Invitation and Requirements for Insurer Certification and Recertification for Participation in 2015

April 25, 2014

Schedule of Key Events

Invitation Released.....April 25, 2014

Letter of Interest Due..... May 9, 2014

Written Questions re: Invitation Due ....May 16 2014

Provider Network Submission Due.....May 26, 2014

Response to Written Questions re: Invitation .....May 30, 2014

Submission of Rates and Forms.....June 1, 2014

Participation Form Submission Due… ....June 1, 2014

Anticipated Notice of Certification. .....September 15, 2014

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Section I. Introduction and Overview

A. Issuing Office and Purpose

This Invitation is issued by the New York State Department of Health (DOH) to invite insurers offering Qualified Health Plans (QHPs) and Qualified Dental Plans through the NY State of Health, the Official Health Plan Marketplace (Marketplace) in 2014 to apply for recertification, and in certain instances as defined below, to invite other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs to be offered on the Marketplace in calendar year 2015. Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and individual plans meet all federal minimum participation standards and other requirements necessary for certification as a QHP. After Applicants and individual plans have been (i) reviewed and found to satisfy all minimum standards and requirements, and (ii) in the case of Applicants permitted to apply for the first time, an Agreement is signed with the DOH, such health plans will be certified as QHPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of plans to be offered on the Marketplace in 2015.

To ensure choice for consumers and small businesses, and to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs, the following new Applicants may apply to offer products during the 2015 calendar year in the Marketplace:

- Health Insurer Applicants that offer medical coverage to consumers in New York's Medicaid Managed Care Program and/or Child Health Plus Program as of the proposal submission due date of this Invitation;
- Health Insurer Applicants may apply as Stand-Alone Dental Applicants in the event that the Health Insurer Applicant currently participates in the Marketplace in 2014;
- Health Insurer Applicants whose participation, as DOH determines in its sole discretion, would help to ensure continuity for persons enrolled in programs or products that are ending.

B. Background

On March 23 and 30, 2010, President Obama signed The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as The Patient Protection and Affordable Care Act (ACA). The ACA authorized the creation of state-based and administered Health Benefit Exchanges.

On April 12, 2012, Governor Cuomo issued Executive Order No. 42 establishing the New York Health Benefit Exchange, now known as NY State of Health, the Official Health Plan

Marketplace, within the DOH. On December 14, 2012, the United States Department of Health and Human Services (HHS) granted New York conditional approval to operate a state based Exchange.

NY State of health opened on October 1, 2013. As of close of business on April 15, 2014, over 960,000 individuals had enrolled for coverage through the Individual Marketplace. Of these, 370,604 were enrolled in QHPs, 525,283 were enrolled in Medicaid, and 64,875 children under age 19 were enrolled in Child Health Plus. In addition, over 3,000 small businesses and nearly 10,000 employees and dependents have signed up for coverage through the NY State of Health Small Business Marketplace.

Section II. Participation Requirements

For purposes of this Invitation, references to "Applicant" and Applicants" shall collectively mean insurer applicant(s) that offer medical or dental coverage and applies for QHP certification or recertification. The term "Health Insurer Applicant" shall collectively mean health insurer applicants applying for QHP certification or recertification that offer medical coverage, including CO-Ops; and references to "Stand-Alone Dental Applicants" refers to insurers that are applying for QHP certification or recertification that offer only stand-alone dental coverage.

A. Licensure and Solvency

Pursuant to 45 CFR § 156.200(b)(4), Applicants must:

- Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

- Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 15, 2014 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 15, 2014.

Applicants that offered QHPs in 2014 may use a different license or an additional license to offer QHPs in the Marketplace for 2015.

B. Choice of Individual Marketplace or Small Business Marketplace

Applicants may apply to participate in both the Individual Marketplace and Small Business Marketplace, but are not required to participate in both. Applicants that currently participate

only in the Individual or Small Business Marketplace, may apply to participate in both the Individual Marketplace and the Small Business Marketplace for calendar year 2015.

C. Service Area

Applicants must apply to participate in their entire service area as approved by the Department of Financial Services (DFS) or the DOH at the time of application, provided all requirements of this Invitation are met. Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace. Pursuant to 45 CFR § 155.1055, Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

Applicants that were certified to offer QHPs in the Marketplace in 2014 may request participation in additional counties subject to the requisite State approval and by identifying on the Participation Proposal the additional counties in which the Applicant seeks to offer QHPs.

D. Applicant-Specific Requirements

1. Health Insurer Applicant Product Offerings

a. Essential Health Benefits. Health Insurer Applicants must agree to provide the Essential Health Benefits (EHB) specified by the DOH for calendar year 2015, and delineated on Attachment A. The EHBs must be included in the calculation of the actuarial values of the products. The federal Department of Health and Human Services has indicated that the Secretary will issue additional guidance on EHBs for 2016 and years following.

b. Metal Levels. Each product in each metal level must meet the following specified actuarial value (AV) levels based on the cost-sharing features of the product and determined using the HHS AV calculator.

Bronze:	60% AV
Silver:	70% AV,
Silver CSR	73% AV (200-250% Federal Poverty Level)
Silver CSR	87% AV (150-200% Federal Poverty Level)
Silver CSR	94% AV (100-150% Federal Poverty Level)
Gold:	80% AV

Platinum: 90% AV

Consistent with federal rules, a *de minimus* variation of +/- 2% AV is permissible, except with respect to the Silver CSR (cost-share reduction) variations, which only permit a variation of +/- 1% AV.

c. Standard Products. Health Insurer Applicants must offer one (1) standard product in each metal level and in every county of its Marketplace service area. The standard product offered by Health Insurer Applicants must include the benefits and visit limits as delineated in Attachment A and the cost-sharing limitations delineated in Attachment B, with the exception that the wellness benefit may be substituted for a different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DFS review and approval. This requirement applies to the Individual Marketplace and the Small Business Marketplace.

