



**NY State of Health 2021 Plan Invitation:
Supplemental Information
May 7, 2020**

Updated Standard Bronze Product

The New York State Department of Financial Services and NY State of Health have updated the Standard Bronze (non-HSA) Product Design for 2021. The updated product design is included in **Attachment B** and is posted online here: <https://info.nystateofhealth.ny.gov/invitation>

The standard Bronze (non-HSA) product includes 3 pre-deductible visits to a primary care provider (PCP) or specialist that are subject to a co-payment. There is a modest increase to the deductible (from \$4,425 in 2020 to \$4,700 in 2021) and cost sharing for PCP and specialist visits will be subject to co-payment instead of co-insurance.

Questions and Answers

Invitation

Question: Given that we are all working remote, can our letters of interest and participation proposals be signed electronically?

Answer: Yes. NY State of Health requests that all plan letters of interest and participation proposals are submitted electronically, including electronic signatures.

Dental

Question: Are we being asked to add “NSD” to the plan name? Or is that for QHPs with dental?

Answer: For QHP products only: Include “NSD” to indicate that the embedded dental benefits are not subject to the QHP deductible. Please note this where applicable for both pediatric and adult/family coverage.

Question: Which entities will be required to complete and submit a Qualified Dental Plan (QDP) Benefit and Cost Sharing Template? Only stand-alone dental plans? Will medical QHPs that include adult dental benefits also be required to submit this template?

Answer: Medical QHP issuers that offer products with adult/family embedded dental benefits must complete the template and only need to provide us with details relating to products that

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have adult/family embedded dental coverage. Medical issuers that offer QHPs without embedded dental benefits or who offer products with only pediatric dental coverage embedded, do not need to complete the template.

Stand-Alone Dental Plans must complete the template for both pediatric standard products and non-standard adult-family products.

The template will be sent to the issuers in the next few weeks by the plan managers. The data submission due date to NY State of Health is August 31, 2020.

New subsection added to (v) to E.1., Page 60 2021 Plan Invitation – Submission of QDP Benefit Cost Sharing Template to DOH.



Invitation and Requirements for Insurer Certification and Recertification for Participation in 2021

QUALIFIED HEALTH PLANS, STAND-ALONE DENTAL PLANS & ESSENTIAL PLANS

Revised May 7, 2020

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2021 Schedule of Key Events

EVENT	DUE DATE	QHP	SADP	EP
Invitation Released	April 30, 2020	x	x	x
Letters of Interest Due to NYSoH	May 7, 2020	x	x	x
Written Questions Accepted by NYSoH	April 28 – May 29, 2020	x	x	x
Dental Forms and Rate Filings Due to DFS in SERFF	May 4, 2020		x	
Medical Policy Forms and Rates Due to DFS in SERFF	May 18, 2020	x		
Dental on Exchange Binders Due in SERFF	May 18, 2020		x	
Participation Proposals Due to NYSoH	May 29, 2020	x	x	x
Medical On Exchange Binders are Due in SERFF	June 5, 2020	x		
Provider Network Submission Due to NYSoH	July 27, 2020	x	x	x
Essential Plan Templates Due to NYSoH	July 31, 2020			x
DFS Rate Decision Due Date	August 6, 2020	x	x	
Essential Plan Subscriber Agreements Due to NYSoH	August 31, 2020			x
Plans Must Complete Approval of Information in Issuer Portal	September 4, 2020	x	x	x
Certification of Plans by NYSoH	September 25, 2020	x	x	x

QHP – Qualified Health Plan • SADP – Stand-Alone Dental Plan • EP – Essential Plan



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:

- (i) Insurers offering Qualified Health Plans (“QHPs”), Stand-Alone Dental Plans (“SADPs”) and Essential Plans (“EPs”), through NY State of Health, the Official Health Plan Marketplace (“Marketplace”), in 2020, to apply for recertification for 2021; and
- (ii) Other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs, SADPs, and EPs to be offered on the Marketplace in calendar year of 2021.

Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and their proposed products meet all federal minimum participation standards and other requirements necessary for certification as a QHP, SADP or an EP. Applicants and individual plans found by DOH to satisfy all minimum standards and requirements, and in the case of Applicants applying for the first time, Applicants who sign a new Agreement with the DOH, will have products certified as QHPs, SADPs, or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of products to be offered on the Marketplace in 2021.

The DOH reserves the right to negotiate with Applicants in the best interest of the Marketplace and its consumers, including, but not limited to, ensuring choice for consumers and small businesses, and to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs.

B. Background

1. NY State of Health, the Official Health Plan Marketplace

NY State of Health, the official health plan Marketplace of New York State, authorized by the Federal Patient Protection and Affordable Care Act of 2010, was established in April 2012 by Governor Cuomo’s Executive Order 42, and codified in the NY Public Health Law in 2019. The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York. By February 7, 2020, more than 4.9 million New Yorkers were enrolled in coverage, an increase of more than 150,000 people from 2019. Marketplace enrollment growth is consistent with New York’s declining uninsured rate, which reached a historic low of 4.7 percent in 2018.

As of February 7, 2020, over 3.4 million New Yorkers were enrolled in Medicaid through NY State of Health and more than 1.5 million people enrolled in a non-Medicaid program through the Marketplace. This includes 272,948 people enrolled in a Qualified Health Plan and 796,998 enrolled in the Essential Plan. The 2020 Open Enrollment Period finished with more than 1 million people (1,069,946) enrolled in a Qualified Health Plan or the Essential Plan.

Applicants can enroll in coverage through NY State of Health online, by telephone, or with the help of an in-person assistor. During the 2020 Open Enrollment Period, nearly 2 million New Yorkers visited the NY State of Health website, Customer Service answered nearly 1.6 million telephone calls, and there were more than 7,500 certified enrollment experts, including navigators, certified application counselors, health plan facilitated enrollers and health insurance brokers who worked with consumers. In-person assistors helped more than three-quarters (80 percent) of enrollees complete their Marketplace applications in 2020. Through its website, NY State of Health makes available to consumers an easy to use plan preview, or anonymous shopping tool, which allows individuals to shop for a health plan and to also receive a personalized premium estimate before starting an application.

In 2020, NY State of Health increased efforts to reach new consumers, renew existing enrollees, and dispel consumer confusion around changes to the Affordable Care Act. NY State of Health got its message out to consumers through its “You Deserve Affordable Health Care” advertising campaign, at more than 250 community outreach events, and by sending nearly 2.4 million emails to consumers reminding them of important steps needed to complete their enrollment. Marketplace statewide advertising was in English, Spanish, and Mandarin, on tv, radio, digital platforms, ethnic print publications and digital and billboards in the metro-NYC region.



**Section II: Qualified Health Plan and Stand-Alone Dental Plans –
Individual and Small Business Marketplaces**

A. Participation Requirements

1. Licensure and Solvency

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

- Be licensed as an insurer under Articles 42 or 43 of NY Insurance Law or certified under Article 44 of NY 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 1, 2020 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2020.

2. Choice of Participation

Applicants may apply to participate in the individual market and small business marketplace. They are not required to participate in both.

3. 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 and consumers. 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 seeking to expand their QHP service area in addition to notifying DFS and DOH must file a service area expansion application with the Division of Health Plan Contracting and Oversight or DHPCO. This application should be sent to bmccsmail@health.ny.gov.

