

# WV Health Benefit Exchange Stakeholder Meeting Summary

<b>Group:</b> Carriers		
<b>Location:</b> Offices of the Insurance Commissioner, 1 Players Club, Third Floor Conference Room	<b>Date:</b> 9/11/12	<b>Time:</b> 10:00 a.m. – 11:30 p.m.
<b>Objectives:</b> See agenda		
<b>Facilitator/Lead:</b> Carl Hadsell	<b>Handouts:</b> Agenda, Summary of QHP Certification Requirements, IRS Definition of Employees, Waiting Periods Guidance, SERFF PM Timeline, SERFF Presentation	
<b>Attendees:</b> Lisa Calderwood, Colleen Cohan (on phone), Bill Crouch, Sherry Davis, Danielle Ewing, Joe Garcia, Diana Hypes, Pam King, Dave Mathieu, Debi McCoy, Bob Roset, Jeremiah Samples, Todd White, Jeff Wiseman, Phil Wright		
<b>Next Meeting Date:</b> Tuesday Oct. 9th, 2012 10:00 a.m. – 12:00 p.m.		

## Discussion Points

1. **What's New OIC newsletter** – The newsletter, September issue just released, is a great resource for all types of information and activities regarding exchanges. Please send any materials and/or submissions you may have to the *What's New* newsletter to Debi McCoy at [Deborah.McCoy@wvinsurance.gov](mailto:Deborah.McCoy@wvinsurance.gov).
2. **Exchange Updates**
  - a. IT
    - IT RFP. The IT RFP for the build of the Exchange is on hold at State Purchasing and could be released if a decision to proceed with a state-based exchange is made. The OIC is also assessing other states' IT procurements with the long-term goal of reusing other systems as applicable in an attempt to make building an exchange more affordable and sustainable.
  - b. **Plan Management**

HHS cancelled a plan management conference that was scheduled for mid-September. There are still outstanding issues about actuarial value calculation, accreditation, network adequacy and other plan management questions that we had hoped would be answered at the conference.
  - c. **Federal Updates**
    - Blueprint. The final version of the Blueprint was released after the last meeting and is available on [bewv.com](http://bewv.com). One change in the Consumer Assistance area is the addition Marketplace Assisters, who seem to have similar functions as Navigators but can be funded by Establishment grants and will be operated by the states. The OIC is having conversations with BOSS, CHIP, and BMS to talk about how Consumer Assistance might work in a Partnership model.
    - Rules: Employee definition and waiting period rules have been released and were provided as handouts for the meeting. Rating rules have not been released and this is concerning, especially the regional rating factor and what the process for federal approval will be. Still awaiting EHB rules, even though the deadline for benchmark selection is approaching, September 30. The OIC was forced to make assumptions for the report of actuarial analysis to submit to the Governor's office. Other states are also making their own assumptions. The OIC previously shared Rhode Island's EHB analysis documents.

#### d. Other Updates

CCRC won the baseline research procurement contract for actuarial analysis and economic modeling. Their analysis will include researching how premium stabilization and regional rating factor determination would work. Meetings with CCRC are being held Wednesday and Thursday to lay out work plan and schedule. The OIC will be in contact with stakeholder groups about the vendor's progress.

Recently the OIC had a kickoff meeting with the National Academy for State Health Policy (NASHP) to bring their research work to explore regional exchange options. NASHP will be looking at models of sharing risk pools, administrative costs and IT systems. The state needs to be creative and carefully assess all options in order to be efficient and effective with funds.

Q: Who is going to determine regional rating factors?

A: The ACA gives discretion for states to determine regional rating method and submit to HHS for approval. If a state doesn't get approved or done, the HHS Secretary will establish the regional rating factors in that state. WV has risk factors based on state demographics. Jeremiah mentioned that the risk pool of the eastern panhandle would be likely to be rated differently than the rest of the state. Parameters for rating will be based on federal rules that have not yet been released. The OIC will be working with carriers to structure formula.

Q: Phil Wright – When does WV have to tell HHS what they're doing?

A: The Declaration Letter stating which model exchange the state will pursue is due on November 16, 2012.

Q: Phil Wright – Will there be delays in timeline because of the lack of information that has been provided thus far?

A: Jeremiah said we shouldn't count on it despite rumor of delays. HHS is moving forward with the federal exchange and we do not want to position ourselves so that we are unable to meet deadlines if they are not delayed.

