

NYSOH Small Business
Marketplace **Administrative**
Guide for Producers

Last Updated: September 2016

Table of Contents

<u>NY State of Health</u>	Page 3
<u>Small Business Marketplace</u>	Page 3
<u>Qualified Health Plans</u>	Page 4
<u>Health Option Riders</u>	Page 5
<u>Dependent Coverage through Age 29</u>	Page 5
<u>Domestic Partner Coverage</u>	Page 5
<u>Qualified Religious Organization</u>	Page 5
<u>Dental Plans</u>	Page 6
<u>Rates and Benefit Details</u>	Page 8
<u>Map of Rating Regions</u>	Page 8
<u>Health Plan Provider Networks</u>	Page 8
<u>Broker Certification</u>	Page 9
<u>Steps for Certification and Registration</u>	Page 9
<u>Online Directory of Registered Brokers</u>	Page 10
<u>Broker of Record Templates</u>	Page 10
<u>Broker Agreement Template</u>	Page 10
<u>Eligibility and Enrollment Policies</u>	Page 11
<u>Employer Eligibility</u>	Page 11
<u>Employee Eligibility</u>	Page 11
<u>Participation and Contribution Requirements</u>	Page 12
<u>Creating and Managing Classes</u>	Page 13
<u>Enrollment Periods</u>	Page 14
<u>Special Enrollment Periods</u>	Page 15
<u>Renewals Processing</u>	Page 17
<u>Appeals</u>	Page 18
<u>How to Use NYSOH Website</u>	Page 18
<u>Step-by-step User Guides</u>	Page 18
<u>Video Demonstrations</u>	Page 19
<u>Webinars</u>	Page 19
<u>Broker Support</u>	Page 19
<u>Customer Service Call Center</u>	Page 19
<u>Broker Responsibilities</u>	Page 19
<u>Security and Privacy</u>	Page 20
<u>Anonymous Shopping or “Get a Quote” Function</u>	Page 20
<u>Small Business Health Care Tax Credit</u>	Page 24
<u>Broker Contacts for Participating Carriers</u>	Page 25
<u>Co-Branding Guidelines</u>	Page 25
<u>Billing Policies</u>	Page 26
<u>COBRA</u>	Page 28
<u>2017 Plan Invitation</u>	Page 28



NY State of Health

NY State of Health (NYSOH) is an organized marketplace where participating insurance carriers offer qualified health and dental plans to small groups, individuals and their families. Certified producers can help employers and individuals in the marketplace compare health and dental insurance options, calculate costs, select coverage, and complete enrollments.

Small Business Marketplace (SBM)

The Small Business Marketplace (SBM) is where employers with between one and one hundred Full Time Equivalent (FTE) employees can select and offer their employees a variety of qualified health and dental plans with no minimum contribution requirement. In order to be eligible to participate in the Small Business Marketplace, there must be one common law employee enrolled in coverage (excludes business owners and their spouses). SBM certified producers can assist employers with the following, (but not limited to) account set up, creating an enrollment offering, assisting employees with enrollment and making plan or enrollment changes.. They can also assist employers with understanding the eligibility criteria for the Small Business Health Care Tax Credit.

This guide is meant to be used as a support tool for producers as they help consumers enroll through the Small Business Marketplace. It provides general guidance and defines important policies and requirements. Other resources are provided on our website at info.nystateofhealth.ny.gov/ProducerToolkit

Qualified Health Plans (QHP)

Issuers must be certified to participate with SBM and must maintain their certification. Participating issuers must offer “standard” QHPs at four metal levels of coverage associated with an actuarial value (AV):

- Bronze – 60% AV
- Silver – 70% AV
- Gold – 80% AV
- Platinum – 90% AV

Participating carriers must offer at least one standard QHP at every metal level, in each county of their service area. Cost sharing for each standard plan metal level will be the same across carriers. For instance, a “Gold plan” from Insurance Carrier A will have the same deductible, copays and coinsurance as a “Gold plan” from Insurance Carrier B. Premiums may differ. Carriers can also offer up to three nonstandard QHPs. The benefits for nonstandard plans can vary slightly from those of the standard plans but nonstandard plans cannot have fewer benefits and the actuarial value for these plans must be equivalent with their standard plan metal level counterparts (i.e., all Gold Plans are 80% AV).