d. Child Only offerings. In accordance with federal regulation, Health Insurer Applicants must agree to offer a child-only product at each metal level described in Section II.D.1.b., above, in the Individual Marketplace. The child-only product must conform to the benefits and visit limits delineated in Attachment A and the same cost sharing limitations delineated in Attachment B. In other words, it must be the Standard Product required in Section II.D.1.c., above, offered at the child-only rate outlined in Section III.C.6.b. Only one child only product is required per metal level. Health Insurer Applicants' participation in the State's Child Health Plus program does not satisfy this requirement.

e. Catastrophic Plans. Health Insurer Applicants must agree to offer at least one standard catastrophic product in each county of the Applicant's service area in the Individual Marketplace. The standard catastrophic plan can be found in Attachment B. As part of the Participation Proposal which is attached as Attachment E, the DOH will require Health Insurer Applicant's affirmative intent to offer or continue to offer a catastrophic product. In the event that the DOH determines there is adequate catastrophic coverage in a particular county, the DOH may in its sole discretion allow other Health Insurer Applicants in the same county the option of not offering the Catastrophic Plan. The DOH will inform the Health Insurer Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the Catastrophic Plan will be made by the DOH prior to certification. In the event there is not adequate coverage in a particular county, all Health Insurer Applicants in that county will be obligated to offer the Catastrophic Plan.

f. Out-of-Network Offerings. An "out-of-network" product is a product that provides coverage for services rendered by health care providers that are not in the health insurer's network. Health Insurer Applicants that offer an out-of-network product outside the Marketplace must offer the out-of-network product on the Marketplace at

the silver and platinum levels. This requirement applies to both the Individual Marketplace and the Small Business Marketplace. Health Insurer Applicants that do not offer an out-of-network product outside the Marketplace are strongly encouraged to offer a QHP on the Marketplace with an out-of-network benefit, so consumers have an option to purchase such a product should they chose to do so. An Applicant may use an additional or different license to offer an out-of-network QHP, provided the different or additional license is for an entity within the same family of companies.

g. Nonstandard Products. Health Insurer Applicants may opt to offer up to three (3) "non-standard" products at any metal level, and in all or any part of its service area, in accordance with the requirements below.

(i) Non-standard products offered for the first time on the Marketplace in 2015 must have meaningful differences from each other and from the standard QHPs. Non-standard QHPs are considered to be meaningfully different when additional benefits not included in the Essential Health Benefits are covered (e.g., adult dental, adult vision, acupuncture), or, as determined by DOH, when the non-standard product allows consumers to easily identify the differences between the non-standard product and standard products to determine which plan provides the highest value at the lowest cost to address their needs. All non-standards plans must comply with federal and state law and regulations and guidance and shall be subject to DFS and Marketplace review and approval.

(ii) In addition, to ensure the Marketplace offers consumers non-standard choices at various metal levels, Health Insurer Applicant may elect to offer the following number of non-standard products:

A. The same number of non-standard products at every metal level (e.g., 2 bronze, 2 silver, 2 gold, 2 platinum); or

B. At least one and not more than 3 non-standard products at each metal level subject to the following:

(1) The number of non-standard product at any metal level may not exceed the number of non-standard products at any other metal level by more than one; and
(2) The number of non-standard products may not exceed the number of non-standard products of at least one other metal level.

Accordingly, the permissible combinations under (ii)(B) above include:

1 bronze, 2 silver, 1 gold, 1 platinum
1 bronze, 1 silver, 2 gold, 1 platinum
1 bronze, 1 silver, 1 gold, 2 platinum

1 bronze, 2 silver, 1 gold, 2 platinum
2 bronze, 2 silver, 1 gold, 1 platinum
2 bronze, 2 silver, 2 gold, 1 platinum
3 bronze, 3 silver, 2 gold, 2 platinum
2 bronze, 3 silver, 3 gold, 2 platinum
3 bronze, 2 silver, 3 gold, 2 platinum
3 bronze, 2 silver, 3 gold, 3 platinum

(iii) Child only products, catastrophic products and out of network offerings will not be counted towards the three (3) non-standard product maximum.

h. QHP Naming Convention. To assist consumers in identifying products and differences between products, Health Insurer Applicants must use the following naming conventions to identify all QHPs offered on the Marketplace (i.e., both QHPs offered in 2014 that will be again be offered in 2015 and new QHPs offered in 2015) in the order as presented below:

Individual Market:

Field Name	**Values**	**Instructions**
Product Name	To be assigned by Applicant	
Metal Tier	Bronze, Silver, Silver CSR1, Silver CSR2, Silver CSR3, Gold, Platinum, Child Only, Catastrophic	Indicate metal tier using entire word for metal level; Silver CSR1 = 73% AV; Silver CSR2 = 87% AV; and Silver CSR3 = 94% AV
Standard/Non-Standard	ST or NS	Indicate Standard or Non-standard by using "ST" for standard and "NS" for non-standard
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded within the QHP
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29
Non-Standard Details	Adult Vision, Family Dental,	List the general categories of

	Family Vision, Wellness, Other	variances from standard benefits in alphabetical order separated by commas. Do not enter for Standard Plans

Examples of permissible QHP names are shown below:
ABC Product, Platinum, ST, INN, Dep25
ABC Product, Gold, ST, INN, Dep29
ABC Product, Silver, NS, OON, Family Dental, Family Vision, Dep29

Small Business Marketplace:

Field Name	**Values**	**Instructions**
Product Name	To be assigned by Applicant	
Metal Tier	Bronze, Silver, Gold, Platinum, Child Only, Catastrophic	Indicate metal tier using entire word for metal level
Standard/Non-Standard	ST or NS	Indicate Standard or Non-standard by using "ST" for standard and "NS" for non-standard
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded in the QHP
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other	List the general categories of variances from standard benefits in alphabetical order separated by commas. Do not enter for Standard Plans
Domestic Partner	DP	Include only if domestic partners are eligible for coverage
Family Planning	FP	Include only if the family planning benefit is covered

Examples of permissible QHP names are shown below:

ABC product, Platinum, ST, INN, Dep25
ABC product, Platinum, ST, INN, , Dep29, FP
ABC product, Gold, OON, NS, Adult Dental, Dep29, DP, FP

i. Prescription Drug Coverage. As required under the federal rules, prescription drug coverage must cover at least 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. All prescription drug information must be submitted to DFS for its review. This requirement is not intended to limit the number of drugs that the Health Insurer Applicant may cover in a drug category or class. Health Insurer Applicants are encouraged to develop formularies that exceed the federal requirements when it is determined to be in the best interest of their members.

