholders as the exchange is developed. Their role in the exchange needs to be further fleshed out. Consumers that want to utilize the service of an agent or broker should not be precluded from doing so. Concepts are being considered that would give agents/brokers special access to the exchange to perform their job functions for consumers.

Other Consumer Tools: In that the Exchange's primary function is to empower the consumer to make good decisions on purchasing coverage, we have considered several tools to give consumers pertinent information. Such tools being considered include: carrier in-network maps; providers by zip code; cost comparisons of medical providers; carrier complaints matrix; community wellness resources; qualified health plan rating; and social media review functions.

Other Exchange Information: Functions such as FAQ, About Us, Common Terms, and a health insurance and exchange tutorial will also be available through the exchange.

West Virginia anticipates using several components of the exchange planning grant to develop relationships and strategies for business operations. This includes the following objectives that have already been outlined:

The fourth objective will be to take the market surveys, studies, and models and assess the pros and cons of various public policy questions.

The fifth objective will be to develop a business plan based on the information gathered as part of this grant and other exchange concept designs undertaken by the state of West Virginia.

The seventh objective will result in an assessment of the technical capacity and need of exchange systems.

The ninth objective will result in a facilitation contract that will serve to better coordinate relationships with stakeholder groups for the purpose of addressing business operation issues.

REGULATORY OR POLICY ACTIONS

There are a number of factors that will contribute to West Virginia's exchange development plans. An assessment is already underway by the OIC to determine what necessary statutory changes will be necessary to develop and carry out the functions of an exchange. This assessment is not taking place in a vacuum and the OIC continues to evaluate developments at the federal rule making level. Regulatory and policy considerations will also be developed based on the input provided by various stakeholder groups, including input from industry and consumer groups; constituent state agencies; the legislative branch of government; and discussions taking place in the National Association of Insurance Commissioner exchange subgroup, which is developing model language for all states.

Many of the objectives outlined in the exchange planning grant will influence these conversations. It is likely that enabling legislation will be sought in 2011 or 2012 at the latest with the hope that broad legislation can be refined through the rule making process when more operational detail is developed. These strategies are already being developed as part of the State Health Access Program grant and will be strengthened by efforts from each of the nine objectives outlined in the exchange planning grant.