

# **New York Health Benefit Exchange**

## **Blueprint Summary for Section 4.0 Plan Management October 26, 2012**

<b><u>Item Number</u></b>	<b><u>Topic</u></b>
<b>4.2</b>	Standard Operating Procedures for Certification of Qualified Health Plans

The New York Health Benefit Exchange has established the process described below for gathering data from qualified health plans, including dental plans, CO-OP plans, and to the extent applicable, multi-state health plans. New York State has had extensive experience with joint agency regulation of health plans through the New York State Department of Health and the New York State Department of Financial Services (formerly the New York Department of Insurance). The Exchange will leverage this experience by working collaboratively with these agencies to review and approve plans for participation in the Exchange.

The Exchange will follow the following steps in certifying health plans:

Step 1: Notice of Intent, Receipt of Proposals and Issuance of Agreement (Request for Response (RFR) Process)

Step 2: Rate, Benefit, Actuarial Value, Essential Health Benefit, and Market Reform Rules compliance analysis

Step 3: Provider Network Data Collection and Network Adequacy Review

Step 4: Quality Data Collection and Transparency Data Collection

Step 5: Certification

Each Step is explained more thoroughly below, will be the same process for QHPs offered in the individual and SHOP exchange, as well as for qualified dental plans and CO-OPs. Also, please see the corresponding flow diagram delineating the responsibilities of the respective agencies throughout this process.

### **Step 1: Notice of Intent, Receipt of Proposal and Issuance of Agreement**

The New York Health Benefit Exchange will distribute to plans an Invitation to participate in the Exchange in early January 2013. This Invitation will outline the QHP Certification Requirements and the

Certification Process and will be non-binding. The purpose of the Invitation is to assess health plan level of interest regarding participation, metal levels, types and number of products, individual and/or SHOP.

In March 2013, the Exchange will begin to accept proposals for QHP Certification. The Exchange is proposing that health plans be given the initial opportunity to participate in the Exchange in 2013 for Plan Year 2014. However, health plans will not be given another opportunity for initial participation in the Exchange until 2015 for Plan Year 2016.

Within thirty days, the Exchange will validate that the health plan is licensed and in good financial standing with the Department of Financial Services and/or the Department of Health. It will notify the respective health plan within thirty days of any issue with respect to licensure and solvency, and if applicable, provide the plan with QHP appeal rights.

In order to participate in the Exchange, the Exchange is proposing that health plans will need to meet all federal minimum participation standards, as well as the following:

- Agree to participate in either the individual market, SHOP market, or both;
- Agree to provide Exchange coverage in the plan's entire rate region unless granted an exception from this requirement by the Exchange;
- Agree to offer any standardized plans developed by the Exchange;
- At its option, offer non-standard plans in each metal level, but no more than a specified number of non-standard plans determined by the Exchange in each level;
- Adhere to network adequacy requirements, including the inclusion of essential community providers;
- Adhere to employer minimum participation requirements for SHOP;
- Adhere to the enrollment timeline and processes established for SHOP;
- Offer a catastrophic plan only in the Individual Exchange market if required by the Exchange.

In the initial year, the Exchange will work with health plans to ensure that all participation requirements are met and there is adequate participation in both individual and SHOP markets. As the Exchange evolves and matures, the certification process and participation requirements will be reassessed and modified as needed.

Upon receipt of proposals for QHP Certification, the Exchange will provide Health plans with an Agreement to Participate in the Exchange ("Agreement"). This Agreement will require health plans to comply with the following:

- All applicable Exchange participation rules and requirements, including minimum standards established by the federal government, network adequacy requirements and quality requirements;
- All applicable marketing and communication standards, including minimum standards established by the federal government;
- All applicable reporting requirements, including prescription drug distribution and cost reporting and other minimum standards established by the federal government;
- All applicable transparency requirements, including minimum standards established by the federal government;
- All applicable requirements regarding the tracing of culturally competent data
- Any applicable broker compensation requirements

## **Step 2: Rate and Benefit Analysis**

Beginning as early as March 2013, and no later than April 1, 2013, health plans will submit rate and benefit information through the System for Electronic Rate & Form Filing (SERFF). The Department of Financial Services currently has the statutory responsibility of reviewing rates, benefits and subscriber forms through its prior approval process, and utilizes SERFF to effectuate this process. DFS will continue to review the rates through SERFF, and will perform the following in collaboration with Exchange staff:

- review benefits to ensure the Essential Health Benefits requirements are met
- ensure the cost-sharing limitations are in place for each plan
- review the service areas for each plan
- ensure actuarial value/metal level requirements are met for each plan
- review the plan to ensure standard plan(s) are being offered at each metal level
- review the product designs to ensure it is not discriminatory

The Exchange's review and the Department of Financial Services review will occur simultaneously. DFS and the Exchange will continuously communicate during their respective review processes. This collaboration allows for the opportunity to minimize duplicative submission requirements for health plans, maximizes efficiency, assists in streamlining and automating filing processes, and takes advantage of the existing DFS expertise that is necessary for rate and benefit reviews.