j. Dental Coverage. Federal law requires coverage for pediatric dental services and permits such services to be covered by health insurers or stand-alone dental carriers. Health Insurer Applicants have the option of embedding pediatric dental coverage within their QHPs, offering QHPs without pediatric dental coverage, or both. In the event the DOH determines that there is no pediatric stand-alone coverage available in a particular county, all Health Insurer Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

Health Insurer Applicants will also have the option of offering adult/family dental, and/or supplemental pediatric dental benefits as an additional benefit per Section II.D.1.g., above. In the event the Health Insurer offers a family dental benefit, the pediatric component must include at least the same pediatric dental benefits as outlined in Attachment A.

k. Effective Dates. All initial and recertified products offered through the Marketplace will have effective dates of January 1, 2015 in the Individual Marketplace and Small Business Marketplace. Qualified Employers will be able to purchase coverage through the Small Business Marketplace at any point during the year, and may modify the effective date of coverage for any 12-month period. Health Insurer Applicants, however, will not be able to establish and offer new products at any time during the year. Products to be offered during calendar year 2015, must be established and submitted to DOH and DFS through this Invitation.

l. Role of Brokers and Agents. To maximize access to health insurance coverage for residents of New York State, brokers and agents (collectively, “Producers”) will be permitted to assist both small businesses and individuals in purchasing coverage through the Marketplace. Producers who have successfully completed the training certification program for each applicable marketplace and entered into an agreement

with the Marketplace will be deemed certified to conduct business in the Marketplace. Such agreements will require Producers to be licensed and in good standing with the DFS.

Producers will be required to comply with all applicable provisions of federal and state law related to the provision of assistance to consumers, employers and employees in the Marketplace and must have required privacy and security measures in place.

All of Health Insurer Applicants' compensation arrangements with Producers must be the same inside and outside of the Marketplace, and must comply with all applicable provisions of State law. For example, the commission for a small group product offered on the Small Business Marketplace must be the same as the commission for a small group product offered outside of the Marketplace. In addition, for the sale of Marketplace products, the Applicant must contract with Producers that have successfully completed the required training program and have entered into agreements with the Marketplace.

m. Navigators and Certified Application Counselors. Consistent with the federal law, the DOH provides grants to qualified organizations to act as Navigators for the Marketplace. The Marketplace has also trained and certified volunteers known as Certified Application Counselors. Navigators and Certified Application Counselors will provide linguistically and culturally appropriate assistance to those applying for coverage through the Individual Marketplace and/or Small Business Marketplace. Applicants must cooperate with Navigators and Certified Application Counselors that have certified by the Marketplace.

2. Consumer Network Protections

a. Access to Out-of-Network Providers and Information. Consistent with Part H of Chapter 60 of the Laws of 2014 ("2014 Out-of-Network Bill"), Health Insurer Applicant must adhere to the following:

(i) Health Insurer Applicant must hold its members harmless from liability for all out-of-network emergency (ER) bills. In addition, Health Insurer Applicant must hold its member harmless from liability for non-emergency (non-ER) surprise out-of-network bills: (i) for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center where an in-network provider is unavailable, or a non-participating physician renders services without a member's knowledge, or unforeseen medical circumstances arise (unless a participating physician is available and the member chose to obtain services from a non-participating physician); or (ii) whenever a participating physician refers a member to an out-of-network provider without the member's written consent; or (iii) in certain cases when disclosure is not made.

(ii) Health Insurer Applicant shall allow its members to request a referral to an out-of-network provider, or request prior authorization to have a service provided by an out-of-network provider, when there is not an appropriate in-network provider available to the member.

(iii) Health Insurer Applicants must allow members to request:

- A standing referral to a specialist provider when the enrollee's condition requires ongoing care from the specialist provider;

- A referral to a specialist responsible for providing or coordinating the member's care when the member has a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which may require specialized medical care for a prolonged period of time; and

- Direct access to primary care services and preventive obstetric and gynecologic services within the network of providers without having to obtain a referral.

(iv) Health Insurer Applicant will provide its members with the ability to appeal a denial for an out-of-network referral and will extend external appeal rights to denials for an out-of-network referral.

(v) Health Insurer Applicant will provide to its members and to DOH information on cost-sharing and payments to providers with respect to any out-of-network coverage pursuant to 45 CFR 156.220(a)(7) and consistent with the 2014 Out-of-Network Bill. Health Insurer Applicant may use a treatment cost calculator to provide estimates of out of pocket expenses for receiving services at an out-of-network provider, provided such calculators provide the information required in 2014 Out-of-Network Bill. Upon request, Health Insurer Applicant will provide a URL link to its out-of-network treatment cost calculator.

b. Enhancements to Network Information. In addition to the Network Adequacy provisions set forth in Section II.F., all Applicants shall adhere to the following, unless otherwise specified:

(i) Provider Directories. The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the QHPs offered through the Marketplace (the "Marketplace Provider Directory"). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians any affiliations with participating hospitals, information on

language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with the 2014 Out-of-Network Bill, such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

The Applicant must make available to DOH a URL link that provides access to the Applicant's Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs, or, if multiple network configurations are offered by the Applicant, it must clearly identify the network(s) for the particular QHP product(s). For example, if one network is used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non-standard product must be distinct and identifiable to a consumer. The directories must distinguish this network(s) from other networks offered by the Applicant so a consumer using the directory can clearly and easily access the correct directory via the URL link provided to the Marketplace.

(ii) Verification of Networks. The Applicant shall implement a system to periodically verify the accuracy of its reported Marketplace provider network(s). Such system may include, but not be limited to, direct outreach to providers listed by the Applicant as participating in Marketplace networks. The Applicant shall provide to the DOH the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of such system are to validate participation by providers and to make sure providers are aware of their participation in Marketplace network(s).