4. QHP Applicant Product Offerings

a. Essential Health Benefits

Applicants must agree to provide the Essential Health Benefits (“EHBs”) specified by the DOH for calendar year 2021, delineated in Attachment “A.” The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels

All products 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 U.S. Department of Health and Human Services (“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 current federal rules, reflected in 2019 final federal regulation, a *de minimus* variation of -4/+2% AV is permissible, except with respect to the Silver Level CSR (cost-share reduction) variations, which only permits a variation of +/- 1% AV and the Bronze Level, which permits a *de minimus* variation of -4/+5% AV. Further, the minimum permissible differential between the Silver (70% AV) and Silver CSR (73% AV) is two (2) percentage points. For purposes of this invitation, standard silver, and non-standard silver level products if offered by the issuer, must have an actuarial value of at least 70%, with a permissible *de minimus* variation of +2% AV. This limit on silver level product variation applies to the Individual Market only and does not apply to the small business marketplace (SHOP).

c. Standard Products

QHP 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 QHP 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 market; there is no requirement to offer standard products for the small business marketplace. The standard products for 2020 are provided in Attachment “B.”

d. Standard Products With 3 Pre-Deductible Visits

The 2021 standard bronze product includes 3 visits to a primary care provider (PCP) or specialist that are not subject to the deductible. ~~copayments, or coinsurance.~~ QHP Applicants may also continue to offer a standard gold level and silver level product

with 3 visits to a PCP that are not subject to the deductible. At these metal levels, copayments will apply. This additional gold or silver product(s) will not count towards the number of non-standard products offered by the QHP Applicant in the individual marketplace. If the QHP Applicant opts to offer this product, it must:

- i. Be offered at the Gold, Silver, Silver CSR 73% AV, and, Silver CSR 87% AV metal levels, in every county of its QHP service area.
- ii. Include the benefits and visit limits as delineated in Attachment “A” and the cost-sharing limitation delineated in Attachment “C,” with the exception that the wellness benefit may be substituted for a different wellness benefit in accordance with federal and state regulation and guidance, as well as DFS review and approval.

e. Child-Only Offerings

In accordance with federal regulation, QHP Applicants must agree to offer a child-only product at each metal level described in Section II(A)(4)(b), above, in the individual market. 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 (A)(4)(b), above, offered at the child-only rate outlined in Section II(B)(4)(b). Only one child-only product is required per metal level. Please note that a QHP Applicant’s participation in the State’s Child Health Plus program does not satisfy this requirement.

f. Catastrophic Products

QHP Applicants must agree to offer at least one standard catastrophic product in each county of the Applicant’s service area in the individual market. The standard catastrophic product can be found in Attachment “B.” As part of the Participation Proposal, which is Attachment “G,” the DOH will require QHP Applicant’s affirmative intent to offer, or continue to offer, a catastrophic product.

If the DOH determines there is adequate catastrophic coverage in a particular county, the DOH may, in its sole discretion, allow other QHP Applicants, in the same county, the option of not offering the catastrophic product.

An Applicant’s decision not to offer catastrophic coverage will be for the entire plan year of 2021.

The DOH will inform the QHP Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the catastrophic product will be made by the DOH prior to certification.

In the event there is not adequate coverage in a particular county, all QHP Applicants in that county will be obligated to offer the catastrophic product.

g. Out-of-Network Products

An “out-of-network” product is a product that provides coverage for services rendered by health care providers that are not in the health plan issuer’s network. QHP 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 the individual market only.

QHP 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 choose 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.

h. Non-Standard Products

QHP Applicants may opt to offer up to three (3) “non-standard” products, as described below, in all or part of its service area, if the partial service area is approved by DOH and DFS in accordance with the requirements listed in Section II(A)(3), those stated below, and any applicable DFS instruction or guidance. This non-standard product limit only applies to the individual market, there will be no limit on the number of products offered by an insurer on the small business marketplace.

Non-standard products offered on the Marketplace must have “meaningful differences” from each other and from the standard QHPs. Non-standard QHPs are considered meaningfully different when additional benefits, not included in the Essential Health Benefits, are covered (e.g., adult dental, adult vision, acupuncture). Non-standard products must allow consumers to easily identify the differences between non-standard products and standard products, so that consumers can determine which plan provides the highest value at the lowest cost to address their needs. All non-standard products must comply with federal and state laws, regulations and guidance and shall be subject to DFS and Marketplace review and approval. Non-standard silver level products, if offered by the issuers, must have an actuarial value of at least 70%, with a permissible *de minimus* variation of +2% AV.

Non-standard products do not have to be offered at all four metal levels. They must, however, be offered at a minimum of two metal levels of the issuer’s choosing (for example, silver and bronze). If the QHP Applicant elects to offer (a) non-standard product(s) at the bronze level, the Applicant must also offer at least the same number of non-standard products at one of the other metal levels.

Examples of permissible and non-permissible combinations:

	Platinum	Gold	Silver	Bronze
Permissible:	0	0	2	2
Permissible:	1	2	0	2
Permissible:	0	1	0	1
	Platinum	Gold	Silver	Bronze
Non-Permissible:	0	0	1	2
Non-Permissible:	2	0	0	3
Non-Permissible:	0	0	0	1

QHP Applicants that offered a Bronze QHP that was HSA eligible in 2020, will be permitted to offer the HSA Compliant Bronze set forth in Attachment “B” in 2021, to ensure the HSA can carry over for their respective enrollees.

Child-only products, catastrophic products, out-of-network products, and the HSA Compliant Bronze product set forth in Attachment “B” will not be counted towards the three (3) non-standard product maximum.

We encourage Applicants to review enrollment in non-standard products offered in prior years, to determine whether they should continue to be offered.

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 review. This requirement is not intended to limit the number of drugs that the QHP Applicant may cover in a drug category or class. QHP 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. QHP 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 QHP Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

QHP Applicants will also have the option of offering adult/family dental, and/or supplemental pediatric dental benefits, as an additional benefit per Section II(A)(4)(h), above. If the QHP Applicant offers a family dental benefit, the pediatric component must include at least the same pediatric dental benefits as outlined in Attachment “A.” These requirements apply to the individual and small group marketplace.

QHP Applicant’s product descriptions must include a plain language description of what services are included within “Basic” and “Major” dental services and must include information about any waiting periods, benefit maximums and whether a deductible is applicable for adult dental care benefits.

To assist the DOH in providing meaningful, detailed benefit and cost sharing dental information to consumers we will be requesting Applicants to complete a Qualified Dental Plan (QDP) Benefit and Cost Sharing Template which will be used to populate the NY State of Health Dental Comparison Tool. The instructions and template will be sent separately from the invitation, no later than May 15, 2020 and will include the due date for the data submission.

The Dental Comparison Tool was added to the NY State of Health website in December 2019. <https://info.nystateofhealth.ny.gov/resource/dental-plan-comparison-tool>

The Dental Comparison Tool assists consumers in review and comparison of dental plans offered on the marketplace. The purpose of the new data collection template is to ensure consistency in dental benefit information across insurers and to facilitate consumer comparisons across insurers.

k. QHP and SADP Naming Conventions

To assist consumers in identifying products and differences between products, QHP and SADP Applicants must use the following naming conventions to identify all QHPs and SADPs offered on the Marketplace, in the order as presented below. Please note that the absence of field name indicates the product DOES NOT include such coverage.

Individual Market

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum, Child-Only, Catastrophic	Indicate metal tier using entire the word for metal level.
Standard/ Non-Standard	ST, ST3PCP or NS	Indicate standard, standard with 3 PCP visits or non- standard by using “ST” for standard, “ST3PCP” for the standard with 3 PCP visits before the deductible, 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.
Network Name	To be assigned by Applicant	Indicate the network name associated with each product
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 Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank
Dental Coverage, Adult/Family, Deductible.	NSD	For QHP Products Only Include “NSD” to indicate that adult/family the embedded dental benefits are not subject to the QHP deductible. Please note this where applicable for both pediatric and adult/family coverage.
Dental Coverage, Adult/Family, Waiting Period	WP	Include “WP” to indicate any waiting periods for adult dental services.

