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New York Issues "Invitation to Participate in the New York Health Benefit Exchange," Clarifying Application Process and State Requirements

RESOURCE LINKS

"Invitation to Participate in the New York Health Benefit Exchange" and related attachments

The New York Department of Health's Office of the New York Health Benefit Exchange issued the long-awaited "Invitation to Participate in the New York Health Benefit Exchange" (the "Invitation") on January 31, 2013. The Invitation clarifies and summarizes the requirements for applicants to be qualified as eligible for certification as a qualified health plan ("QHP"), which permits them to be offered on the New York Health Benefit Exchange (the "NY Exchange"). Some of the more interesting and helpful features of the Invitation are summarized below. The full Invitation can be found online at http://www.healthbenefitexchange.ny.gov/invitation, along with a number of related attachments ("Attachments").

I. Timeline

The Invitation sets out a timeline that applicants—insurers, stand-alone dental plans, and consumer operated and oriented plans ("CO-OPs")—will need to follow to offer a QHP on the NY Exchange. This timeline includes the following deadlines:

February 15, 2013:	Letter of Interest due. (This is a non-binding indication of interest by the applicant.)
April 5, 2013:	Participation Proposal Form submission due date. (This is the application that is required for a plan to be approved as a QHP.)
April 12, 2013:	Provider network submission date
April 15, 2013:	Submission of rates and forms
July 15, 2013:	Anticipated notification of certification

In order to comply with these deadlines, applicants will need to be comfortable that they have a network in advance of the provider network submission date of April 12, 2013, although the DOH just clarified in a frequently asked question posted on February 11, 2013, that it will expect a quarterly update of the provider network from applicants in July 2013, and it will review an applicant's network

adequacy based on the April and July 2013 submissions. Similarly, the April 15, 2013, submission of rates and forms will require that the applicants are also fairly confident of the rates that they will be paying the providers. It appears that this will be the only opportunity for insurers to apply for certification for calendar years 2014 and 2015, although the New York Department of Health ("DOH") has the discretion to permit new applicants for calendar year 2015.

II. Overview of Requirements for Applicants

1. General Requirements

There is no requirement to participate in both the exchange for individuals ("Individual Exchange") and the Small Business Health Options Program ("SHOP") Exchange, although existing New York law requires health maintenance organizations ("HMOs") to offer products in both the individual and small markets, and provisions in Governor Andrew Cuomo's proposed budget bill make clear that this will continue to be the case. Specifically, the proposal is that HMOs must offer one product at each level of coverage and a child-only plan, although it appears that this could be either on or off the NY Exchange and would allow HMOs to offer catastrophic policies—but only on the NY Exchange.

There are several other general requirements:

- Applicants must apply to participate in their entire service area, unless an exception is granted on a case-by-case basis.

- "Essential health benefits" ("EHBs") must be provided. The Invitation includes the list of EHBs as Attachment A, which is based on Oxford Health Plan's EPO product.

- The products in each metal level (bronze, silver, gold, and platinum) must meet the required actuarial value ("AV") for that level. Bronze must provide 60 percent AV, silver 70 percent AV, gold 80 percent AV, and platinum 90 AV.

2. Health Insurer Applicants

Health insurer applicants *must* offer the following:

- One standard product in **each** metal level **and** in each county of its service area;

- The EHBs and their visit limit that are set out in Attachment A and the required cost-sharing is set out in Attachment B;

- At least one child-only product at **each** metal level in the Individual Exchange, and participation in Child Health Plus is not a substitution for this offering;

- At least one standard catastrophic product in each county of its service area, subject to the DOH's determination that such a product is optional in a particular county;

- Prescription drug coverage that at least covers the greater of "(i) one drug in every United States Pharmacopeia (USP) category and class; or (ii) the same number of prescription drugs in each category and class of the benchmark plan chosen by the State";

- Pediatric dental coverage, as a separately priced benefit, for both standard and non-standard product proposals, unless the DOH determines that there is adequate pediatric stand-alone coverage in a particular county; and

- Out-of-network offering in any county in which the applicant offers an out-of-network product outside the NY Exchange but only for silver and platinum levels in both the Individual Exchange and the SHOP Exchange.

Health insurer applicants *may* offer up to three non-standard products per metal level and at any or all metal levels and in all or any part of its service area. Products can be non-standard if they:

- substitute benefits within two categories: (i) Preventive/Wellness/Chronic Disease Management, and (ii) Rehabilitative and Habilitative;

- modify cost-sharing in any category;

- add benefits in any EHB category, including offering higher visit limitations; and/or

- add benefits that are not EHBs.