(iii) Treatment Cost-Calculators for Participating Providers. The Health Insurer Applicant must have in place a treatment cost calculator available through an Internet Web site and such other means for individuals without access to the Internet. Such treatment cost calculators must be able to demonstrate enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual.

3. Stand-Alone Dental Applicants

Stand-Alone Dental Applicants shall offer products through the Marketplace in accordance with federal and state laws and regulations, and in accordance with the following participation requirements:

a. Essential Health Benefits. The Stand-alone Dental Applicant must agree to provide the pediatric dental benefits outlined Attachment A. The pediatric dental benefits are minimum benefits and the Stand-alone Dental carrier may add benefits.

b. Standard Product. The Stand-alone Dental Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the Stand-alone Dental Applicant must include the same pediatric benefits as delineated in Attachment A. The Standard product must comply with federal regulation and DFS guidance. This requirement applies to both the Individual Marketplace and the Small Business Marketplace.

c. Non-Standard products. The Stand-alone Dental Applicant may opt to offer up to two (2) non-standard products. The non-standard product may be an adult/family dental plan or a second pediatric dental product offering. This requirement applies to both the Individual Marketplace and the Small Business Marketplace.

d. Other Applicable Provisions. Stand-Alone Dental Applicants must meet the requirements set forth in Section II.D.1.k. and II.D.1.l., above.

4. Consumer Operated and Oriented Plans (CO-OPs)

Applicants designated as CO-OPs must adhere to the standards and processes set forth in this Invitation. Once a CO-OP has met all the standards set forth in this Invitation, DOH will make a determination whether to certify the CO-OP's QHPs and inform the Center for Consumer Information and Insurance Oversight (CCIIO) of its determination. Once the CO-OP is certified, federal regulations require it to be deemed certified for two (2) years, with recertification determined by DOH. The CO-OP entity will be subject to the DOH decertification criteria, and any recommendation of decertification will be made to CCIIO.

5. Small Business Marketplace

In addition to the above participation requirements, Applicants seeking to participate in the Small Business Marketplace agree to adhere to the following requirements**:**

a. Definition of a Small Group. For calendar year 2014 and 2015, the definition of a small group shall mean a group of fifty (50) or fewer employees with at least one common law employee as defined federal regulation, (see 26 CFR 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor's spouse.

b. Employer Choice. Through the Small Business Marketplace, Qualified Employers will have flexibility of choice when determining the products to offer their employees, including the following options:

- Selecting one metal level and all products within that metal level;
- Selecting one specific health insurer and one specific metal level offered by such insurer;
- Selecting one specific health insurer and offering multiple products from such insurer;
- Selecting all metal levels and all health insurer products.

The Small Business will also permit the ability to offer an "employee choice" model through defined contribution mechanisms. Qualified Employers will have similar options available to them for stand-alone dental products.

c. Minimum Participation & Employer Contribution Standards The are no minimum participation requirements or minimum employer contribution requirements in the Small Business Marketplace.

d. Payment and Grace Period. Applicants must adhere to the methodology and processes developed by Small Business for payment and remittance of premium. Applicant must provide employers purchasing health care coverage through the Small Business Marketplace with a thirty (30) day payment grace period.

6. Health Savings Accounts and Health Reimbursement Accounts

Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs) are financial mechanisms created under law and regulated by the Internal Revenue Service (IRS) that provide individuals with tax advantages to offset healthcare costs. HSAs are accounts held by a trustee or custodian (i.e., a bank) on behalf of individuals. HRAs are accounts held solely by an employer on behalf of an employee. For more information, visit http://www.irs.gov/uac/Publication-969,-Health-Savings-Accounts-and-Other-Tax-Favored-Health-Plans.

Applicants will be permitted to offer high deductible health plans that meet the IRS requirements and may arrange for the applicable HSA and HRA, if requested by the consumer and/or employer.

7. Non-Discrimination

Applicants must not, with respect to their QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

E. Quality and Enrollee Satisfaction

The DOH monitoring of the quality of care delivered by entities whose products are certified as QHPs (Certified QHP Insurer), will be ongoing and determined through use of a variety of quality, utilization and satisfaction metrics that have been validated, have clinical relevance to the populations served, and are widely in use by health plans serving other populations in New York State. Measuring performance across a wide range of quality metrics will ensure Marketplace members across the age spectrum and with various health conditions are included in this assessment. This process will also help to establish the DOH's active agenda for continuous quality improvement. Public reporting of Certified QHP Insurers' performance will also be a central feature of the DOH plan for quality oversight.

Outlined below are the DOH expectations related to quality of care and enrollee satisfaction for which the Applicant must adhere:

1. Develop and Maintain a Quality Strategy

Applicants must develop a quality strategy that encompasses all the requirements set forth in 1311(g) of the ACA. This strategy must be implemented, updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

A) the implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities;

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings; and

(F) a description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in children and adults.

2. Quality Assurance Reporting Requirements

All Applicants will be required to participate in the DOH Quality Assurance Reporting Requirements (QARR). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's (NCQA) Health Care Effectiveness Data and Information Set (HEDIS) with New York State-specific measures added to address health issues of importance to the State. QARR data will be used as a major component of Certified QHP Insurer quality rankings that will appear on the Marketplace website and will also be used in identifying clinical best practices, as well as, areas of concern with respect to quality of care and administering the health plan benefit package. The QARR data collected from Certified QHP Insurer will also be posted on the DOH website in eQARR and related publications.

The QARR technical specifications are released annually during the fall season of the measurement year, with reporting of QARR data due on or about the following June 15. The current QARR specifications for reporting year 2013 are posted on the DOH webpage and can be viewed at the following link:

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2013/docs/qarr_specifications_manual_2013.

The Certified QHP Insurer will be required to report quality measures as well as all other required member-level files. QARR reporting will require all Certified QHP Insurers to have:

a) HEDIS Volume 2

b) Programming for all required measures (either in-house capability of through a vendor)

c) A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to the DOH.

d) A certified CAHPS vendor to administer CAHPS

QARR submissions with respect to Marketplace enrollment is anticipated to begin on or around June 2016 for calendar year 2015.