Examples of permissible QHP Individual Market names are shown below:

ABC Product, Platinum, ST, INN, 123 Network, Dep25

ABC Product, Gold, ST, INN, Dep29

ABC Product, Silver, NS, OON, Dep29, Family Vision Family Dental NSD, WP

Small Business Marketplace

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum,	Indicate metal tier using the entire word for metal level.
Network Coverage	INN or OON	Indicate network type using “INN” for in-network and “OON” for out-of-network coverage.
Network Name	To be assigned by Applicant	Indicate the network name associated with each Product.
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 Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank.
Dental Coverage, Adult/Family, Deductible	NSD	For QHP Products Only Include “NSD” to indicate that adult/family the embedded dental benefits are not subject to the QHP deductible. Please note this where applicable for both pediatric and adult/family coverage.
Dental Coverage, Adult/Family, Waiting Period	WP	Include “WP” to indicate any waiting periods for adult dental services.
Domestic Partner	DP	Include only if domestic partners are eligible for coverage.
Family Planning	FP	Include only if the family planning benefit is covered.
Healthy NY	HNY	Include if the product is a Healthy NY product.

Examples of permissible QHP Small Business Market names are shown below:

ABC product, Platinum, ST, INN, Dep25

ABC product, Gold, NS, OON, Adult Dental, Dep29, DP, FP

ABC product, Silver, ST3PCP, ONN, Dep25

ABC product, Gold, ST, INN, Dep 25, HNY

I. Effective Dates

All certified and recertified products offered through the Marketplace will have effective dates of January 1, 2021, in the individual market and the small business marketplace.

Qualified employers will be able to purchase Marketplace certified products directly from the plan issuer at any point during the year.

QHP 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 2021, must be established and submitted to DOH and DFS through this Invitation.

5. Stand-Alone Dental Applicant Product Offerings

SADP Applicants shall offer products through the Marketplace in accordance with federal and state laws and regulations, and in accordance with the participation requirements set forth below.

SADP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about any waiting periods, benefit maximums and whether a deductible is applicable for adult dental care benefits.

a. Essential Health Benefits

The SADP Applicant must agree to provide the pediatric dental benefits outlined Attachment "A." The pediatric dental benefits are minimum benefits and the SADP Applicant may add additional benefits.

b. The Standard Product

The SADP Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the SADP 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 the individual market.

c. Non-Standard Products

The SADP Applicant may opt to offer up to three (3) non-standard products for the individual market. The SADP Applicant may opt to offer unlimited non-standard products for the small business marketplace.

The non-standard product(s) may be a(n) adult/family dental product or additional pediatric dental product offering(s). These requirements apply to both the individual market and the small business marketplace.

d. Other Applicable Provisions

SADP Applicants must meet the requirements set forth in Section II(A)(4)(I) above and Section II(B)(5), below.

6. 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

Small group is a group that meets the definition of “small group” in the NY Insurance Law and regulations, which is currently defined as a group of one hundred (100) or fewer full time equivalent employees (“FTEs”) over the prior calendar year with at least one common law employee enrolled as defined by federal regulation, (see 26 CFR § 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor’s spouse. The small business marketplace will determine the size of the employer by following the definitions set forth by the Department of Financial Services, which can be found on their website at: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

b. Employer Choice

Qualified employers will have the flexibility to offer their employees any SHOP certified product(s) offered by health plan issuer(s).

c. Product Offerings

Issuers proposing to no longer offer products in 2021 that were certified in 2020 on the small business marketplace, must inform the NY State of Health by the date Medical Policy Forms and Rates are due to DFS as indicated in the 2021 Schedule of Key Events, explaining the reason for the removal.

There will be no designation of “standard” and “non-standard” products in the small business marketplace. That is, Applicants applying for the small business marketplace in 2021 are not required to offer the standard benefits shown in

Attachment “B.” Applicants must, however, adhere to metal level actuarial value requirements and must agree to offer at least one product at each metal level on the small business marketplace.

There will be no limit on the number of plans offered by an insurer on the small business marketplace. Insurers are encouraged to offer all small group market products approved for offer in the outside market to increase the availability of tax credits to small employers.

For Plan Year 2021, Healthy NY issuers will continue to have the option of seeking SHOP- certification. This will allow existing HNY employers to access the Federal small business health care tax credit, if otherwise eligible. SHOP-certified Healthy NY products will only be displayed on the NYSOH website to employer groups that attest that they are a current Healthy NY employer group.

d. Minimum Participation and Employer Contribution Standards

While insurers in the small business marketplace and the off-marketplace small group insurance market are discouraged from imposing minimum participation requirements, non-HMO insurers are permitted to impose minimum participation requirements. However, if a small group cannot meet the insurer’s minimum participation requirements, an insurer must still permit the group to enroll during an annual small group market open enrollment period that begins November 15 and extends through December 15 of each year. The annual open enrollment period applies to coverage issued or renewed between November 15 and December 15 and coverage applied for between November 15 and December 15 with an effective date of January 1. Insurers may impose minimum participation requirements on renewal outside of the open enrollment period but only to the extent the same requirements were imposed upon the group’s initial application for coverage.

For coverage issued by the small business marketplace prior to April 1, 2018, insurers were not permitted to impose minimum participation requirements. Therefore, insurers may not impose minimum participation requirements upon renewal for small business marketplace employer groups who were issued small business marketplace coverage prior to April 1, 2018.

e. 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,

please visit <https://www.irs.gov/forms-pubs/about-publication-969>.

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.

f. Non-Discrimination

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

B. Premium Rates and Policy Form Filings

1. New York State Department of Financial Services (“DFS”) Statutory Authority

Pursuant to Sections 3201, 3231, 4235, and 4308 of the NY 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 NY 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 to issuing or delivering such contracts and prior to QHP certification or recertification.

2. Policy Form Filings

All policy forms for QHP products and SADPs shall be submitted to DFS by the date shown in the 2021 Schedule of Key Events, for approval through the System for Electronic Rate and Form Filing (“SERFF”) in accordance with instructions established by DFS and HHS.

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.

DFS will develop updated model language for the Subscriber Agreements to all QHP products and SADPs, which will be available on the DFS website. All QHP Applicants and SADP Applicants must use the model language.

3. Rate Filings

All premium rate applications for Marketplace products must be received by DFS on or before the due date shown in the 2021 Schedule of Key Events for SADP Applicants and QHP Applicants.

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

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.

QHP 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 must rerun their products through the updated AV calculator to ensure that all proposed products meet the required 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 <https://www.cms.gov/cciio/resources/regulations-and-guidance/index#plan-management>.

4. Provisions Applicable to QHP Applicants

a. Rating Tiers

Individual and small group products in New York State are community rated in accordance with state law, regulations and guidance. QHP Applicants cannot consider 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
Single + spouse	2.00

Single + child(ren)	1.70
Single + spouse + child(ren)	2.85

These relativities shall apply to 2021 rates in the individual market and the 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, QHP 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

QHP Applicant's premium rates should reflect the risk adjustment and federal reinsurance programs as directed by DFS.

d. Single Risk Pool Inside and Outside of the Marketplace

Under the ACA and applicable regulations, QHP 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 business marketplace, respectively. This requirement applies to products offered both inside and outside of the Marketplace, for each market. Consequently, if the QHP Applicant offers a small group or individual product on the Marketplace, it should submit one rate adjustment filing per market containing the non-grandfathered products offered inside and outside the Marketplace. DFS will issue instructions as to how to submit the rate adjustment filings. Catastrophic products will have their own risk pool.

e. Premium Rate Periods

- (i.) Small Group Products: Applicants may use quarterly rolling rates for Marketplace products offered through the small business marketplace, with a 12-month guarantee for the employer.