Qualified Health Plans are available in four standard tiers of coverage:

- Employee only
- Employee + spouse
- Employee + child
- Employee + family

All QHPs offered through NYSOH must cover ten categories of “Essential Health Benefits”:

1. Ambulatory patient services
2. Emergency room services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorders
6. Prescription drugs
7. Rehabilitation and habilitation services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision

You can view a detailed breakdown of the [New York Essential Health Benefits](#).

Health Option Riders

Three health option riders are available for all qualified health plans:

Dependent Coverage through Age 29 Option

Employers have the option to select whether or not they want to offer coverage to dependent children through age 29 to their employees. This option must be selected at the time of the initial enrollment and cannot be added after the open enrollment period has ended. This option is available at the class level, meaning that each class an employer creates can be different. Cost of coverage may increase when this rider is selected.

Domestic Partner Coverage Option

Employers have the option to select whether or not they want to offer coverage to the Domestic Partners of their employees. This option is available at the employer group level, and is selected when setting up the initial enrollment. **This option, once selected, applies to all classes created by the employer** and cannot be changed after the open enrollment period has ended.

Qualified Religious Organization Option

Employers may claim an exemption from the requirement to provide, without cost-sharing, coverage of certain contraceptive services for employees if they are determined to be a qualified religious organization.

For purposes of this exemption, a qualified religious organization is defined as an organization that meets the following criteria:

- The inculcation of religious values is the purpose of the organization.
- The organization primarily employs and serves persons who share the religious tenants of the organization.
- The organization is a non-profit.

The system default deselects “Qualified Religious Organization”, which means family planning and counseling services will be included in coverage. If the employer checks “Qualified Religious Organization”, they will be presented with a pop-up message requiring attestation to 3 conditions (see exemption criteria above). Employer attestation will effectively exclude coverage of family planning services, including contraceptive services. This option is available at the employer group level, and is selected when setting up the initial enrollment. **This option, once selected, applies to all classes created by the employer** and cannot be changed after the open enrollment period has ended.

Dental Plans

Dental enrollment is linked to enrollment of a QHP; employers cannot offer dental without also offering QHP coverage. Dental plan tiers match SBM tiers (employee only, employee + spouse, employee + child, employee + family) with the addition of a “pediatric only” tier and dental premiums are specific to the tier of coverage.

Pediatric dental services are required in all QHPs. For tiers of coverage that include children, pediatric dental is either embedded in the QHP or made available as a stand-alone product.

- Pediatric dental is available to child dependents to age 19. If a child dependent is turning 19 before the effective coverage date, the child dependent is not eligible for pediatric dental coverage. Dental coverage will be terminated at the end of the month in which the child dependent turns age 19 (for example, if the dependent’s 19th birthday is June 15th, coverage will end June 30th).
- Dependent age out notices will be sent to employees 45 days before the child’s 19th birthday..
- **Aging out of pediatric dental is not considered a qualifying event so the dependent child will be without dental coverage until the next open enrollment period, at which time the employee may choose another tier of coverage.**
- The employee must select which children are to be covered by pediatric dental during the enrollment process. For example, an employee may choose not to have an infant covered for pediatric dental.
- An employee and/or spouse who are under the age of 19 do not qualify for pediatric dental; pediatric dental is only available to child dependents.

When creating an offer for a class of employees, if the employer chooses to offer dental, the employer will be presented with the equivalent dental plan tiers and Pediatric Only dental. For the employee to select Pediatric Only dental, the child dependent must be included in the QHP enrollment. The Pediatric Dental premium that displays during plan selection is per child and will be multiplied by the number of children covered, capped at three children (one-child x 3 rate).

The employer can choose to only offer Pediatric Only dental, if the QHP offer includes Employee + Child/ren or Employee + Family tiers.

See the **Dental Enrollment Chart** on the next page for enrollment options.