3. Consumer Assessment of Health Care Providers and Systems (CAHPS)

All Certified QHP Insurers will also be required to annually survey a sample of their Marketplace eligible members using the standardized CAHPS Health Plan Survey tool. The CAHPS Health Plan Survey allows the DOH to assess many aspects of the members' experience of care, including their access to care and services and their interactions with their providers and health plan. The DOH may add New York State-specific questions to the tool to aid the state in learning about newly insured's experience and/or to provide additional information. Like QARR, the DOH uses CAHPS data to identify any opportunities for improvement and DOH analyses of CAHPS data may require some plans to develop and implement quality improvement strategies.

The initial CAHPs survey for Certified QHP Insurers is for 2015 and will be reported to DOH with the QARR data in June 2016.

4. Quality Improvement Initiatives

The DOH will require Certified QHP Insurers to have the infrastructure in place (or the ability to contract for such services) which allows them to implement their Quality Strategy and related improvement activities as well as participate in a variety of DOH sponsored quality improvement work. This could include administration of member's surveys, offering member education/outreach or incentive programs, offering physician training and/or incentive programs, supporting systematic changes at the practice level and practice level assessments among other things. The Certified QHP Insurers will also be welcome to participate in DOH sponsored statewide improvement initiatives that target issues of importance such as readmissions, coordinated care for members with chronic disease, and other topics.

For Certified QHP Insurers with performance that falls outside normal ranges for quality or satisfaction performance, a barrier analysis and an improvement plan will need to be developed and operationalized once approved by the designated DOH office.

5. Accreditation

For calendar years 2014 and 2015, the DOH will not require Applicants to be accredited as a condition of participation. This requirement will be reviewed for calendar year 2016.

F. Network Adequacy

Applicants will establish and maintain a network of Participating Providers that is consistent with 45 CFR § 156.230 and existing DOH managed care network adequacy standards. Specifically, Applicant must adhere to the following:

1. General Standards

a) In establishing the network, the Applicant must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients, and the geographic location of the providers and enrollees.

b) To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

c) The DOH may, on a case-by-case basis, defer any of the contracting requirements set forth in this Section II.F if it determines there is sufficient access to services in a county. The DOH reserves the right to rescind the deferment at any time should access to services in a county change.

2. Specific Standards Applicable to Health Insurer Applicants

a. Network Composition. The Health Insurer Applicant's network must contain all of the provider types necessary to furnish the Marketplace products, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, Durable Medical Equipment (DME) providers, home health providers, and pharmacies. Specifically, the Health Insurer Applicant's network must meet the following:

(i) Each county network must include at least one hospital; however, for the following counties and boroughs, the network must include at least 3 hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan, Queens;

(ii) Each county network must include the core provider types and ratios established through the Provider Network Data System (PNDS);

(iii) Provide a choice of three (3) primary care physicians (PCPs) in each county, but more may be required based on enrollment and geographic accessibility;

(iv) Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

(v) meet the following time and distance standards:

A. Primary Care Providers

- Metropolitan Areas – 30 minutes by public transportation for primary care providers;
- Non-Metropolitan Areas – 30 minutes or 30 miles by public transportation or by car for primary care providers;
- In rural areas, transportation requirements may exceed these standards if justified.

B. Other Providers

- It is preferred, but not required, that the Health Insurer Applicant meet the 30 minute or 30 mile standard

b. Essential Community Providers. Health Insurer Applicant is required to have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the Health Insurer Applicant's service area. The Health Insurer Applicant must make every good faith effort to include in its network the essential community providers defined under federal regulation, and at a minimum, must include in each county network a federally qualified health center and a tribal operated health clinics, to the extent such providers are available.

c. Behavioral Health Providers. The Health Insurer Applicant is required to include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities in its behavioral health network. The network must include facilities that provide inpatient and outpatient mental health and inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

3. Specific Standards Applicable to Dental Benefits and Stand-Alone Dental Carriers

The Applicant's dental network shall include geographically accessible general dentists sufficient to offer each enrollee a choice of two (2) primary dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 enrollees. Networks must also include at least one (1) pediatric dentist and at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network must include dentists with expertise serving special needs populations (e.g. HIV+ and developmentally disabled patients).

4. Sanctioned Providers

The Applicant shall not include in its network any provider who

a) has been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA; or

b) has had his/her licensed suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

5. Method of Review

Network adequacy shall be reviewed by the DOH on a county-by-county basis. For some network adequacy purposes, however, the county may be extended by approximately ten (10) miles beyond the county in the event the Applicant demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside the county. In such cases, and for rural areas in particular, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements.

6. Frequency of Review

The DOH shall review the adequacy of an Applicant's network upon submission of the application and on a quarterly basis thereafter. The frequency of submission and review will be increased incrementally to monthly submissions. Until the frequency increases to a monthly submission, Applicants are required to submit to the Marketplace changes in their networks as soon as they occur (e.g., addition or termination of a hospital or large physician practice) but no later than fifteen (15) days from the date of occurrence.

7. Submission of the Network

The Applicant shall submit its network through the Health Commerce System (HCS) in accordance with the Provider Network Submission Instructions set forth in Attachment F, or through any successor provider network system developed and implemented by the DOH after consultation with health plans and other stakeholders. Submission must include out-of-state providers within the Applicant's network and must include arrangements with specialty centers and centers of excellence. The DOH reserves the right to ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

G. Administrative Requirements

1. Enrollment and Member Services

a. Enrollment Periods. The Applicant must adhere to the open enrollment periods established under 45 CFR § 155.410, 45 CFR § 155.725, and the special enrollment periods established under 45 CFR § 155.420. Enrollment is not effectuated until receipt of initial payment of premium from the prospective Enrollee. However, once payment is received, the Applicant must adhere to the grace period standards set forth in federal regulation and DFS guidance for those Enrollees receiving Advance Premium Tax Credit assistance. For Enrollees in the Individual Market that do not receive Advance Premium Tax Credit assistance, once the initial premium is paid, the Applicant must provide a thirty (30) day grace period to pay premiums in accordance with DFS guidance.

b. Enrollment Transactions. In addition, the Applicant must be able to send and receive HIPAA Compliant 834 and 999 transactions in accordance with the 834 and 999 companion guide developed by the DOH and CMS pursuant to law, regulation and guidance.

c. Member Services General Functions. The Applicant must agree to operate a Member Services Department during regular business hours, which must be accessible to Marketplace Enrollees via a toll-free telephone line. Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines) not less than during regular business hours to address complaints and utilization review inquiries. In addition, the Applicant must have a telephone system capable of accepting, recording or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received. The DOH may require the Applicant to periodically report member services call statistics such as the number of calls received related to the Marketplace, the number of calls answered and caller wait times. Applicants must be prepared to adjust member services staff to meet expected performance levels on peak Marketplace volume days.

d. Accessibility. Information must be provided to prospective enrollees and enrollees in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. In particular, the Applicant must:

(i) Provide written materials in a prose that is understood by an eighth- grade reading level and must be printed in at least ten (10)-point type.

