

OHIO HEALTH CARE REFORM STAKEHOLDER FORUM

August 27, 2010

HIGH RISK POOL

Q: How many people have been enrolled thus far in the High Risk Pool and what has MMO been doing to market the high risk pool?

A: We have 282 people enrolled and 11 pending as of today (8/27). We have mailed 500 packets, viewed 3,000 applications and have had 3,000 hits on our website. We are working with stakeholder groups to get the word out about the high risk pool and contacting local media outlets.

Q: If a short-term plan excludes pre-existing conditions and provides reduced benefits, how will that affect eligibility to the high risk pool?

A: Short-term plans may not be creditable coverage. People should contact Medical Mutual directly, as applications are reviewed on an individual basis.

Q: Has Medical Mutual established a statewide network of providers for the high risk pool?

A: Yes. Enrollees of the high risk pool have access to the same network as any other Medical Mutual health insurance enrollee.

Q: Is dental coverage mandated, optional, or an essential benefit?

A: Dental coverage is not included in the high risk pool.

Q: Can BCMH patients use the BCMH letter of approval as proof of their chronic condition?

A: Yes, the letter should be sufficient. Medical Mutual will work those individuals. The letter must have been issued within 6 months of application to the high risk pool. The letter does contain a date of issuance on it, which is good. For letters issued outside the six month window, follow up documentation would be required.

Further, the conditions on the letter should be linked to conditions that would result in two denials from insurers. If it is not clear whether the listed condition would result in two denials, follow up information or documentation would be required.

Individuals should contact Medical Mutual directly with questions.

Q: What are the premium rates for the high risk pool?

A: They can be found at www.ohiohighriskpool.com. Premium rates are determined by location, age, and smoking status.

Q: What are the financial performance targets or requirements for the high risk pool?

A: The funding for the high risk pool comes from the federal money allocated to Ohio, and the premiums paid by the enrollees. All funds will be used to pay claims, except for Medical Mutual's administrative costs, which are between 3 and 3.5%. The contract is very specific, and is also a public record. All costs must be justified to HHS.

Q: What is the estimated population that is eligible for the high risk pool, and is there enough money to cover them all?

A: We had a study done and it is estimated that about 25,000 Ohioans who would be able to afford the premium and who are in poor health. Not all of those people will choose to enroll. According to our actuarial study, 5000 Ohioans could be covered by the money allocated for the high risk pool. We will monitor the enrollment and make adjustments if necessary.

MEDICAID

Q: How is Medicaid preparing for the expansion?

A: We currently have 2 million people enrolled in Medicaid. Due to the new parameters based on the expansion, Medicaid will need to modify its current approach to some policies and processes. For example, a new, consistent approach to income disregards will be used by all states for the expansion population. Also, benefit plan offerings for the expansion population MAY be a bit different than traditional Ohio Medicaid benefits; research is underway to determine options and next steps. Ultimately, we want to maintain a system that provides healthcare and supports the family. We would have to establish a rate and analysis process for the expansion and the extent of benefits may be different. This will be ongoing and we are waiting on guidance from HHS.

Q: Will providers have to negotiate new contracts to provide care to the expanded Medicaid population?

A: It's possible. We are still doing an analysis of the potential expanded population. We do not know if there will be different payment tiers.

EXCHANGE

Q: Does the Ohio Department of Insurance (ODI) have a position on whether there will be a market outside of the Exchange?

A: At the last NAIC conference, some commissioners made comments about this. However, ODI does not have a position. Some commissioners have discussed whether there will be a market outside of the exchange and to give consumers a choice of which systems to go, what is going to be affordable for consumers. Commissioners are concerned about adverse selection. We prefer

a state-run exchange instead of a federal exchange and will have to perform analysis to make these decisions.

Q: How do you envision the flow of data and funds regarding the purchase of insurance on the exchange with free choice vouchers?

A: We will not know until we receive more information from the Department of Health and Human Services (HHS).

Q: Do you see a role for agents within the exchange?

A: Yes. Both NAIC and ODI know that agents should play an important role within the exchange.

Q: How will the exchange contact employers regarding the availability of plans?

A: We don't know. The exchange we build will really need to help employers. These types of issues will need to be addressed.

Q: What do you consider the biggest challenge in setting up the exchange?

A: There are numerous challenges: receiving guidance and being able to implement it in a timely fashion; designing an exchange that will not disrupt the market; ensuring the transparency of the exchange.

MISCELLANEOUS QUESTIONS

Q: How is the state addressing the likely shortage of primary care providers?

A: We share the interest in developing primary health care workforce capacity, both to meet the needs of more individuals with coverage as well as to assure access to primary care services in a patient-centered delivery system. State agencies with an interest in workforce and/or health care are coordinating activities and strategies to address this issue. Grant and other opportunities available as a result of federal health reform are being closely monitored and funding applications submitted as appropriate.

Q: Has ODI received information on the definition of essential benefits?

A: No, we have not. HHS is still working on it, and it may not be released for several months.

Q: Will mini-medical policies apply for a waiver?

A: We don't know. ODI is not pursuing a waiver for such plans.

Q: Will these reforms help special needs children and adults?

A: These reforms may make it easier for special needs adults to be eligible for Medicaid. Childless adults will also have new eligibility standards. The Affordable Care Act has several assistance opportunities for special needs children.

Q: How do the reforms affect public employee benefit plans?

A: Certain laws apply to public employee benefit plans, but there are some exceptions that are not in the insurance sections of the Ohio Revised Code.

Q: Can carriers bill older-age dependents directly?

A: ODI has not told employers how they should bill for older dependent coverage. We have offered employers guidance on how the coverage should be priced. If there are specific concerns, they should contact ODI directly.

Q: Do carriers only have to maintain one pool?

A: There are Affordable Care Act provisions about pooling risk inside and outside of the exchange. Employers can also self-insure, which could lead to adverse selection. We at ODI need to do some analysis around the adverse selection issue, quantify the opportunities for adverse selection, and figure out how to effectively counter such opportunities.