### 3. Plan Management Presentation – Danielle Ewing

Danielle discussed QHP certification requirements and gave a brief update about SERFF enhancements and implementation timeline. SERFF will be presenting at the next Carrier stakeholder meeting on October 9th. If there are SERFF specialists or other people in their organization that work more closely with SERFF, carriers may want to invite them for that presentation.

QHP Certification Requirements. Danielle discussed QHP certification requirements at the issuer and plan level. Carrier must be in good standing and compliance with WV licensure and solvency requirements. Carriers must meet established network adequacy requirements, serve a minimum geographic services area and include essential community providers (ECPs). Jeremiah shared that we've asked HHS about presumptive network adequacy. We'd want to make sure there's not two processes for network adequacy; currently HMOs have standards and we would not want them to not be duplicative.

Q: Phil Wright asked if high cost providers will be in the Exchange. Will network adequacy requirements override the high cost of some providers?

A: Jeremiah said he's heard some discussion about this on national level but we don't have an answer. This is an issue across the country. OIC may work with the WV's Health Care Authority on this.

The Exchange must make a provider directory available electronically, and there is some flexibility in how this could be done here is some flexibility in doing this. SERFF is looking at creating enhancement that would allow submission of directory through SERFF.

- Issuer must offer one gold and one silver plan in the Exchange.
- Issuer must charge same rate inside and outside the Exchange for same QHP.
- Must offer same plan as a child-only plan.
- Must comply with state regulator's established marketing standards. The OIC has been told verbally that current WV standards are sufficient.

Accreditation – NCQA and URAC have been approved to accredit exchanges. Plans that aren't currently accredited must schedule review with NCQA and URAC for the first operational year.

Q: Phil Wright asked since no QHPs exist yet, does that mean that no one has existing products that would be accredited for exchange certification.

A: Danielle described a glidepath process by which an issuer can receive accreditation for their products if they attest that their standards and processes for the new QHPs are the same as existing, accredited products.

Q: Jeremiah asked if carriers had heard from NCQA and URAC concerning how much the new accreditation will cost.

A: Carriers have not heard, but said that if it's anything like existing accreditation, it will be expensive. Beyond say \$100,000 for just the accreditation process fee, there are thousands of dollars in preparation time and people engaged, could range up to a \$1 million was Phil's estimate.

- There will be an analysis of the carriers' past compliance and complaints.
- Attestations – Carriers will have to attest that they will participate in risk adjustment, pay fees, comply with requirements related to fraud and abuse, etc.
- At the plan level, actuarial value must be calculated and assigned a metal level designation. There are also three silver plan variations to accommodate cost sharing reductions (CSRs). Danielle encouraged those interested in how actuarial value is calculated to look at the bulletin released on the subject, which is posted on bewv.com.
- Plan-level analysis of discriminatory benefit design will occur for all plans attempting to become a QHP. Rules on discriminatory benefit design have not yet been released.
- Analysis of meaningful difference will be conducted at the plan level. Details on how this will be evaluated have not been released yet. The goal of this requirement is to help ensure there's a manageable number of QHPs on the Exchange. I.e., a carrier isn't minimally changing a plan to make more QHPs.
- Review of rates will occur at the plan level.
- Quality measures will be assessed at the plan level. HHS will develop a rating tool which will be accessible to consumers on the portal. HHS has said this provision will be delayed until 2016. CAHPS data will be used initially and will be provided directly from NCQA and URAC.
- Quality improvement strategies will be evaluated at the plan level. Implementation of this provision is likely to be delayed until 2016.
- HHS is to develop an enrollee satisfaction survey that will be required in 2016.
- Plans must provide for essential health benefits, with the exclusion of pediatric dental benefit which is not required as a part of the QHP if stand-alone dental plans (SADP) are offered on the Exchange.

Q: Carl asked about how WVU's evaluation plan development for the Exchange will coordinate with the enrollee satisfaction survey.

A: Jeremiah said that we have a meeting with HHS to see how we can retain some control over this. Another related research initiative that is underway is the WVSOM project looking at quality of care. We want to be able to use our work to evaluate quality and enrollee satisfaction in a way that is meaningful for WV citizens.

#### Process/Ownership Difference Based on Exchange Model

- State-Based Exchange (SBE). The state performs traditional regulatory functions, reviews and approves certification criteria, enters into agreements with carriers and performs issuer account management. The federal role is limited to high-level oversight.
- Federally-Facilitated Exchange (FFE) Plan Management Partnership. The state would perform traditional regulatory functions, reviews and approved certification criteria and coordinated issuer account management responsibilities with a Federal Exchange "account manager." HHS ratifies

the OIC's certification decision, enters into agreement with issuers, and displays QHP information on the Exchange portal.