Dental Enrollment Chart

Employer Health Offer	Employer Dental Offer	Employee Health Enrollment	Employee Dental Enrollment Options
Employee Only	Employee Only	Employee Only	<ul style="list-style-type: none"> Employee Only decline
Employee + Spouse	Employee Only and Employee + Spouse	Employee + Spouse	<ul style="list-style-type: none"> Employee Only Employee + Spouse decline
Employee + Child/ren	Employee Only, Employee + Child/ren, and Pediatric dental	Employee + Child/ren	<ul style="list-style-type: none"> Employee Only Employee + Child/ren Employee Only and Pediatric Dental Pediatric Dental decline
		Employee + Child/ren with Pediatric Dental included	<ul style="list-style-type: none"> Employee Only Pediatric Dental (As dental backup) decline
Employee + Family	Employee Only, Employee + Spouse, Employee + Child/ren, Employee + Family, and Pediatric dental	Employee + Family	<ul style="list-style-type: none"> Employee Only Employee Only and Pediatric Dental Employee + Spouse Employee + Spouse and Pediatric Dental Employee + Child/ren Employee + Family Pediatric Dental decline
		Employee + Family with Pediatric Dental included	<ul style="list-style-type: none"> Employee Only Employee + Spouse Employee + Child/ren (Disclaimer : some coverage will be duplicative of ped dental embedded in QHP) Employee + Family (Disclaimer: some coverage will be duplicative of ped dental embedded in QHP) decline

Rates and Benefit Details

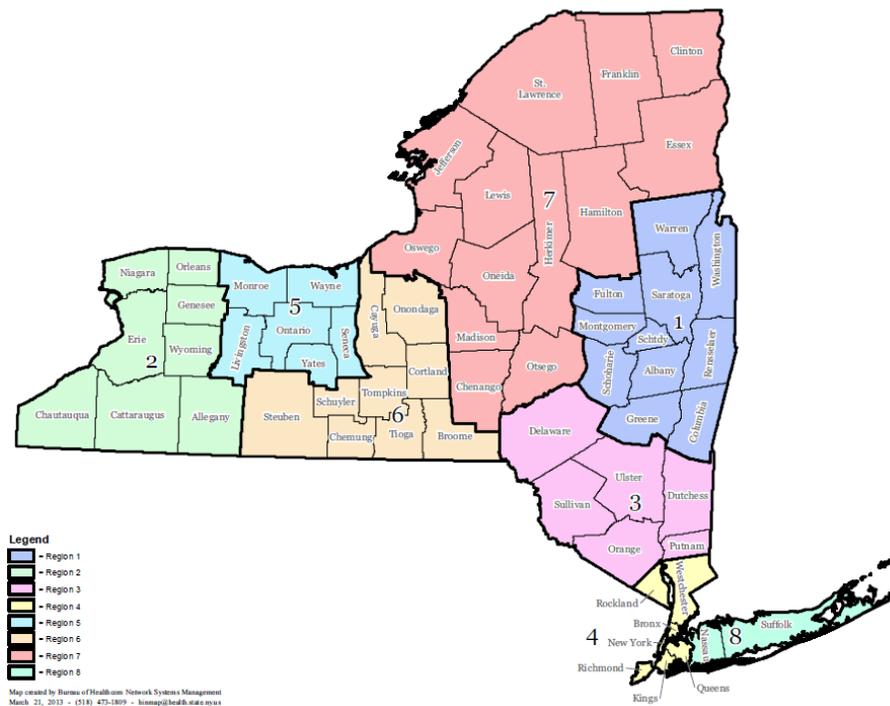
Small Business Marketplace rates are updated quarterly on the NYSOH website. An eligible business may enroll in the SBM at any time during the calendar year. Once an effective date – the day that coverage goes into effect for members of the plan – is chosen for a group it becomes the start date for that group’s **plan year** (Group Effective Date). The rates for any group will remain the same for the entire plan year and will be based on the quarter in which coverage becomes effective. A plan year can begin on the first of any month throughout the calendar year.

[Small Business Marketplace Qualified Health Plan and Dental Rates](#)

[Small Business Marketplace Benefit Details](#)

[“Plan Compare” with Benefit Details for Small Business Marketplace Plans](#)

New York Map of Rating Regions



The items below provide geographical and organizational resources about plan characteristics and provider networks.

[NY Map of Rating Regions](#)

[Health Plan Provider Networks](#)

Broker Certification

Producers interested in assisting consumers through the NYSOH Marketplace must first have a New York State health insurance license in good standing with the Department of Financial Services (DFS). Additionally, a producer must complete the certification course(s) offered by DFS-approved continuing education (CE) provider organizations. Certification on the Small Business Marketplace (SBM) is a prerequisite for certification on the Individual Marketplace. Producers completing these courses will earn CE credits toward the renewal of their insurance licenses.

PLEASE NOTE: These approved courses are the only courses that will qualify a producer for certification to sell insurance through NY State of Health.