For example, if the employer's plan year begins April 1, 2020, the rate provided to that employer will be guaranteed for all employees through March 31, 2021, as well as new employees or special enrollments that occur during the plan year, through March 31, 2021.

- (ii.) Individual Market Products: Premium rates for Marketplace products offered in the individual market must run on a calendar year basis, from January 1, to December 31, of the applicable year.

f. Rating Regions

When submitting products for rate review, Applicants must adhere to the rating regions set forth in Attachments “D” and “E”.

5. 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 groups and individuals in purchasing coverage through the Marketplace.

a. Producer Certification

Producers who have successfully completed the training certification program for each applicable market 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.

b. Producer Compliance

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

c. Producer Compensation

All QHP and Essential Plan Applicants’ must comply with all applicable provisions of New York State insurance law. In addition, all QHP Applicants’ compensation arrangements with Producers must be the same for products sold inside and outside of the Marketplace. For example, compensation for a policy sold on the Marketplace must be the same as the compensation for a policy sold outside of the Marketplace. In addition, if compensation is provided, QHP Applicants must provide the same compensation at all metal levels.

Essential Plan compensation arrangements must follow the same requirements as in

the individual market. Essential Plan producer compensation schedules will be requested during the Essential Plan rate setting process.



Section III: Essential Plans

A. Essential Plan Participation Requirements

New York elected to establish a Basic Health Program, an option provided to states in the ACA, in April 2015. The Essential Plan is authorized by Section 369-gg of the NY State Social Services Law and was approved by the Centers for Medicare and Medicaid Services on March 27, 2015.

To be eligible for the Essential Plan, individuals must meet the following requirements:

- Be less than age 65 at the beginning of the plan year;
- Reside in New York State;
- Not be eligible for Medicaid or Child Health Plus (“CHP”);
- Not be eligible for affordable Minimum Essential Coverage (“MEC”); and
- Have income between 138%-200% of the Federal Poverty Level (“FPL”) or less than 138% of the FPL and be ineligible for Medicaid due to immigration status.

Insurers must provide health care services as detailed in the attachments to this Invitation. Monthly premium contribution is set in NY State Social Services Law and cost-sharing cannot exceed the amount the individual would have paid for QHP coverage in the Marketplace.

1. Licensure and Solvency

Pursuant to 42 CFR § 600.415(a) and NY State Social Services Law, Section 369-gg(1)(a), Essential Plan (“EP”) Applicants must:

Be licensed as an insurer under Articles 32 or 42 or 43 of NY State Insurance Law, or certified under Article 44 of NY 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 1, 2020 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2020.

2. Choice of Participation

Applicants that apply to participate in the Essential Plan may also apply to participate in both the QHP individual market and the QHP small business marketplace but are not required to participate in either. EP Applicants may participate with the Medicaid or Child Health Plus programs but are not required to participate in either program.

3. Service Area

EP 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. EP 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. EP 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 seeking to expand their EP service area in addition to notifying DFS and DOH must file a service area expansion application with the Division of Health Plan Contracting and Oversight or DHPCO. This application should be sent to bmccsmaill@health.ny.gov

Pursuant to 42 CFR § 600.420(a), the DOH reserves the right to negotiate service area with EP Applicants, to ensure compliance with the federal requirement of choice of EP insurer in each county of the state.

4. Benefits, Cost-Sharing and Individual Premium Contributions

a. Standard Essential Plans

EP Applicants must agree to offer four variations of EP products based on enrollee income as a percentage of FPL and other factors as described below and delineated in Attachment “H” (hereinafter referred to as the “Standard EP”).

All Standard EPs below are based on the essential health benefits benchmark plan specified by DOH for calendar year 2021, with the following exceptions: pediatric services, including oral and vision care, will not be included in the benefit, the wellness benefit may be substituted for a different wellness benefit or benefits in accordance with federal and state regulations, guidance and DOH review and approval.

All EPs offered shall include only in-network options and at no time shall an EP Applicant impose cost-sharing with respect to preventive health services, or items, as defined in 45 CFR § 147.130.

- (i) For individuals with incomes greater than 150% and less than or equal to 200% of FPL (“Essential Plan 1” in Attachment “H”), EP Applicants must provide the Standard EP. Individual enrollees will pay \$20 per individual, per month, for Essential Plan 1 coverage. EP Applicants must also offer a version of this product for the American Indian/Alaska Native (“AI/AN”) population with no cost-sharing for any services.
- (ii) For individuals with incomes greater than 138% and less than or equal to 150% of FPL (“Essential Plan 2” in Attachment “H”), EP Applicants must provide the Standard EP. Enrollees will have no monthly premium for Essential Plan 2 coverage. EP Applicants must also offer a version of this product for the AI/AN population with no cost-sharing for any services.

- (iii) For individuals with incomes greater than 100% and less than or equal to 138% of FPL, who are not eligible for Federal Medicaid due to immigration status (“Essential Plan 3” in Attachment “H”), EP Applicants must provide the Standard EP. Pursuant to Section 369-gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of the federal poverty level, and who previously would have qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, adult vision care, adult dental. Non-emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 3 coverage.
- (iv) For individuals with incomes at or below 100% of FPL, who are not eligible for Federal Medicaid due to immigration status (“Essential Plan 4”, in Attachment “H”), EP Applicants must provide the Standard EP. Pursuant to Section 369-gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 100% of the federal poverty level, and who would have previously qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, adult vision care, adult dental. Non-emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 4 coverage and will have no cost-sharing on benefits.

b. Standard Essential Plan Plus Adult Vision/Dental Benefits

For individuals who qualify for Essential Plan 1 and Essential Plan 2, above, EP Applicants may also elect to offer one additional EP product that offers the same benefits and cost-sharing as the Standard EP, but that also includes coverage for adult dental and vision benefits as defined in Attachment “H” (“Standard EP Plus Adult Vision/Dental”). These are the only additional benefits that may be added, and both benefits must be added.

Individual enrollees will pay the applicable Standard EP premium per individual, per month, plus any additional costs for the dental and vision coverage.

All EP Applicants must complete Attachment “K” confirming their commitment to offer the Standard EP and indicating whether they will offer the Standard EP Plus Adult Vision/Dental. Applicants that elect to offer the Standard EP Plus Adult Vision/Dental must make the option available to enrollees at both income levels for Essential Plan 1 and Essential Plan 2.

c. Standard Essential Plan and Stand-Alone Dental Products

Stand-alone dental products can be offered to individuals who qualify for Essential Plan 1 and Essential Plan 2. Individual enrollees will pay the applicable Standard EP premium per individual per month, plus any additional costs for the stand-alone dental plan.

d. Additional Features of Essential Plans

EP Applicants must include in the Standard EP and the Standard EP Plus Adult Vision/Dental, the following features per 42 CFR § 600.410(d):

- (i) Care coordination and care management for enrollees, with a focus on enrollees with chronic health conditions;
- (ii) Foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;
- (iii) Incentives for the use of preventive services.

e. Essential Plan Naming Conventions

To assist consumers in easily identifying the EP Plans, all EP Applicants must use the same names for their products, and the Marketplace will attach the insurer logo and/or company name on its website to identify the insurer. The EPs must be labeled as follows (see Attachment “H”):

- Essential Plan 1
- Essential Plan 2
- Essential Plan 3
- Essential Plan 4

Optional EP 1 and 2 Product Variations:

- Essential Plan 1 Plus Vision and Dental
- Essential Plan 2 Plus Vision and Dental

f. Effective Dates

Individuals who enroll in the Essential Plan in 2021 will have the following effective dates:

- (i) For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status, and are newly enrolling in coverage, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2021, will have coverage starting February 1, 2021.

