New York Health Benefit Exchange

HEALTH PLAN CEO MEETING

September 21, 2012

Agenda

I. Goals of Today's Meeting

I. Topics of Discussion

A. Expedited Rate Review Process

B. Licensure and Solvency

C. Agency Oversight at Product Levels

D. Standardization of Benefits

E. Metal Levels

F. Limits on Non-Standard Plans

G. Broker Compensation

H. Network Adequacy

I. Gated EPO Products

J. Minimum Participation Rules

III. Next Meeting

Expedited Rate Review Process

For commercial products, the Exchange will require metal level products to be submitted through SERFF and DFS will need to approve the products. Time frame for submission has been targeted to be April 1, 2013.

EXCHANGE PROPOSAL: Form a subgroup to develop a fast-track rate approval methodology, similar to the one developed when prior approval was first implemented.

Licensure and Solvency

The Exchange is required to ensure that each QHP is "licensed and in good standing… to offer health insurance coverage." Given the timeframe needed to implement the QHP Certification process, the Exchange will need to base many of the decisions it is making on existing statute and regulation in order to provide the health plans with the information they need to develop products and rates. Below is a chart that proposes the approach the Exchange could use in meeting this requirement:

	Commercial HMO	Commercial Non-HMO	Exchange
Network Product	*Article 44/Part 98 (NYS Ins Law 1109) * PHSP – "substantial" rule	*Article 43	*Article 44 (*NYS Ins Law 1109) *Article 43 *PHSP – substantial rule + NYS Ins Law 1109 and Part 98 reserve regulations
Out-of-Network Product	*Article 44/Article 43 (POS) (10% out of network limit) * PHSP – "substantial" rule	*Article 43	* Article 44/43 (POS)(10% out of network limit) * Article 43 * PHSP "substantial rule"+ 10% out of network limit
Medicaid/CHP	*Article 44 * Medicaid/PHSP Regs	N/A	* Article 44 * Medicaid/PHSP Regulations

NETWORK ADEQUACY – APPLICABLE STANDARDS FOR QUALIFIED HEALTH PLANS

The Exchange is obligated to ensure an adequate network is available to consumers who purchase plans through the individual and SHOP networks. Currently, New York has the following standards for Managed Care Organizations:

- Service delivery networks are county specific and service areas are defined as the county;
- A "county" may be extended 10 miles beyond the county border;
- Each county network must include primary, specialty and ancillary providers consistent with the benefits offered;
- Each county must include a hospital;
- For Medicaid/FHP, network must also include presumptive eligibility providers, Designated AIDS centers and Federally qualified health centers;
- In rural counties, obtaining the full array of providers may not be possible due to lack of resources, so MCOs may contract with providers in adjacent counties or service areas;
- The network must include a sufficient number of each provider, be geographically distributed and ensure choice of primary and specialty care providers;
- Choice of at least 3 geographically accessible PCPs and contract with at least 2 required specialist types in each county (could increase depending on enrollment);
- Distance/Time standard is 30 minutes/30 miles for PCPs; preferred for all other providers;
- Medicaid, HIV SNPS, FHP and CHP – 30 minutes by public transportation in metro areas; non-metro areas – 30 minutes/30 miles by public transport or car; rural areas can exceed if justified

EXCHANGE PROPOSAL: Use the above standard as the basis for Network Adequacy Review. Pediatric dental benefit can be satisfied, as long as a stand-alone dental plan is available. Pediatric vision will need to be included in benefit.

NETWORK ADEQUACY – ESSENTIAL COMMUNITY PROVIDERS DEFINITION

The Exchange must develop a definition for "essential community providers" and must determine what the contracting requirements must be for QHPs. The final regulations indicate that the State can define for itself "essential community providers" and "sufficient number" so long as the State's working definitions/practices meet the intent of the regulations.