Steps for Certification and Registration (see also, [“How to Complete Broker Certification”](#))

1. Register for classes, complete your training and test requirement:

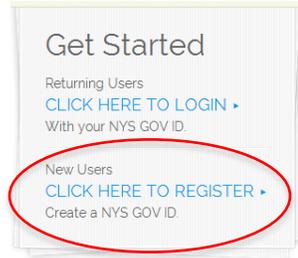
http://www.dfs.ny.gov/insurance/agbrok/ab_shop.htm

Please Note: Some of the training providers listed in the link above may no longer offer the NYSOH certification courses. Please call the provider to confirm if the certification is currently offered. Register your certification with the Department of Financial Services (DFS):

<https://myportal.dfs.ny.gov/nylinxext/>

- If you do not already have an account, you must create one.
 - When you are able to sign in, complete all steps in this process.
 - If you take both courses (SBM and Individual Marketplace), you must register both separately with DFS
2. You will receive only one email from NYSOH with an invitation code, regardless of the number of courses you register with DFS. Go to www.nystateofhealth.ny.gov and click on **Brokers** (see below). Chose the **Click Here to Register** option for **New Users** and follow the steps to create a NY.gov ID and password. When you sign in with your new NY.gov ID username and password, you will need to have both your invitation code and NYS license number to create your account.





Broker Recertification

Recertification is required every two years to remain an active broker with NYSOH. However, unlike the original certification, the recertification process is provided solely online through NYSOH. Courses will consist of refresher material as well as any policy and system functionality updates. There will be no continuing education (CE) credits available for completing the recertification. All brokers seeking recertification must be duly licensed and in good standing with the New York State Department of Financial Services.

Please note: Your NYSOH certification date begins on the date when you register your certification courses with NYSOH.

Online Directory of Registered Brokers

Employers can go to the NYSOH web portal and use the “Search Broker/Navigator” directory. DFS transmits the broker certification information to the NYSOH ensuring that it is always up to date and only brokers who can operate in the Marketplace are listed. Brokers can choose to NOT be listed in the directory by selecting this option through their account.

Broker of Record Templates

Small group employers or individuals may authorize a Broker to work on their behalf in the NYSOH Marketplace. A completed and signed Broker of Record (BOR) letter should be uploaded as part of the online employer application for group enrollment. You can use your own or your agency’s BOR document or download and use the NYSOH template (link below).

[Broker of Record: Small Business Marketplace](#)

Broker Agreement Template

The NY State of Health will certify licensed brokers and agents to assist eligible employers in purchasing QHPs and stand-alone dental plans through the Small Business Marketplace, provided that the agent or broker agrees to and satisfies the requirements set forth in the Agent/Broker agreement (link below).

[Broker Agreement](#)

Eligibility and Enrollment Policies

Employer Eligibility:

A business may be eligible to purchase a qualified health plan and dental insurance through the Small Business Marketplace (SBM), if it meets the following criteria:

- Have a physical location in New York State.
- Be comprised of 1-100 Full Time Equivalent employees.
- Make an enrollment offering to **all** eligible employees who work 30 hours or more.
 - It is optional for an employer to offer coverage to employees who work less than 30 hours per week, but if the employer elects to offer coverage to part time employees, such employees must work on average a minimum of 20 hours or more per week in order to be eligible.
- Have at least one common law employee **enrolled** through SBM.
 - Under 29 CFR 2510.3-3, an employee would not include a sole proprietor or the sole proprietor's spouse.
 - A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

Employee Eligibility:

In order to be considered an eligible employee under a small group health plan in the SBM, an employee must:

- All employees who work 30 or more hours per week are considered eligible and must receive an offer of coverage.
 - It is optional for an employer to offer coverage to employees who work less than 30 hours per week, but if the employer elects to offer coverage to part time employees, such employees must work on average a minimum of 20 hours or more per week in order to be eligible.
- An eligible employee would not include a sole proprietor or the sole proprietor's spouse.
- All employees eligible for health insurance coverage, including owners and those who are not intending to enroll in coverage, should be included in the roster and enrollment offering.
- If an employee resides in Canada, they must obtain a U.S. mailing address (a P.O. Box is acceptable for an employee) OR use the employer's mailing address.
- Sub-contractors and independent contractors are not considered employees, and should not be included in the roster.