- (ii) For individuals who have incomes above 138% of the FPL, and are newly enrolling in coverage, the effective date shall follow the “fifteenth of the month” rule, which means individuals who enroll in an Essential Plan between the first and the fifteenth of the month will have coverage that begins the first day of the next month; and individuals who enroll in an Essential Plan between the sixteenth and the last day of the month, will have coverage on the first day of the second month following the month in which they enrolled.
- (iii) For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status, and are renewing coverage, the effective date will be the first of the following month.
- (iv) For individuals who have incomes above 138% of the FPL, and are renewing coverage, the effective date shall be the first of the following month.

Note that EP enrollees who renew coverage after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin the first of the following month and they will be enrolled into their same plan. Consumers who change plans at renewal and renew after the fifteenth of the month will be enrolled into their same plan the first of the following month and then transitioned to their new plan the first of the next month. For example, an enrollee whose coverage ends December 31, 2020 returns on December 25, 2020 and completes necessary updates and remains eligible for the Essential Plan will be enrolled in their same plan beginning January 1, 2021. If the enrollee is changing plans, coverage in their new plan will begin February 1, 2021.

g. Compensation

EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP and will separately collect the applicable premium payment made from enrollees. The capitation payments made to the insurer must be used in accordance with federal and state laws and regulations, including 42 CFR Part 600. EP Applicants will be informed of their monthly capitation payment amount around August 31, 2020.

Essential Plans are subject to the MLR provisions at 85% (*See Patient Protection and Affordable Care Act § 1331(b)(3); 45 CFR § 158.210(c), 45 CFR § 158.240(b)*). The EP Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination on whether to participate in the Essential Plan in 2021.

h. Premium Payment

EP Applicants must accept premium and cost-sharing payments made from third party entities on behalf of a member, including payment from the Ryan White HIV/AIDS Programs under title XXVI of the Public Health Service Act, Indian tribes and tribal organizations, and State and Federal Government Programs.

i. Rating Regions and Risk Adjustment

Capitation payments will be made to EP Applicant on a county basis and in accordance with the nine rating regions set forth in Attachments “I” and “J” to this Invitation. The DOH currently risk adjusts for certain rating groups within the Essential Plan rating structure. The DOH will expand risk adjustment to all rating groups once complete encounter data is available.

j. Subscriber Agreements and Template Submissions

EP Applicants must use the subscriber agreements that will be provided to them shortly after the release of this Invitation. Revisions to the model language contained in the subscriber agreements will be limited to the bracketed sections of the subscriber agreements. EP Applicants can include their logos and numerical contract-identifying information on agreements. The subscriber agreements must be submitted to the DOH by the due date shown in the 2021 Schedule of Key Events.

EP Applicants must submit the required EP templates to DOH that provide, prescription drug information, links to plan information, service area information, plan rates and contact information. The templates must be submitted to DOH by the due date shown in the 2021 Schedule of Key Events.

k. Non-Discrimination

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



**Section IV: Requirements Applicable to Qualified Health Plans,
Stand-Alone Dental Plans, Essential Plans and Small Business Marketplace**

A. Administrative Requirements

a. Enrollment and Member Services

a. Enrollment Periods for QHPs and Stand-Alone Dental Plans

QHP Applicants and SADP Applicants must adhere to the open enrollment periods and special enrollment periods established under applicable law and guidance. 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 advanced premium tax credit assistance. For enrollees in the individual market that do not receive advanced 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 Period for the Essential Plan

Enrollment in the Essential Plan will be open all year. Eligibility for the Essential Plan will be recertified every twelve (12) months. If an EP enrollee updates his/her information within a 12-month enrollment period, eligibility will be re-determined. If the enrollee is determined to remain eligible for EP, a new, 12-month enrollment period will begin. Effective dates of dental coverage for Essential Plan 1 and Essential Plan 2 enrollees, who elect to purchase vision and dental, shall follow the same eligibility periods as medical coverage.

The EP Applicant must provide a ten (10) day initial grace period and a thirty (30) day grace period thereafter to pay the premium. If an enrollee fails to pay their premium within the grace period, the enrollee will lose coverage on the first of the following month. The EP Applicant will continue to receive a capitation payment for the grace period month and EP Applicant will be obligated to cover claims for services incurred during the grace period.

Essential Plan 2 enrollees who elect to purchase vision and dental coverage will only have a premium for the vision and dental portion of their coverage. If an enrollee is disenrolled from Essential Plan 2 coverage on the basis of non-payment of premium, they will be re-enrolled into the equivalent Essential Plan medical-only product.

c. Enrollment/Disenrollment Transactions

Applicants 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. In addition, the NYSOH provides these transactions to insurers on a daily basis and Applicants must process these transactions regularly, and more specifically in accordance with the following timeframes:

- (i) Transaction files, including maintenance and termination transactions, must be picked

up daily;

- (ii) Acknowledgement transactions (999 transactions) must be sent within 24 hours of picking the files up;
- (iii) Effectuation transactions, which are the basis of Federal Advance Premium Tax Credit (APTC) payments to issuers, must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned member identification number;
- (iv) Terminations and cancellations must be sent within five (5) business days of the grace period end date;
- (v) Error files are sent to insurers daily; error files must be reviewed and corrected on a regular basis, but no less frequently than once per week.

d. 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.

e. Subscriber Contracts

All Applicants must post all approved subscriber contracts on their website so that they are available to prospective members when open enrollment begins.

f. 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 limited English proficiency (“LEP”) and

individuals with disabilities, including accessible websites 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.

The Applicant and its contractors 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 fonttype;
- (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, in any county of the service area where the applicants and/or enrollees of the issuer speak a common non-English language, the issuer must provide taglines in those languages indicating the availability of written translation of materials in any language the prospective or current enrollees speaks;
- (iii) Pursuant to 45 CFR § 155.205(c)(2)(iii), before the beginning of the 2021 open enrollment period, documents and website content that are considered critical (see HHS Technical Guidance, March 30, 2016 at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Language-access-guidance.pdf>) for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees or enrollees must include taglines in the top 15 language spoken by the LEP population as determined by the Secretary of HHS (<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf>);
- (iv) Make verbal interpretation services available 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;
- (v) 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; and
- (vi) 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.

g. 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 twenty-four (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.

B. Marketing Standards

a. New York State of Health Marketing and Outreach

The DOH intends to continue its multi-faceted advertising, marketing and outreach campaign focused on connecting New Yorkers with quality, affordable health insurance. The DOH will engage in targeted outreach to consumers through navigators, certified application counselors, facilitated enrollers, consumer advocates, small businesses, brokers, and other stakeholders to promote enrollment through the Marketplace.

b. QHP and EP Applicant Responsibilities

Applicant may conduct advertising campaigns, including but not limited to television, radio, digital, 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.

The Applicant shall use the NY State of Health 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.

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.

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 a Marketplace enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives to potential enrollees to enroll in a Marketplace product or renew their coverage.

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.

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

C. 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, Applicants must adhere to the following:

a. General Standards

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.

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.

b. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP Applicant's and EP 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 use providers, allied health professionals, ancillary providers, durable medical equipment ("DME") providers, home health providers, and pharmacies. Specifically, the Applicant's network must meet the following minimum standards:

- (i) Each county network must include at least one (1) hospital; however, for the following

counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan and Queens;

- (ii) Each county network must include the core provider and service types established in the Data Dictionary through the Provider Network Data System (“PNDS”) website;
- (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:

Primary Care Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and
- In rural areas, transportation requirements may exceed these standards if justified.

Dental Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and
- A time and distance standard of 45 minutes/45 miles may be used in the following rural counties and provider types, where a lack of providers has been demonstrated to DFS:
 - o Pedodontists: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins.
 - o Oral Surgeons: Essex, Franklin, Lewis, Schoharie and Steuben.
 - o Orthodontics: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.