(ii) Make available written materials and other informational materials in a language other than English whenever at least five (5%) of the applicants and/or enrollees of the Issuer in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, provide taglines in common non-English languages indicating the availability of written translation of materials in any language the prospective or current enrollee speaks.

(iii) Make available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

(iv) Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include assistive technologies for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

To the extent HHS establishes standards on written materials and/or verbal materials for the Marketplace that provides greater protections than the standards set forth above, Applicant shall adhere to such HHS standards.

e. Consumer Complaints. Consumer complaints received through the Marketplace and sent to the Applicant require a response from the Applicant no later than three (3) business days from the day the Marketplace sends the complaint. If the matter involves an urgent coverage issue, the Applicant must respond and act upon the complaint within 24 hours of issuance by the Marketplace. These timeframes apply regardless of whether the complaint is generated as a result of technical problems with the Applicant's system or technical problems with the Marketplace system. In the event the complaint involves a technical error by the Marketplace or the Applicant needs a technical transaction to resolve the complaint, the Applicant will work cooperatively and diligently with the Marketplace to ensure the consumer's coverage is not delayed in any way as a result of waiting for the technical issues to be resolved.

2. Marketing Standards

a. Marketplace Marketing and Outreach. The DOH is implementing a multi-faceted marketing and outreach campaign focused on connecting New Yorkers with quality, affordable health insurance through its user-friendly website. The DOH will

engage in targeted outreach to consumers through navigators, consumer advocates, small businesses, brokers, Regional Advisory Committee members and other stakeholders to promote the use of the Marketplace. The DOH will also initiate an advertising campaign designed to publicize the access to quality, affordable health insurance.

b. Applicant Responsibilities

1. Applicant may conduct advertising campaigns, including television, radio, billboards, subway and bus posters. The Applicant may distribute marketing materials in local community centers, health fairs and other areas where potential enrollees are likely to gather.

2. The Applicant shall use the logo and branding designated by the DOH in referring to Marketplace products in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Applicant will cooperate in good faith with DOH's marketing and outreach activities, including the development of advertising materials and descriptive literature for its Marketplace products.

3. Applicant may not employ marketing practices that will have the effect of discouraging the enrollment of individuals or small businesses with significant health needs in their Marketplace products.

4. The Applicant shall comply with all provisions of federal and State law regulating advertising material and marketing practices. The Applicant's advertising materials must accurately reflect general information that would be applicable to an Marketplace Enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives of any kind to potential enrollees to enroll in an Marketplace product or renew their coverage.

5. The Applicant is prohibited from door-to-door solicitations of potential enrollees or distribution of material, and may not engage in "cold calling" inquiries or solicitation. The Applicant may not require participating providers to distribute Applicant-prepared communications to their patients. Marketing may not take place in patient rooms or treatment areas.

6. Applicant will provide copies of advertising materials and/or descriptions of its advertising campaigns to the DOH upon request.

3. Reporting

a. General. The Applicant will maintain a health information system that collects, analyzes and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, claim denials, customer service information, rating of provider practices, cost-sharing and payments with respect to out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the DOH reporting requirements, and any other information requested by the DOH and/or required under applicable federal and state laws or regulations.

b. Timing and Instructions for Reporting. The Applicant must submit required reports to the DOH in a manner consistent with federal requirements under Section 45 CFR Part 156, or as otherwise instructed by the DOH.

c. Encounter Data. Certified QHP Insurers will be required to submit encounter data for all contracted services obtained by each of their members. Encounters are records of each face-to-face interaction a member has with the health care system and includes, outpatient visits, inpatients admissions, dental care, emergency room and urgent care visits. Encounters for ordered services such as pharmacy and labs shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on site of service and may also include diagnosis information. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Encounters are to be submitted on at least a monthly or more frequent basis through the DOH designated vendor in a format and manner to be prescribed by the DOH.

For more information on current encounter data reporting requirements *for plans serving Medicaid recipients,* Applicants may visit the DOH website at the following address:

http://www.health.ny.gov/health_care/managed_care/docs/dictionary_meds3.pdf

d. Financial Reporting. Applicant shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the DOH and DFS in a timely manner as required by State and federal laws and regulations. Applicant must agree to also submit separate premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the DOH.

4. Certification, Recertification and Decertification Process

a. Certification. The Marketplace will grant certification through SERFF. All Applicants that meet the requirements set forth in this Invitation, will have their health plans certified to be offered through the Marketplace.

b. Decertification. A Certified QHP Insurer may be decertified if it fails to adhere to the certification standards set forth in this application, fails to resolve state agency sanctions, fails to comply with any applicable corrective action plan, or fails to recertify, and for any other reason set forth in the Agreement between DOH and the Certified QHP Insurer. Decertification shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

d. Non-renewal. Certified QHP Insurers may opt not to renew participation or products in the Marketplace. The Certified QHP Insurer must notify DOH of its decision to not renew in a manner and timeframe that consistent with existing state law, and in accordance with the Agreement between DOH and the Certified QHP Insurer. The Certified QHP Insurer must follow applicable laws and regulations in terminating the respective Certified QHP Insurer from the Marketplace, including notification to enrollees. The DOH will monitor the transition process, coordinating processes with Marketplace Customer Service and DFS to facilitate transition.

e. Suspension. The DOH may suspend enrollment in a QHP in the event a respective state agency requires suspension, or in the event the DOH determines it is in the best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

Section III. Premium Rate and Policy Form Filing

A. New York State Department of Financial Services (DFS) Statutory Authority

Pursuant to sections 3201, 3231, 4235, and 4308 of New York State Insurance Law, the New York State Department of Financial Services (DFS) is authorized and directed to review and approve policy forms and premium rates before such policy forms may be issued or delivered. HHS has determined that New York State has an effective rate review mechanism and, as such, New York State is authorized to conduct rate review pursuant to State standards. Accordingly, pursuant to the requirements of the State Insurance Law, Applicants must file with DFS proposed policy forms and premium rates for Marketplace products and obtain the Superintendent's approval of such policy forms and premium rates prior issuing or delivering such contracts and prior to QHP Certification or Recertification.