Specifically, 29 CFR 2510.3–3 states the following:

(c) Employees. For purposes of this section:

(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and

(2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.¹

A note about sole proprietors:

Sole proprietors that do not employ at least one common law employee are not eligible to purchase coverage through the Small Business Marketplace. The definition of a common law employee does not include a sole proprietor's spouse or a partner in a partnership and his or her spouse (see definition in above section).

Sole proprietors without at least one common law employee may buy health insurance coverage through the Individual Marketplace. Some sole proprietors may be eligible for financial assistance to reduce the cost of coverage.

Full-time Equivalent Employee Calculator

Small Business Marketplace provides a Full-Time Equivalent (FTE) employee calculator to determine employer eligibility for new, reactivated or renewing groups with plan years beginning 1/1/2016.

- New and reactivated employer groups seeking enrollment with group effective dates of 1/1/16 or later will be required to use the FTE calculator to determine eligibility.
- Existing employer groups will not have to use the FTE calculator to determine eligibility, even at renewal. The FTE calculator will be available for use, but it will be optional.

Participation and Contribution Requirements

In order to be eligible to participate in the Small Business Marketplace, an employer group must have a minimum of one common law employee enrolled. The business owner cannot be the sole employee enrolled. Employers must also offer coverage to all eligible employees working 30 hours per week or more.

There is no minimum contribution requirement for employer groups on the SBM, though employers may choose to contribute to employee premiums for QHPs or dental. To be eligible for the Small Business Health Care Tax Credit, however, an employer must contribute at least 50% of the premium for the Employee regardless of which tier of coverage they choose, based on the benchmark plan (this can be the lowest cost plan) the employer offers at the employee only level. To review other eligibility criteria for this credit, see the [Small Business Health Care Tax Credit section](#) of this guide.

¹ 29 CFR 2510.3-377 [FR 18309, Page 18399, "Eligibility Standards for SHOP"].

The employer can choose to contribute to the cost of dental premiums separate from what is contributed towards their health plan premiums. For both QHP and dental, the employer can indicate a percentage, a dollar amount, or both, which implies a percentage up to the dollar amount. The system will calculate and apply the lower amount (percentage or dollar amount) to each employee's selection.

Creating and Managing Classes

When completing an enrollment offering, the employer may separate employees into different classes of "similarly situated individuals". Each class may have a different QHP and dental offering, as well as a different contribution rate and new hire waiting period from another class, but **each person within a class must receive the same offer** – an employer cannot treat any group of two or more similarity situated employees differently.

Federal regulations require that separating employees into classes that may contain differing benefit offers may only be based upon traditional employment-based classifications that are consistent with the employer's usual business practices. Common classifications that are generally acceptable may include full-time versus part-time status, different geographical location, date of hire, length of service, and different occupations, among others. Classification of employees is often used for determining eligibility for other employee benefits or other terms of employment. Employee classification may NOT be based on any health factors including, but not limited to, health status, claims experience, medical history, genetic information, evidence of insurability, or, disability.

When setting up classes, it is important to create all of the classes the employer will conceivably need throughout the group's plan year, whether or not there are any employees in these classes at the initial enrollment. New classes cannot be created after the group's open enrollment period. When a new hire or newly eligible employee needs to be added to the group plan during the plan year, this employee must be added into an already existing class.

Retiree Benefits

A new "Retiree" class is now available for all Employers with a plan year in 2016 and beyond to offer continuous coverage to employees who are currently, or become, retired.

- The Retiree Class can only be created during the employer's open enrollment period or at the group's renewal.
- Employees who are terminated with "Retirement" as the reason code will be placed into the Retiree Class enrollment offering and will be able to enroll.
 - There will be no waiting period for retiree benefits.

Enrollment Periods

An eligible business may enroll in the SBM at any time during the calendar year. Once a plan effective date is chosen for a group – the first of any month of the calendar year – it becomes the start date for that group’s **plan year**. The SBM features three distinctive enrollment periods:

Open Enrollment Period – the period of time from the date employer completes enrollment offering until the end of the month prior to the month of the effective date. *For example, if an employer completes an enrollment offering on May 15th for coverage starting July 1st, the enrollment period will be May 15th – May 31st. Any group also has the option to extend their open enrollment period until the 15th of the month prior to the coverage month. In this case, the open enrollment period would be May 15th – June 15th.*

During this period, an employer may create new classes and manages existing classes, make updates to their offering such as changing the contribution rate or tiers of coverage offered, and add or remove health option riders. If an employer makes updates after an employee has enrolled, the employee may modify their completed enrollment based on the updates the employer has made to their offering but the employee may then need to re-enroll. For instance, an employee is able to add dental if the offer for dental is extended by the employer or add a dependent if new tiers of coverage are made available by the employer.