Other Provider Types

- It is preferred, that the Applicant meet the 30-minute or 30-mile standard, unless justified.
- (vi) QHP Applicants and EP Applicants that contract with a hospital with greater than 50 beds must meet the patient safety standards and documentation collection requirements set forth in such regulation;
- (vii) QHP Applicants and EP Applicants are 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 QHP Applicants' and EP Applicants' service area;

- (viii) The QHP Applicant and EP 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 clinic, to the extent such providers are available;
- (ix) QHP Applicants and EP Applicants are 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.

Pursuant to applicable law, QHP Applicants and EP Applicants are required to notify enrollees of significant changes in their networks which will be effective in the 2021 plan year. Applicants are required to submit disruption analysis reports to the NY State of Health, when a network is scheduled to have a hospital disenroll, an IPA or major medical group, or is scheduled to lose or change their pharmacy carrier.

- (x) DOH requests Applicants to conduct additional outreach to their enrollees in advance of significant network changes as indicated above, to ensure their awareness. Applicants are required to inform DOH of such outreach plans.

b. Specific Standards for 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 two (2) orthodontists, 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).

In addition to these requirements, the Applicant's dental network must meet the time and distance standards set forth above in Section IV(C)(2)(a)(v).

c. Sanctioned Providers Applicable to All Applicants

The Applicant shall **not** include in its network any provider who has:

- (i) Been sanctioned or prohibited from participation in Federal Health Care Programs under either Section 1128 or Section 1128A of the SSA; or
- (ii) Had his/her license suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

d. 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 the DOH 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, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

e. 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. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDs submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

f. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, <https://pnds.health.ny.gov>, in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "Q". Submissions 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 Identification and Use of Existing Essential Plan Network for Current and New Issuers

To the extent the EP Applicant intends to use an existing network to satisfy the network adequacy requirements of the Essential Plan, the Applicant shall identify such intent and the corresponding network. The existing network being used to support the EPs must be the same network that is approved by the Marketplace or DOH.

D. Enhancements to Network Information.

In addition to the Network Adequacy requirements set forth in Section IV(C), all Applicants shall adhere to the following, unless otherwise specified:

a. Provider Directories

The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the products 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 NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), 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, SADPs or EPs.

If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace 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 individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates

In order to ensure that the most accurate and timely information is displayed to consumers, the Applicant must indicate within its online provider directory when an individual provider, group, or facility will be leaving the network. The Applicant must provide reasonable notice and indicate the date on which the provider, group or facility will no longer be in the Applicant’s network.

b. Verification of Networks and Appointment Availability Standards/Monitoring

1. The Applicant shall provide their process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process 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 processes are to validate participation by providers and to make sure providers are aware of their participation in Marketplace networks.

2. Applicants and their contractors must submit for review appointment availability standards established for office hours and after office hours. Access standards should include but not be limited to routine care, follow up visit for emergency/hospital discharge, urgent care and emergency care for medical, behavioral health and substance use appointments. Applicants and their contractors must explain the health plan process to ensure compliance with these standards including frequency of review and advise where appointment availability standards may be found by consumers, such as, member handbook or Applicant's website.

c. Addressing Provider Directory Disputes

Applicants must develop and implement protocols to effectively address inquiries and complaints concerning provider directories. Applicants shall provide to the DOH the protocols developed within a timeframe specified by DOH.

d. Treatment Cost Calculators for Participating Providers

The QHP Applicant and EP Applicant must have in place a treatment cost calculator available through an internet website and such other means for individuals without access to the internet. Such treatment cost calculators must be able to demonstrate enrollee cost-sharing using current price data 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.

E. Consumer Network Protections

a. Access to Out-of-Network Providers and Information

Consistent with Financial Services Law Article 6, QHP Applicant and EP Applicants must adhere to the following:

- (i) QHP Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency ("ER") bills. In addition, QHP Applicants and EP Applicants must hold their member harmless from liability for non-emergency ("non-ER") surprise out-of-network bills: (a) 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 (b) whenever a participating physician refers a member to an out-of-network provider without the member's written consent.

- (i) QHP Applicants and EP Applicants shall allow their 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.
- (ii) QHP Applicants and EP 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.
- (iii) QHP Applicants and EP Applicants will provide its members with all grievance, utilization review and external appeal rights, including the ability to appeal a denial for an out-of-network referral and external appeal rights to denials for an out-of-network referral.
- (iv) QHP Applicants and EP Applicants 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 Part H of Chapter 60 of the Laws of 2014 (the "Out-of-Network Law").

QHP Applicant and EP 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 by the Out-of-Network Law. Upon request, QHP Applicant and EP Applicant will provide a URL link to its out-of-network treatment cost calculator.

F. Prescription Drug Benefits

a. Formulary Requirements

QHP and EP Applicants must make available to DOH, (a) URL link(s) that will easily allow consumers to access the Applicant's prescription drug formulary or formularies. At a minimum, the following must be met:

- (i) The link(s) must provide an up-to-date listing of all covered drugs;
- (ii) Separate links must be provided for each product offered on the Marketplace and the formulary or formularies must clearly identify the product(s); and

- (iii) The link must allow consumers to identify the cost-sharing amount for each drug or indicate that the drug is not subject to cost-sharing.

QHP Applicants and EP Applicants must comply with NY Public Health Law § 4406-c, and NY Insurance Law § 3216(i)(27), § 3221(a)(16) and § 4303(jj). Formularies will be reviewed to ensure the intent of the state law is being followed. QHP Applicants and EP Applicants should not place all prescription drugs to treat a specific condition on the highest tier or should provide information to DOH or DFS to demonstrate that they are otherwise in compliance with 45 CFR § 156.125 which prohibits discriminatory benefit designs.

G. Pharmacy and Therapeutics Committee

The QHP Applicant and EP Applicant must use a pharmacy and therapeutics committee that meets the standards set forth in 45 C.F.R. § 156.122(a)(3).

H. Pharmacy Rules

Pursuant to 45 C.F.R. § 156.122 (e)(1), QHP Applicants and EP Applicants must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless: (1) the drug is subject to restricted distribution by the U.S. Food and Drug Administration; or (2) the drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Prescription Drug Co-payments

QHP and EP Applicants must comply with: (i) NY Insurance Law § 4325(h) and NY Public Health Law § 4406-c(6) to assure that enrollee co-payments do not exceed the usual and customary cost of a prescribed drug, and (ii) NY Insurance Law § 3217-b(a)(2) and 4325(a)(2), and NY Public Health Law § 4406-c(2) to ensure that contracts with pharmacies, whether negotiated directly or through a pharmacy benefit manager, do not contain “gag clauses” or other provisions in violation of (i) NY Insurance Law § 4325(h) and NY Public Health Law § 280-a, NY Public Health Law § 4406-c(6) or NY Education Law § 6826-a.

I. Quality and Enrollee Satisfaction

a. QHP Applicant Requirements

1 Quality Rating System

New York will use U.S. Centers for Medicare and Medicaid Services (“CMS”) generated quality ratings in 2019, which is based upon data provided to CMS by health insurers in 2018. Each rated health plan has an “overall” quality rating, ranging from 1 to 5 stars, which accounts for member experience, medical care and health plan administration.

More information about these ratings is available at <https://www.healthcare.gov/quality-ratings/>

2 Quality Improvement Strategy (“QIS”) or Quality Strategy (“QS”)

QHP Applicants must submit either a **Quality Improvement Strategy (“QIS”)** or a **Quality Strategy (“QS”)**, as determined below. Quality Improvement Strategy (“QIS”)

QHP Applicants that offered QHP coverage through the Marketplace in 2018 and 2019 and had more than 500 QHP enrollees in a “product” (defined by CMS for this purpose as insurer model, including HMO, EPO, PPO, POS, etc.) as of July 1, 2019, must submit at least one initial **QIS Implementation Plan** and **Progress Report Form for the 2021 Plan Year**.