OPTION A: 340B AND 1927 PROVIDERS	**OPTION B: (1) 340B AND 1927 PROVIDERS (2) Other providers that treat a substantial number of low-income and medically underserved populations**
OPTION C: *** FQHCs & FQHC look alikes** *** Family planning projects receiving grant funds under Title X of the Public Health Service Act** *** Ryan White Care Act providers furnishing HIV/AIDS services** **State AIDS drug purchasing assistance programs (ADAP)** *** Black lung clinics** *** Hemophilia diagnostic treatment centers** *** Urban Indian health clinics & Indian Health Services** *** Tribally-operated programs** *** Tuberculosis treatment clinics** *** Public hospitals receiving DSH payments under Medicare** *** Children's hospitals** *** Critical access hospitals** *** Rural referral centers and sole community hospitals meeting DHS payment thresholds** *** School-based clinics** *** Community mental health centers** *** Other mental health and substance use disorder organizations that are licensed or certified by the state as providers** *** Other providers that treat a substantial number of low-income and medically underserved populations**	

NETWORK ADEQUACY – ESSENTIAL COMMUNITY PROVIDERS CONTRACTING

The Exchange must develop a definition for "essential community providers" and must determine what the contracting requirements must be for QHPs. The final regulations indicate that the State can define for itself "essential community providers" and "sufficient number" so long as the State's working definitions/practices meet the intent of the regulations.

OPTION A: QHPs must ensure that plan members have access to timely and affordable healthcare through a variety of providers, including those who treat a substantial number of low-income and medically underserved populations

OPTION B: The network for each QHP must have sufficient overlap with networks/independent physicians for public programs

OPTION C: QHPs must offer a contract to all ECPs in their service area

GATED EPO PRODUCT

The concept of a “gated EPO product” has been brought to the attention of the Exchange. Traditionally, EPO products are written under Article 43 (non-HMO) licensure, and the “gatekeeper” concept is embedded within Article 44 (HMO) products. It has been suggested that the gated EPO product would be useful in parts of New York State.

EXCHANGE PROPOSAL: permit a gatekeeper EPO product if it affords adequate consumer protections.

NUMBER AND MIX OF PLANS IN EXCHANGE

The Exchange is required to ensure an optimal number of benefits are offered in the exchange markets. To ensure optimal choice without offering too much choice, parameters need to be placed around the products offered in through the Exchange. The assumption to the below proposals are as follows: (1) standard = benefits + established cost-share; (2) health plans agree to the standard benefits; (3) the proposal applies to both SHOP and Individual Markets

EXCHANGE PROPOSALS:

(1) Provide a health plan a standard plan at each metal level. The Exchange will recognize HMO plans that have higher cost-sharing

(2) Limit non-standard plans to 2 per metal level

(3) Provide a standard out-of-network benefit in the Individual Exchange

(4) Offer standard tiers

(5) Offer the plans for entire service area associated with product

(6) Offer at least one catastrophic plan

BROKER COMPENSATION

The Exchange is obligated to comply with federal regulation and guidance with respect to brokers. Currently, there are restrictions on the individual market with respect to brokers. However, it is left to the states as to how the broker relationship should be handled with respect to the SHOP market.

New York State law states that HMOs are capped at reimbursing brokers up to 4% of premium. There are no limits placed on non-HMO business and PHSPs do not utilize brokers.

EXCHANGE PROPOSAL: Exchange proposes that given the tight time frame for implementation, to create parity inside and outside the exchange SHOP market. The Exchange recognizes the concerns raised by health plans regarding the disparity between the cap placed on HMO broker commissions and the absence of a cap on non-HMO commissions. This concern involves changes to existing New York laws and should be addressed both inside and outside the Exchange by DFS.

MINIMUM PARTICIPATION

Federal regulations provide the Exchange with an option of having a minimum participation standard. If the Exchange has a minimum participation rule, it must be standard and uniform.

New York State requires that non-HMOs have at least 50% participation to be considered a group. A DFS regulations states that HMOs are not allowed to maintain this minimum participation requirement.

EXCHANGE PROPOSAL: Require and establish a fixed minimum participation rule for non-HMO business, which will be agreed upon by the health plans. This create similar standards inside and outside the Exchange until the regulations can be amended. The Exchange also proposes to develop a standardized method to count employees towards the minimum standard.