Edit Period – the period of time from the end of the Open Enrollment Period to the day before the coverage effective date.

For example, if the Open Enrollment Period is May 15th – May 31st, with coverage starting July 1st, the Edit Period will be the month of June, June 1st – June 30th. If the group has extended their open enrollment period to end on the 15th of the month prior to the coverage month, the edit period will be June 15th – June 30th.

During this period, an employer may make changes to the premium contribution and an employee may modify their completed enrollment based on contribution changes. An employee may also add a missing dependent to his or her completed enrollment during the Edit Period.

Retroactive Period – the first 30 days of the plan year (first month of coverage).

For example, if the Open Enrollment Period is May 15th – May 31st, with coverage starting July 1st, and the Edit Period is the month of June, June 1st – June 30th, the Retroactive Period will be the month of July, July 1st – July 31st.

During this period, an employer may add an employee who was inadvertently left off the Roster during the initial Open Enrollment Period, and employees may make some modifications to their completed enrollment if authorized by the employer.



Subsequent to the Retroactive Period, the plan members - enrolled employer(s) or employee(s) - may not make modifications to coverage until “renewal” or the next open enrollment period for the group, which will be 12 months from the initial offer of coverage, unless a plan member or dependent experiences certain life events that trigger a special enrollment period (for more about Special Enrollment Periods, see the next section).

The chart below indicates what a group plan’s coverage effective date will be, based on the open enrollment end date.

Open Enrollment End Dates *	Coverage Effective Dates for 2016
December 15	January 1
January 15	February 1
February 15	March 1
March 15	April 1
April 15	May 1
May 15	June 1
June 15	July 1
July 15	August 1
August 15	September 1
September 15	October 1
October 15	November 1
November 15	December 1

***Employers may extend the open enrollment period up to the 15th of the month by selecting the “extend open enrollment” button during the enrollment or renewal process. If an Employer comes in to the Small Business Marketplace, for the first time, between the 1st and 15th of the month, the employer will have the option to pick an effective date of the first of the following month.**

For more detailed information about enrollment periods, see the [COBRA and Enhanced Enrollment Capabilities webinar](#) on the NYSOH website.

Special Enrollment Periods

Certain qualifying life events will trigger a special enrollment period (SEP) for eligible employees in the Small Business Marketplace (SBM). Members and their dependents who are enrolled in a qualified health plan (QHP) may make certain changes to their enrollment during a qualifying SEP, and eligible employees not enrolled in their employer’s SBM coverage may be able to enroll during a qualifying SEP.

LSC events that may trigger SEPs include:

- Marriage

- Divorce/Legal Separation
- Birth
- Adoption
- Relocation
- American Indian or Alaskan Native
 - Can enroll year-round or change plans once per month
- Legal Orders
- Retirement
- Death
- Remove Enrolled Dependent(s) Loss of Medicaid/CHIP Coverage
- Loss of Health Insurance for Qualified Dependent

Employers cannot change the tiers of coverage they offer mid-year. Upon a qualifying event, an employee can change to any tier of coverage, as well as any plan offered by their employer. Employees can only change to a tier of coverage that has been offered by the employer. If an employee tries to report a qualifying life event that is not supported by the tier of coverage offered by their employer then a message will display telling the employee that their employer does not currently offer coverage for the life event they are trying to report.

A special enrollment period of 60 days from the date of the event will be triggered by the loss of CHIP/Medicaid coverage for a qualified individual - if the employer has offered coverage that would extend to the individual losing coverage (e.g., employee plus Children or employee plus spouse/domestic partner plus children for loss of CHIP; or Employee plus spouse/domestic partner or employee plus spouse/domestic partner plus children for loss of Medicaid coverage).

For all other triggering events, a special enrollment period of 30 days from the date of the event will be triggered by the event.

- For Birth, Adoption, Death, adding a new hire, and certain legal orders, the change in coverage will be effective the date of the triggering event. For loss of coverage for an employee (employer roster) or loss of coverage for a qualified dependent, the effective date will be the following day after the date of occurrence.