Applicants must:

- (i) Implement a QIS, described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- (ii) Implement a QIS that includes at least one of the following:
 - Activities for improving health outcomes;
 - Activities to prevent hospital readmissions;
 - Activities to improve patient safety and reduce medical errors;
 - Activities for wellness and health promotion; and/or
 - Activities to reduce health and health care disparities.
- (iii) Adhere to guidelines, including the QIS Technical Guidance and User Guide for the 2020 coverage year, established by Health and Human Services (“HHS”), in consultation with experts in health care quality and stakeholders.
- (iv) Report on progress implementing the QIS to the DOH on a periodic basis.

QHP Applicants must submit the required QIS information as part of their participation proposal for the 2021 coverage year by completing the required parts of the 2020 Plan Year QIS Implementation Plan and Progress Report forms.

The submitted QIS Implementation Plan and Progress Report form for the 2021 plan year will be evaluated by the New York State Department of Health “(NYS DOH)” Office of Quality and Patient Safety, in consultation with the NY State of Health. Based upon the results of the QIS evaluation, an overall outcome of “meets” or “does not meet” will be assigned to the QIS submission. QHP Applicants will be notified in writing regarding any corrective actions required.

3 Quality Strategy (“QS”)

QHP Applicants that did not offer QHP coverage through the Marketplace in 2018 and 2019 or did not have more than 500 enrollees enrolled in a product as of July 1, 2019, must develop a **Quality Strategy (“QS”)** that encompasses all the requirements set forth in 1311 (g) of the Affordable Care Act (“ACA”). This strategy must be implemented and updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

- (i) 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;
- (ii) 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;
- (iii) 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;
- (iv) The implementation of wellness and health promotion activities;
- (v) The implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, and cultural competency trainings; and
- (vi) 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.

4 Quality Reporting System (“QRS”)

QHP Applicants must submit quality data collected as part of the Quality Reporting System (“QRS”) and QHP enrollee survey requirements to NYS DOH. QHP Applicants should follow the 2019 Quality Rating System Measure Set Technical Specifications. These quality indicators 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”).

Applicants must report quality measures such as satisfaction data, birth files and optional enhancement files. All Applicants will be using one tool, the National Committee for Quality Assurance (“NCQA”) Interactive Data Submission System (“IDSS”) to submit to both NYS DOH and

NCQA. All quality measures will be reported via the NCQA IDSS tool. CMS-QRS reporting will require Applicants to have:

- HEDIS Volume 2;
- NCQA IDSS tool;
- Programming for all required measures (either in house capability or via a vendor);
- A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to NCQA; and
- A certified and HHS approved survey vendor to administer enrollee experience surveys.

5 Enrollee Satisfaction Survey

QHP Applicants must annually survey a sample of their Marketplace eligible members to allow the DOH to assess members' experience of care, including their access to care as well as their interactions with their providers and health plan. This information will be collected through the enrollee satisfaction survey under CMS guidelines. The NYS DOH will use the experience of care information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies.

a. EP Applicant Requirements

1 Quality Strategy ("QS")

EP Applicants must comply with the **Quality Strategy ("QS")**, as outlined above.

2 Quality Reporting ("QR")

EP Applicants will be required to participate in the NYS 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 ("NCQA") and the 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 plan issuer 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 the plan issuer will also be posted on the DOH website in eQARR and related publications.

The QARR technical specifications are released annually during the Fall of the measurement year, with reporting of QARR data due on or about the following June 15th.

Applicants must report quality measures such as satisfaction data, birth files and optional

enhancement files. All Applicants will be using one tool, the National Committee for Quality Assurance (“NCQA”) Interactive Data Submission System (“IDSS”) to submit to both NYS DOH and NCQA. All quality measures will be reported via the NCQA IDSS tool. CMS-QRS reporting will require Applicants to have:

- HEDIS Volume 2;
- NCQA IDSS tool;
- Programming for all required measures (either in house capability or via a vendor);
- A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to NCQA; and
- A certified and federally approved CAHPS vendor to administer satisfaction surveys.

3 Satisfaction Survey (“CAHPS”)

EP Applicants will be required to annually survey a sample of their eligible members to allow the DOH to assess many aspects of the member’s experience of care, including their access to care and services, their interaction with their providers and health plan.

For EP, this information will be collected using a national satisfaction survey methodology called Consumer Assessment of Healthcare Providers and Systems (“CAHPS”).

The DOH will use the experience of care information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies

4 Accreditation

The DOH will not require Applicants to be accredited as a condition of participation in 2021.

J 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, the number of claims that are denied, customer service information, rating of provider practices, information on cost-sharing and payments with respect to any 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

Applicants 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 the site of service and may also include diagnosis information. Each encounter must be recorded in an information system as each unique occurrence between recipient and provider. Encounters must 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.

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 also 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.

K Certification, Recertification and Decertification Processes

e. Certification

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

f. Decertification

A plan issuer certified by the Marketplace 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 applicable law. Decertification of individual products shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

g. Non-Renewal

Plan issuers may opt not to renew participation or products in the Marketplace. The issuer must

notify DOH of its decision not to renew, no later than thirty (30) days prior to the start of Open Enrollment. The Issuer shall cooperate with DOH in the development of a plan to facilitate the orderly transition of its members, including, but not limited to, notification to consumers and providing DOH with member specific information to the extent permitted by law.

h. Suspension

The DOH may suspend enrollment in a health plan in the event a 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.

L 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, as amended. The two laws are collectively referred to as the Affordable Care Act (“ACA”);
- 45 C.F.R. Parts 155 and 156 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; and
- 42 CFR Part 600 and other related guidance and instruction;

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:

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 § 4308 (Supervision of Superintendent);

- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance);

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);
- The Out-of-Network Law, Chapter 60 of the Laws of 2014;
- Health Insurance Coverage for the Treatment of Gender Dysphoria, DFS Insurance Circular - Letter No. 7 (2014) (found here: http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf);
- Changes in Utilization Review Standards for Substance Use Disorder Treatment Pursuant to Chapter 41 of the Laws of 2014;
- Updated FAQs Regarding 18 Approved Forms of Contraception Issued by CMS May 11, 2015 (found here: <http://www.dol.gov/ebsa/faqs/faq-aca26.html>);
- Discrimination Based on Sexual Orientation, Gender Identity and/or Gender Dysphoria, DFS Insurance Circular Letter No. 9 (2018), June 25, 2018

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); and
- 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. Letters of Interest

Applicants are requested to submit non-binding Letters of Interest as soon as possible, but no later than the date set forth in the 2021 Schedule of Key Events, 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 “F” for QHP Applicants, EP Applicants, SADP Applicants and Small Business Market (SHOP) Applicants. Please indicate which offerings you are interested in participating in for 2021.

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 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. 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 NY State of Health website (nystateofhealth.ny.gov), unless the party

submitting a question demonstrates that the question/answer will contain confidential and/or proprietary information.

NAME: Invitation Administrator

EMAIL: nyhxpm@health.ny.gov

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:

- Withdraw the Invitation at any time, at the DOH's sole discretion;
- Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation;
- 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; and
- At any time during the Invitation process, amend the Invitation to correct errors or omissions, 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 the PNDS website 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 Contents

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

For QHP Applicants and Stand-Alone Dental Plan Applicants:

- (i) Participation Proposal;
- (ii) Submission of Policy Form, Rates, and Binders to DFS for QHP and SADP Applicants;
- (iii) Submission of Provider Network Information; and
- (iv) QIS Implementation Plan and Progress Report Form or Quality Strategy (QHP Applicants Only).
- (v) **Submission of QDP Benefit Cost Sharing Template to DOH**

For EP Applicants:

- (i) Participation Proposal;
- (ii) Submission of Subscriber Agreements to DOH for EP Applicants;
- (iii) Submission of EP Information Templates to DOH;
- (iv) Submission of Provider Network Information; and
- (v) Quality Strategy.