- Full FFE. OIC performs traditional regulatory function and the federal government performs all exchange functions.

Jeremiah mentioned HHS will be auditing states' compliance in enforcing all ACA reforms, not only Exchange.

Q: Sherry Davis asked which model exchange the state would be pursuing.

A: Jeremiah said all options are still on the table. No official decision has been made by the Governor's office.

Q: Phil Wright asked about what the contract between the carrier and HHS would entail. A: Danielle said that the OIC has asked HHS for templates of the agreements but have not been supplied with one yet.

Q: It was more directly asked if certification was a contract? And, what are the financial implications of breach of contract?

A: Jeremiah said we can ask HHS. There was some thought a carrier could be de-certified.

- Recertification frequency has not yet been determined. Issuers must submit plan rates, benefits and cost-sharing structures annually prior to September 15<sup>th</sup>.
- Stand-Alone Dental Plans (SADPs). Limited scope dental benefits plans must be allowed on the Exchange; this may be offered as an independent SADP or in conjunction with a QHP.

#### Projected Implementation Timeline

Danielle said she wanted to get some feedback from carriers about when QHPs might be ready to be submitted to SERFF for certification. According to current projected timeline, carriers would need to submit QHPs between January 15<sup>th</sup> and the end of March 2013 in order to be certified by June 30th.

Q: Danielle asked if carriers thought this seemed reasonable.

A: Carriers responded that without answers to all the outstanding questions, it's impossible to say if this would be possible or not.

Q: Would a 30 day window long enough?

A: Carriers agreed 60-90 day window would be the minimum timeframe necessary.

Q: Carl asked if any carriers represented at the meeting were planning to not participate.

A: They responded that they definitely would have to evaluate costs based on final rules before they could decide to participate. There was discussion of concerns that consumers may sign up during enrollement time, but drop out, especially after some major health expense.

Q: Jeremiah asked if carriers have run models on what would happen with new consumers coming in during open enrollment and then dropping coverage. Jeremiah asked the carriers to really take a critical look at models and provide feedback to OIC.

A: Phil Wright said that's not only factor that will contribute to rise in costs - rating rules, mandated benefits, and other new requirements will affect the increased cost.

Q: What if no plans participate?

A: At minimum, multi-state plans that will be administered by the federal government through the OPM will be available. There will likely also be CO-OP plans available.

Q: Carl asked if any new carriers would participate.

A: Carriers suggested that business in West Virginia is already costly and new reforms will only increase it, so it is unlikely that new carriers will enter the market.

#### SERFF Update

- The SERFF team has developed a proposed workflow for creating a plan submission, transmitting information to the Exchange, and the plan review process. Enhancements that have already been released include a state-generated message feature and QHP-specific general instructions.

**Q:** Jeremiah asked if any carriers had an estimate of how many QHPs they would plan to be submitting if they do choose to participate in the Exchange. He noted that this information could be helpful to OIC to know staffing levels for review of QHPs in a timely manner.

**A:** Sherry said she'd be willing to share with Jeremiah but she didn't have the information with her. Phil said it will depend on a number of factors that are still unknown.

Jeremiah asked if the Carriers have started to develop plans with respect to marketing for 2014? He wanted to know if there was interest in meeting with other stakeholder groups on this specific topic. Jeremiah talked about the shared goal among stakeholder groups to enroll consumers in plans. Maximizing enrollees would be in best interest of all groups. OIC will continue to look at strategies to get groups together to talk about E&O, cooperative advertising, etc.

A question was asked as to the value of the AV calculator. The intent is to have it based on standard populations. Will there be a standard specific for WV? How will these be determined? Need to better understand the AV calculator.

### Next Meeting

The next meeting will be held Tues., October 9, 2012 10:00 a.m. – 12:00 p.m.

### Action Register

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What/Task	Who	When
1. Prepare notes from meeting	OIC	9/12/12
2. Provide information on number of possible QHPs	Carriers	When known

### Follow-up Questions

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Question
1. <b>Q:</b> What will the agreement/contract between issuers and HHS entail? <b>A:</b>
2. <b>Q:</b> <b>A:</b>

### Session Plus/Delta

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A Plus/Delta was not done for this meeting.