Nonstandard products must comply with federal and state regulations and guidance as well as review by the New York State Department of Financial Services. The limit of three non-standard products applies to the applicant and its affiliates collectively. But the limit does not apply to child-only products, catastrophic products, and required out-of-network products. Moreover, high-deductible health plans that meet the IRS's requirements and, if requested by the purchasing individual or employer, applicants may arrange for a health savings account or health reimbursement account, as regulated by the IRS, to be used for such plans.

3. Stand-Alone Dental Applicants

Stand-alone dental applicants must offer at least the pediatric dental benefits that are listed as part of the EHBs on Attachment A, but may offer additional benefits. Additionally, these applicants must offer one standard pediatric stand-alone dental product in every county of its service area and at either the "high level" or "low level"—that is, either 85 percent of AV or 75 percent of AV. This applies to both the Individual Exchange and the SHOP Exchange. However, stand-alone dental applicants may offer up to two non-standard products from the following list: adult dental, family dental, and another pediatric product. This also applies to both the Individual Exchange and the SHOP Exchange.

4. CO-OPs

CO-OPs must meet the Invitation's standards and processes. Once these standards are met, DOH will recommend that the Center for Consumer Information and Insurance Oversight ("CCIIO") certify the CO-OP. If CCIIO certifies the CO-OP, the certification will last for a two-year period.

III. Brokers, Agents, and Navigators

1. Brokers and Agents

Brokers and agents may assist both individuals and small businesses in purchasing insurance through the NY Exchange. Additionally, brokers and agents must (i) have an agreement with the NY Exchange, and (ii) take the training program approved by the NY Exchange and pass a test certifying completion of the program.

Compensation arrangements between the brokers and agents and the health insurer applicants must be the same for products offered on the NY Exchange and for products offered outside the NY Exchange.

2. Navigators and In-Person Assistors

Navigators and in-person assistors will be available. Qualified organizations may receive grants from the DOH to provide in-person, linguistically, and culturally appropriate assistance to applicants for the Individual Exchange or SHOP Exchange.

IV. Special Rules for SHOP Exchanges

There are three special rules for SHOP Exchanges:

1. A "small group" is defined as a group of 50 or fewer employees for calendar years 2014 and 2015.

2. Employers will have flexibility in determining the products to offer their employees and may offer an "employee choice" model through defined contribution mechanisms.

3. To enroll in non-HMO products on the NY Exchange, at least 50 percent of an employer's employees must have health coverage.

V. Additional Provisions Applicable to "Exchange Participants" (Applicants Certified as QHPs)

1. Quality and Enrollee Satisfaction

Quality and enrollee satisfaction with Exchange Participants (except for stand-alone dental plans) will be monitored by the DOH and publically reported. Exchange Participants will be required to develop and maintain a quality strategy, participate in the DOH Quality Assurance Reporting Requirements,

and conduct annual surveys using a Consumer Assessment of Health Care Providers and Systems survey tool for health plans. No accreditation will be required for calendar years 2014 and 2015.

2. Network Adequacy

Exchange Participants must comply both with the general federal requirements to include essential community providers and to maintain a network, including mental health and substance abuse services "to assure that all services will be accessible without unreasonable delay," and with current DOH managed care network adequacy standards. The Invitation summarizes a number of general and specific standards. Network adequacy will be reviewed on a county-by-county basis, with the DOH having the ability to make certain exceptions. Network adequacy also will be reviewed upon submission of the application to participate as a QHP, and on a quarterly basis initially. The review of network adequacy will eventually be done monthly.

3. Treatment Cost-Calculators for Participating Providers and Treatment Cost-Calculators for Out-of-Network Providers

Each Exchange Participant is required to have a treatment cost calculator available both through a website and otherwise available to individuals without Internet access. These cost calculators must demonstrate enrollee cost sharing under that individual's plan or coverage for specific covered items or services. Treatment cost calculators for cost sharing and payments to out-of-network providers must be provided by applicants to the DOH, along with a URL link to such cost calculators.

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For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

Jane L. Kuesel
Senior Attorney
Epstein Becker Green
New York, NY
(212) 351-3723
JKuesel@ebglaw.com

Jackie Selby
Member of the Firm
Epstein Becker Green
New York, NY
(212) 351-4627
JSelby@ebglaw.com

Linda V. Tiano
Member of the Firm
Epstein Becker Green
Washington, D.C.
(202) 861-1812
LTiano@ebglaw.com

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Lisa C. Blackburn
Business Development Manager
National Health Care and Life Sciences Practice
Epstein Becker & Green, P.C.
1227 25th St., NW, Suite 700
Washington, D.C. 20037
phone 202/861-1887 – fax 202/296-2882
lblackburn@ebglaw.com

Name:_____ Title:_____

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E-mail Address:_____