Essential Plan (EP) Guidance 1.0

Office of Health Insurance Programs

Division of Finance and Rate Setting

EP Guidance 1.0: Information Regarding EP Rate Setting Assumptions and Emergency Out-of-Network Hospital Reimbursement

Date of Issuance: September 10, 2015

The purpose of this document is to provide Information Regarding the Department of Health's Essential Plan Rate Setting Assumptions and Emergency Out-of-Network Hospital Reimbursement guidance.

Essential Plan Rate Setting Assumptions

- The Affordable Care Act (ACA) provides states the option to establish a basic health program for:
    - Individuals with incomes between 138-200% of the Federal Poverty Level (FPL) who are ineligible for Medicaid or Child Health Plus (CHP), and do not have access to affordable employer coverage; and
    - Individuals with incomes below 138% of FPL who are ineligible for Medicaid due to immigration status.
- The EP premium groups, which will align with the nine rating regions used in the Medicaid Managed Care (MMC) program, are as follows:

Rating Group	Population	% FPL	Monthly Premium	Ages	Premium*
Essential Plan 1	Non-Medicaid/QHP	151-200% FPL	$20 + Dental/Vision	19-64	$490.82
Essential Plan 2	Non-Medicaid/QHP	139-150% FPL	$0 + Dental/Vision	19-64	$567.72
Essential Plan 3	Aliessa	100-138% FPL	$0	21-64	$423.25
Essential Plan 4	Aliessa	< 100% FPL	$0	21-64	$425.26

* Final Statewide average capitation rate (net of premium) across all regions.

- Benchmarking assumptions built into rates:

    - EP1 & EP2 (non-Medicaid/QHP) – Medicaid + 20%
    - EP3 & EP4 (Aliessa) – Medicaid
- Graduate Medical Education assumptions built into rates:
    - Dollars included in EP1 & EP2 (non-Medicaid/QHP) rates
    - Dollars excluded and billed separately by hospital in EP3 & EP4 (Aliessa)
- Tax assumptions built into rates:
    - Covered Lives Assessment applied along with HCRA Commercial rate of 9.63%

Reimbursement for Emergency Out-of-Network Hospital Services Received by Essential Plan Enrollees

For Aliessa members, the health plan is required to pay the Medicaid default rate as now applies for such members.

For non-Aliessa members, the following guidance applies:

1. The Affordable Care Act (ACA) establishes minimum reimbursement amounts that health plans must pay for out-of-network emergency services. In addition, New York State Insurance and Public Health Law and regulation currently require insurers and HMOs to hold insureds harmless in the event a provider seeks payment in excess of the combined plan payment and patient in-network deductible, copayment or coinsurance for OON emergency services in a hospital.
2. As Essential Plan (EP) enrollees have no liability for charges in excess of any applicable in-network cost sharing, it is the expectation of the Department of Health that insurers and hospitals will make best effort**s** to negotiate resolution of disputes that may arise over appropriate reimbursement for out-of-network emergency services to EP enrollees without involving the enrollee, unless information is needed from the enrollee to make or support a coverage determination. Consistent with this expectation, with respect to such services, DOH discourages:

    a) Insurers from issuing payment to patients rather than to the providers in order to avoid the necessity of providers billing patients, and;

    b) Hospitals from balance billing patients for charges in excess of payments received from insurers.
3. Patterns of reimbursement or billing for emergency services received by EP enrollees that hospitals and/or insurers believe to be unreasonable should be brought to the attention of DOH.