B. Policy Form Filings

1. All policy form filings for Marketplace products must be received by DFS by June 1, 2014.

2. All policy forms for Marketplace products shall be submitted to DFS for approval through the System for Electronic Rate and Form Filing (SERFF) in accordance with instructions established by DFS and HHS.

3. DFS will update a checklist and instructions for policy form filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all policy form submissions are complete.

4. DFS will develop updated model policy form language for Marketplace products, which will be available on the DFS website. All Applicants must use the model language.

C. Rate Filings

1. All premium rate applications for Marketplace products must be received by DFS by June 1, 2014.

2. All premium rate applications for Marketplace products shall be submitted to DFS through SERFF in accordance with instructions established by DFS, DOH, and HHS.

3. DFS will develop a checklist and instructions for premium rate filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all rate application submissions are complete.

4. Health Insurer Applicants must use the updated federal AV calculator when determining whether the Marketplace products meet the actuarial values required for the respective products. HHS has updated the AV calculator, so Applicants will have to rerun their products through the updated AV calculator to make sure that the products meet the proper AV levels. To the extent the AV calculator is not built into the rate templates, Applicants must include in the rate application a printout from the AV calculator for each Marketplace product submitted and a clear benefit description for each product submitted. The federal AV calculator can be found at http://www.cciio.cms.gov/resources/regulations/index.html#hie.

6. Provisions Applicable to Health Insurer Applicants

   a. Rating Tiers. Individual and small groups products in New York are community rated in accordance with state laws, regulations and guidance, and Health Insurer Applicants cannot take into account age, sex, health status, occupation or tobacco use when establishing premium rates. All products shall be initially priced to reflect four tiers with the following relativities:

Tier	Relativities
Single person	1.00
Singe + spouse	2.00
Single + child(ren)	1.70
Single + spouse + child(ren)	2.85

These relativities shall apply to 2015 rates in the Individual Marketplace and Small Business Marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-only Products. In addition to the tiers specified above, Health Insurer Applicants must offer child-only products in conjunction with the standard product designs. Only one child-only product is required per metal level. Separate policy forms must be created and provided to enrollees of child-only products. The child-only rate must be set at 41.2% of the corresponding single rate product. The Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

c. Risk Adjustment and Reinsurance. The Marketplace has elected to utilize the federal risk adjustment methodology and reinsurance methodology. Health Insurer Applicant's premium rates should reflect the anticipated impact of these programs.

d. Single Risk Pool Inside and Outside the Marketplace. Under the ACA and applicable regulations, Health Insurer Applicants must consider all of the enrollees in all non-grandfathered products offered by the Applicant to be members of a single risk pool in the Individual market and the small group market, respectively. This requirement applies to products offered both inside and outside of the Marketplace for each market. Consequently, if the Health Insurer Applicant offers a small group or individual product on the Marketplace, it should coordinate its rate application filings with the rate filings for non-grandfathered small group or individual products outside the Marketplace. DFS will issue instructions as to how to coordinate the filings. Catastrophic plans will have their own risk pool.

7. Premium Rate Periods

a. Small Business Products. Applicants may use quarterly rolling rates for Marketplace products offered through the Small Business Marketplace, with a one year guarantee for the employer. For example, if the employer's plan year begins April 1, 2015, the rate provided to that employer will be guaranteed for all employees through March 31, 2016, as well as new employees or special enrollments that occur during the plan year through March 31, 2016.

b. Individual Marketplace Products. Premium rates for Marketplace products offered in the Individual Marketplace Market must run on a calendar year basis, from January 1 to December 31 of the applicable year.

8. Rating Regions. When submitting products for rate review, Applicants must adhere to the rating regions set forth on Attachment C.

SECTION IV. Federal and State Laws and Regulations

A. Federal Laws, Regulation and Guidance

The Applicant shall at all times strictly adhere to all applicable federal laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted, including the following:

- The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as the Affordable Care Act (ACA).
- 45 C.F.R. Parts 155 and 156 (2012) Marketplace establishment standards and other related standards under the Affordable Care Act, insurance standards under the Affordable Care Act, including standards related to Exchanges.
- Health Information Technology for Economic and Clinical Health Act of 2009
- Health Insurance Portability and Accountability Act of 1996
- The Privacy Act of 1974

B. State Laws and Regulations

The Applicant shall at all times strictly adhere to all applicable state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted. Applicant acknowledges that such laws include, but are not limited to the following:

a) Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations

N.Y. Insurance Law § 3201, 11 N.Y.C.R.R. 52.1, et. seq.
(Approval of policy forms)
N.Y. Insurance Law § 3231
(Rating of individual and small group health insurance policies; approval of superintendent)
N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2
(Group Accident and Health Insurance)