Medicaid Managed Care Plans and Child Health Plus health plans will continue to be approved by the New York State Department of Health. Part of this approval already includes network adequacy review, review of benefits, and quality reporting. The Exchange will not duplicate this review. Keeping this

function with the Department of Health will serve to minimize duplication of submittal requirements, assist with streamlining and automating filing processes, and maintain expertise that is necessary for Medicaid and Child Health Plus plan review. The data for Medicaid Managed Care Plans and Child Health Plans will be collected, reviewed by the Exchange, and placed on the IT platform for the Exchange. See the IT Supporting Documentation – Plan Management Business Requirements for Section 4.3.

### **Step 3: Provider Network Data Collection and Network Adequacy Review**

Managed care plans (i.e, HMOs) currently submit information regarding provider networks through the Provider Network Data System (PNDS) on a quarterly basis. This system has been enhanced to accept network information for plans offered at each metal level and will be upgraded to obtain information on a monthly basis in the near future. The Department of Health will continue to assist with Network reviews for Medicaid Managed Care plans and Child Health Plus plans, and will also continue to run the provider data through various databases to ensure the providers' license is current and to check on any sanctions. The Exchange will perform Network Adequacy reviews for the metal level plans in a manner that is consistent with current Managed Care Network Adequacy Standards and inclusive of essential community providers.

As of today, the Exchange is evaluating its options with respect to the definition of essential community providers and the number of providers needed to meet the federal sufficiency standards. It is in the process of seeking input from various stakeholders regarding this issue. It is the Exchange's expectation that this issue will be resolved prior to the in-person review, and this document will be updated accordingly.

### **Step 4: Quality Data Collection and Transparency Data Collection**

The Department of Health has been collecting, analyzing and public reporting health plan performance since 1994. Plan performance is evaluated annually across a broad range of nationally recognized quality, utilization and satisfaction metrics. The data generated from this reporting system, known as the Quality Assurance Reporting Requirements (QARR), is collected for a variety of plan products including commercial products, Medicaid, and Child Health Plus. There are two primary components to the QARR dataset: (1) the access, quality and utilization measures, largely adopted by the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS), and (2) the consumer experience of care survey questions from the Consumer Assessment of Health Care Provider and Systems (CAHPS) survey. In addition a small number of New York-state specific measures are added to both the quality and satisfaction measures to address areas of particular concern to the state (e.g., quality of adolescent preventive care).

The Department of Health will continue to collect this quality data, and convey the data results to the Exchange as part of its certification review process. The Exchange will work collaboratively with the quality experts at the Department of Health to ensure that the plan has, and has maintained,

satisfactory QARR scores. For more detail, please see the artifact under Section 4.8 - Quality and Satisfaction Ratings Proposal.

As part of the certification process, the Exchange is evaluating how the following data should be transmitted by the health plans:

- claims payment and policies – currently New York State requires health plans to divulge on their web sites the protocol used to determine claims payment; the Exchange will work with the Department of Financial Services and the Department of Health to determine whether this is sufficient to meet the needs of the Exchange;
- Financial disclosures – currently health plans provide financial information to the Department of Financial Services through SERFF; the Exchange will work with the Department of Financial Services and the Department of Health to determine whether this is sufficient to meet the needs of the Exchange;
- Information on enrollee rights – Currently, New York State has numerous enrollee protections under the Public Health Law; the Exchange will work with the Department of Financial Services and the Department Health to determine what additional information will be needed to ensure information on enrollee rights is adequately available;
- Data on enrollment/disenrollment – this data is currently collected by CCIIO for the Plan Finder Services and the Exchange will analyze methods of leveraging this collection effort;
- Data on number of claims denied - this data is currently collected by CCIIO for the Plan Finder Services and the Exchange will analyze methods of leveraging this collection effort;
- Data on rating practices – the Exchange will work with the Department of Health to determine what information will be needed to ensure transparency with respect to health plans rating practices;
- Data regarding cost-sharing and cost-sharing with respect to a specific service – the Exchange will require plans to submit information regarding its treatment cost calculators, and their availability to current members and prospective members. In addition, copies of the CCIIO-developed Summary of Benefits are submitted to the Department of Financial Services, and the Exchange will work with the Department of Financial Services to determine whether this should also be required as part of the qualified health plan certification process.

## **Step 5: Certification**

After all of the above has been evaluated and reviewed, and the Agreement is signed, the Exchange will certify the health plans. The Exchange proposes that the final certification will entail a checklist of issues being completed and notification of certification to the Department of Health and the Department of Financial Services. The Exchange will notify the health plans of qualified health plan certification through

SERFF, as well as potentially via an email or letter addressed to the health plan. The Exchange anticipates certification of all health plans to occur no later than June 30, 2013.