



Frequently Asked Questions

The Uninsured Small Business Health Insurance Plan (A Program Unique to West Virginia)

1. Will this plan be subsidized by the State?

No. The Small Business Plan will not receive any state funds. It must be self-sufficient, operating on premium income and by standard actuarial guidelines.

2. How will the plan be structured?

Senate Bill 143 allows the creation of a private/public partnership between the state and private carriers that elect to offer this plan through their broker network. The State's role is allowing access to its PEIA physician and provider reimbursement rates. The carrier's primary roles include risk assumption and plan operation. The health insurance carriers will be taking a smaller administrative fee. With this combination, the Plan's premium cost should be 20-25% below the usual market rate.

3. What will the fee schedules be? Will balance billing be allowed?

The fee schedule, as stated in SB143, will be the PEIA rates as set for each plan year. SB143 prohibits balance billing and requires that the PEIA rates be accepted as payment in full. Providers may bill or collect co-payments, co-insurance or deductibles.

4. What will this plan mean to my practice or facility?

The Small Business Plan should increase the numbers of working persons who will seek out the medical services, including routine primary care and specialty procedures, they previously avoided. Patients now seen in the ER, many with advanced or chronic conditions, will seek primary or specialty care before conditions become life threatening. Patients enrolled in this Plan, who now fall under charity care, will become paying clients.

5. What if I do not participate with one of the health carriers that are offering this plan, do I have to see patients under this plan if I do not opt out?

No, you do not have to see those patients; you will only be providing services to members of those carriers with which you have a contract to provide medical care for their other commercial products. For example you contract with plan A but not with plan B. You will only be required to see patients of plan A but not plan B if you do not opt out.

6. I am a member of a large group and I do not want to participate. Should I opt out individually or through the group?

It is up to you but we would prefer hearing from the group. You may also want to determine if you have a contractual relationship between yourself and the group as it relates to participation in various insurance products.

7. Will I have to wade through new or increased paperwork for reimbursement?

No. The required paperwork for the Small Business Plan will be the same as for plans now offered by the private carriers that choose to participate.



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8. When will this Plan be available to small business? Can small businesses drop their existing coverage and buy this new plan?

It is anticipated that the Plan will be available in the 4th quarter of this year. Senate Bill 143 includes a standard crowd-out policy, which states that the plan will be available to small businesses (2-50 employees) that have been uncovered for 6 months prior to the effective date of the legislation, which is June 13, 2004. After the effective date of June 13, a qualifying business must have been without coverage for 12 months. A covered business is defined as having offered a company-sponsored plan to its employees.

9. Are small businesses that already offer coverage being penalized by this program?

No. Without this Plan you are fully supporting the medical expenses of uninsured small business employees through higher physician and provider costs as well as higher health care insurance premiums.

10. How will I know the difference between ID cards?

A special look for this program will be developed in concert with the participating carriers.

11. I have an individual policy for my family but I do not cover my employees. Could my office take advantage of this program?

Yes, if your office has 2- 50 eligible employees and you meet the other participation rules. The issue of being uninsured is determined by the status of the business.

12. What will be the benefit plan? Will it be a standard set of benefits that covers physician, hospital, outpatient, etc?

Yes. The Plan is intended to be the same as a commercially available one. It will not be a stripped down version. Full details will be developed in concert with the participating carriers. Plan elements, such as deductibles, co-pays, etc. will be communicated to you.

12. Will any special services or hours be required by my staff or me?

No.

13. Will there be any outside oversight on this Plan?

Yes. SB143 mandates that the Insurance Commissioner establish a policy advisory committee to monitor the effectiveness of this Plan. The committee shall include, but not be limited to, members of these groups: labor, hospital providers, physicians, private business, local government, insurance carriers and the uninsured. The Plan will be subject to all regulations, oversight and reporting by the Commissioner as is usual and customary.

14. How will I receive future information?

The main information sources will be the participating carriers when the Plan is finalized. PEIA will also be an information source.