N.Y. Insurance Law § 4308
(Supervision of Superintendent)

b) Access to Care

- N.Y. Public Health Law § 4403(5)(a), 10 N.Y.C.R.R. 98-1.13(b)
  (Health Maintenance Organizations, network adequacy)
- N.Y. Public Health Law § 4403(6)(a), 10 N.Y.C.R.R. 98-1.13(a)
  (Health Maintenance Organizations, access to appropriate providers)
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.13(j)
  (Health Maintenance Organizations, emergency health services)
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.6, 10 N.Y.C.R.R. 98-1.12
  (Health Maintenance Organizations, quality management program)
- N.Y. Insurance Law § 4325
  (Prohibitions)
- N.Y. Insurance Law § 3224-a
  (Standards for prompt, fair and equitable settlement of claims for health care and payments of health care services)

c) Access to Information

- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.16
  (Disclosure and filing)
- N.Y. Public Health Law § 4405-b
  (Duty to report)
- N.Y. Public Health Law § 4408
  (Disclosure of information)
- N.Y. Public Health Law § 4910
  (Right to external appeal)
- N.Y. Insurance Law § 4323
  (Marketing material)
- N.Y. Insurance Law §§ 3217-a and 4324
  (Disclosure of information)

C. Medicaid and Child Health Plus Programs

Applicants that also participate in the Medicaid Managed Care Program and the Child Health Plus Program shall adhere to the requirements of the respective programs. Nothing contained herein shall be interpreted to supersede the laws, regulations, guidance or instructions issued under the Medicaid Managed Care Program and Child Health Plus Program.

Section V. Application Process

A. Issuing Agency

As stated in Section I.A., this Invitation is issued by the DOH. DOH is responsible for the requirements specified herein and for processing all Applications in partnership with the DFS. This Invitation has been posted on the DOH Marketplace informational website.

DOH shall review Applications in an objective, comprehensive manner designed to benefit both the Marketplace and Applicants. The DOH intends that all Applications will be reviewed uniformly and consistently. For the purpose of its review, the DOH may seek assistance from any person, other than one associated with an Applicant.

B. Letter of Interest

Applicants are requested to submit a non-binding Letter of Interest as soon as possible but no later than the date set forth in the Schedule of Key Events timetable contained on page 2 of this Invitation, via electronic or regular mail at the addresses set forth in paragraph C below. Submission of the Letter of Interest does **not** bind a prospective Applicant to submit an Application. If an Applicant would like to receive e-mail notification of updates/modifications to the Invitation, including the issuance of DOH responses to questions raised regarding the Invitation, the Applicant may include such request in their Letter of Interest. A Form Letter of Interest is attached to this Invitation as Attachment D.

C. Inquiries

All responses and requests for information concerning this Invitation by a prospective Applicant or an Applicant, or a representative or agent of a prospective Applicant or Applicant, should be directed to the contact listed below. In order for DOH to address questions efficiently, prospective Applicants are requested to send their inquiry in writing by email to the email address below. Inquiries of a technical nature may result in either a written response or a referral to the appropriate individual for a verbal response (e.g., guidance and assistance regarding use of the HCS System). To the extent possible, written questions concerning a specific requirement of the Invitation should cite the relevant section of the Invitation for which clarification is sought. Questions of this nature will be responded to by the DOH in writing and such questions and answers will be posted on the website in Section V.A., above, unless the party submitting a question maintains that the question/answer will contain confidential and/or proprietary information.

NAME: Invitation Administrator
EMAIL: nyhxpm@health.state.ny.us
ADDRESS: NY State of Health
NYS Department of Health
Corning Tower, Suite 2378
Albany, New York 12237

D. Changes to the Application

The DOH reserves the right to:

1. Withdraw the Invitation at any time, at the DOH's sole discretion.
2. Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation.
3. Seek clarifications and revisions of Applications. The DOH may require clarification from individual Applicants to assure a complete understanding of the Application and/or to assess the Applicant's compliance with the requirements in this Invitation.
4. At any time during the Invitation process, amend the Invitation to correct errors or oversights, and to supply additional information. Prospective Applicants are advised that at any time during the course of this application process, pertinent federal and state laws, regulations, and rules may change, and the protocol for using required systems such as SERFF and HCS may change. In addition, scheduled dates may need to be adjusted. All Prospective Applicants and Applicants will be informed of such changes, and Applicants may be directed to supply additional information in response to such amendments.

E. Submission of the Application

1. Application. As part of the certification process, Applicants are required to submit the following, which collectively constitutes the Application:

a. Participation Proposal
b. Submission of Policy Form and Rates
c. Submission of Provider Network Information

Each of the three component parts must be received by the due dates set forth in the Schedule of Key Events listed in this Invitation. Late submissions may not be accepted.

2. Instructions:

a. Participation Proposals. Applicants shall submit two (2) original, signed copies of the Participation Proposal by mail or hand delivery to the address listed above in Section V.C. Electronic submissions are also required and can be sent to the email address noted in Section V.C. Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with capacity and legal authority to bind the Applicant to the authenticity of the information provided. The Participation Proposal Form to be completed and submitted by Applicants is attached to this Invitation as Attachment E.

b. Submission of Policy Form and Rates. As set forth in Section III, Marketplace products, rates and policy forms must be submitted to DFS per DFS instruction, which will be available on the DFS website.

c. Submission of Provider Network Information. As set forth in Section II.F.7, Applicants shall submit their network through the Health Commerce System (HCS) in accordance with the Provider Network Submission Instructions contained in Attachment F to this Invitation.

d. Vendor Responsibility. On or around the same time Applicants submit Forms and Rates, Applicants that are applying for the first time will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System. The VendRep System Instructions are available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us.

F. Public Information

Disclosure of information related to this Invitation process and resulting contracts shall be permitted consistent with the laws of the State of New York and specifically the Freedom of Information Law (FOIL) contained in Article 6 of the Public Officers Law. Information constituting trade secrets or information that if disclosed would cause substantial injury to the competitive position of the subject enterprise for purposes of FOIL shall be clearly marked and identified as such by the Applicant upon submission. Determinations regarding disclosure will be made when a request for such information is received by the DOH Records Access Office.

VI. Agreement with DOH

Following completion of the activities outlined in this Invitation and having been determined to have met all the requirements, the DOH will offer Applicants that are applying for the first time with the opportunity to enter into an Agreement. The Agreement resulting from this Invitation will be effective only upon approval of the New York State Office of the Attorney General (OAG) and the Comptroller of the State of New York (OSC). Applicants must enter into an Agreement with the DOH in order for their products to be certified as QHPs and to offer such QHPs through the Marketplace.