Each of the component parts must be received by the due dates set forth in the 2021 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 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 “G” (QHP Applicants and SADP Applicants) and Attachment “K1” (EP Applicants). Applicants applying to offer both QHPs and EPs must complete **both** Attachments.

b. Submission of Policy Forms and Rates to DFS for QHP Applicants

As set forth in Section II(B), 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 Subscriber Agreements and Templates to DOH for EP Applicants

As set forth in Section II (B), EP Applicants will be required to submit EP Subscriber Agreements to DOH. EP Applicants will also be required to submit plan information via DOH required templates. Policy forms and templates must be sent directly to the Applicant’s assigned Plan Manager by the due

date indicated in the 2021 Schedule of Key Events.

d. Submission of Provider Network Information

As set forth in Section IV (C)(6), Applicants shall submit their network through the Provider Network Data System (“PNDS”) in accordance with the Provider Network Submission Instructions contained in Attachment “Q” to this Invitation.

e. Submission of Quality Improvement Strategy or Quality Strategy

As set forth in Section IV (G), QHP Applicants and EP Applicants shall submit their QIS or QS as part of the Participation Proposal.

f. Vendor Responsibility

On or around the same time that Applicants submit forms and rates, Applicants 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 questions about the VendRep System contact 866-370-4672 or 518-408-4672 or ITServiceDesk@osc.state.ny.us

g. Submission of HHS Form 690, Assurance of Compliance

Applicants shall, as a condition of certification pursuant to 45 C.F.R. Part 92.5, submit an original, signed copy of HHS Form 690, Assurance of Compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act.

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 NY 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.

G. Agreement with DOH

Following completion of the activities outlined in this Invitation and having been determined to have

APPENDIX D

met all the requirements, the DOH will provide Applicants with an Agreement. The Agreement resulting from this Invitation will be effective only upon approval by 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 for their products to be certified and offered through the Marketplace.



Section VI: Attachments

APPENDIX D

Attachment Designation	Attachment Name
Attachment "A"	2021 QHP Essential Health Benefits
Attachment "B"	2021 Standard Products Cost-Sharing Chart
Attachment "C"	2021 QHP Standard Product With 3 PCP Visits Cost-Sharing Chart
Attachment "D"	QHP and SADP Rating Regions by County
Attachment "E"	QHP and SADP Rating Regions Map
Attachment "F"	2021 Letter of Interest
Attachment "G (1)"	2021 QHP and SADP Participation Proposal
Attachment "G (2)"	2021 QHP Non-Standard Product Offering Details
Attachment "G (3)"	2021 QHP Products Offered by County and Market
Attachment "G (4)"	2021 SADP Products Offered by County and Market
Attachment "H"	EP Benefits and Cost-Sharing Chart
Attachment "I"	EP Rating Regions
Attachment "J"	EP Rating Regions Map
Attachment "K (1)"	2021 EP Participation Proposal
Attachment "K (2)"	2021 EP Products Offered by County
Attachment "L"	2021 EP Template Instructions
Attachment "M"	2021 EP Admin Template
Attachment "N"	2021 EP Plans Template
Attachment "O"	2021 EP Rates Template
Attachment "P"	2021 EP Service Area Template
Attachment "Q"	2021 Provider Network Submission Instructions
Attachment "R"	2021 URL Template Instructions
Attachment "S"	2021 URL Template



Section VII: Definitions

For purposes of this Invitation:

"Affordable Care Act ("ACA")" shall mean the Federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152).

"Applicant" and **"Applicants"** shall mean health plan issuers applying to offer medical or dental coverage and applying for certification or recertification.

"Certification" shall mean the Marketplace's authorization of a Qualified Health Plan, Stand-Alone Dental Plan or an Essential Plan to be offered on the Marketplace based on verification that a Plan complies with the requirements of the Invitation, as modified by the Marketplace.

"Cost-Sharing Reduction (CSR)" shall mean the Federal Program pursuant to 45 C.F.R. § 155.305(g), which provides federal reductions to cost-sharing on Essential Health Benefits for an Enrollee with a household income at or below a specified percent of the federal poverty level.

"Essential Plan" or "EP" shall mean a health benefit plan that has been certified by the state as an Essential Plan pursuant to NY Social Services Law § 369-gg(1)(e), to be offered through the Marketplace in accordance with NY State Social Services Law § 369-gg(1)(a).

"Essential Plan Applicant" or "EP Applicant" shall mean an insurer that is applying to offer the Essential Plan.

"Enrollee" shall mean an Eligible Individual enrolled in a Qualified Health Plan, Stand-Alone Dental Plan or an Essential Plan offered through the Marketplace.

"Invitation" shall mean the Invitation and Requirements for Insurer Certification and Recertification for Participation and the attachments thereto, issued by the Marketplace to health plan issuers to participate in Qualified Health Plans, Essential Plans and Stand-Alone Dental Plans, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website.

"Marketplace" shall mean NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange or Exchange) established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012 and codified in the NY Public Health Law in 2019.

"Non-Participating Provider" shall mean a provider of health care services or dental services with which the Applicant has no provider agreement.

"Participating Provider" shall mean a provider of health care services or dental services that has a provider agreement with the Applicant.

"Personally Identifiable Information" ("PII") shall mean information that can be used to distinguish

or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information" ("PHI") shall refer to individually identifiable health information as defined in 45 CFR 164.402.

"Qualified Employee" shall mean an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the small business marketplace, in accordance with 45 C.F.R. § 155.20 and Marketplace policies and procedures.

"Qualified Employer" shall mean an employer that (i) has 100 or fewer employees; (ii) small business marketplace (a) has its principal business address in the Marketplace service area small business marketplace or (b) offers coverage to each eligible employee through the small business marketplace serving that employee's primary worksite. An employer that meets these criteria and which has at least one employee that is not the owner's spouse enrolled in coverage shall be authorized to offer Qualified Employees the ability to purchase Qualified Health Plans through the small business marketplace.

"Qualified Health Plan" or "QHP" shall mean a health benefit plan that has received the Marketplace's certification to be offered through the Marketplace, including a Stand-Alone Dental Plan except where otherwise noted.

"QHP Applicant" shall mean a health insurer that is applying for QHP certification or recertification that offers medical coverage.

"Qualified Individual" shall mean an individual that is eligible, pursuant to the ACA and federal regulation, to enroll in a QHP through the Marketplace.

"Recertification" shall refer to the Marketplace's annual review and verification of a Qualified Health Plan's compliance with the requirements for certification and the provisions of applicable law regarding Qualified Health Plans.

"Service Area" shall mean the geographic area(s) designated by the NY State Department of Health or NY State Department of Financial Services ("DFS") in which an Applicant's Qualified Health Plan(s) shall be offered.

"Small Business Marketplace" (a/k/a the "Small Business Health Options Program, or SHOP") shall mean the Small Business Health Options Program, as defined at ACA § 1311 (b)(1)(B) and 45 C.F.R. Part 155.

"Small Employer" shall mean an employer with 1-100 FTE employees.

"Special Enrollment Periods" shall, as described in 45 C.F.R. § 155.420, and applicable law and guidance, mean the periods during which a qualified individual or enrollee who experiences

certain qualifying events as set forth in federal regulation, may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual open enrollment periods.

"Stand-Alone Dental Plan" or "SADP Applicants" shall mean a dental services plan that has received the Marketplace's certification to be offered through the Marketplace.