An employee **MUST** report loss of CHIP/Medicaid within 60 days in order to trigger a special enrollment. An employee **MUST** report all other triggering events within 30 days. Failure to adhere to the time constraints will preclude the employee from opening a special enrollment.

If an employee tries to trigger a special enrollment past the 30-60 day time frame noted above, a notice will display that:

- The timeframe for reporting this event has elapsed. User will have to wait until the open enrollment period to make the change. User can contact customer service for additional assistance.



For a detailed overview of qualifying events and special enrollment periods that includes eligibility criteria, timelines, how to request a SEP, and what SEPs will trigger a COBRA enrollment opportunity, see the QUALIFYING EVENTS & SPECIAL ENROLLMENT PERIODS chart posted on the NYSOH informational website.

Renewals Processing

Employer groups with an active account in the NYSOH Small Business Marketplace and who have had at least one enrollee during the current benefit year will annually qualify for either an automatic (auto) renewal or a manual renewal.

Auto renewals and manual renewals are determined by pre-defined criteria and both renewal processes are considered rolling – groups are renewed at the end of the twelve month benefit period at the employer group’s anniversary date:

- Notices are sent 90 days prior to the group’s coverage end date.

Brokers are notified via e-mail by the NYSOH SBM of their employer group’s upcoming plan renewals by renewal date.

Auto Renewal

Employers -

To be eligible for auto renewal:

- Employer must have a valid and eligible Marketplace account.
- Employer must have at least one employee enrolled during the plan effective year. A sole issuer in one of the employer’s offers must not have withdrawn from NYSOH.
- There must be at least one active QHP in a completed offer.
 - Note that only *completed* offers will be renewed.

Employees -

To be eligible for auto renewal, an employee must:

- have a valid, active, and enrolled Marketplace account
- be employed or a COBRA beneficiary
- be enrolled in a plan that has not been discontinued for the following plan year.
 - If a QHP is continued but the dental plan has been discontinued, the employee will be auto-renewed into their QHP plan without a dental selection in the new plan year.

Manual Renewal

If required to renew manually, the employer or broker has up to 60 days (75 days with an open enrollment extension) to complete a new renewal offering. Employee renewals can be completed only after the employer renewal offering is completed.

- For example, if a group’s coverage ends on October 31st, 2016, the employer will be notified by August 1st to renew their group for November 1st. To avoid any lapse in coverage, a new offering must be completed **and all employee enrollments must be completed**, prior to the group’s open enrollment end date of September 30th (October 15th with an open enrollment extension).

Appeals

Employers and employees have the right to request an appeal if they disagree with a determination made by the NYSOH Marketplace. If an employer or employee has received a recent decision from the Small Business Marketplace about affordable health insurance coverage and does not agree with the decision, the employer or employee may request an appeal within **90 days** from the date on the letter or may lose the right to an appeal. To learn more about the SBM appeals process, see [Employer-Employee Appeals](#).

Please NOTE: Not all requests for appeal will be determined to involve a valid issue. A customer service specialist may contact you to try to resolve your issues through an informal resolution process. Participating in the informal resolution process will not delay the review of your appeal by an impartial hearing officer who was not directly involved in the original determination or any prior appeal decisions in the same matter.

How to Use NYSOH Website

When an employer or a designated representative such as an agent or broker begins participating in the SBM, the first step is to create a NY.gov ID that will be used to log in to the portal and create an account and, ultimately enroll.

Next, the employer or broker must set up an employer group account. The employer or broker will have to add employer company details and set up the benefits and contribution before choosing the Qualified Health Plans (QHPs) to be made available to employees.

Employers or their broker will upload an employee roster and the SBM will communicate to employees the availability of coverage through their employer via email. The employee will receive a participation code to link the employee to their employer. The employee will choose from the QHPs provided by the employer and complete their enrollment. Alternatively, the broker or employer can assist the employee with the completion of their enrollment as well.

Step-by-step User Guides

The following guides include screen shots and detailed instructions for many of the actions a broker may need to perform on the NYSOH enrollment portal:

<http://info.nystateofhealth.ny.gov/ProducerUserGuides>

- How to Complete Broker Certification
- How to Create a NY.gov ID
- How to Create a Broker Account
- How to Add an Agency Affiliation
- How to Add a Small Group Client
- How to Add an Employee to the Roster
- How to Create an Enrollment Offering
- How to Enroll an Employee

- How to Invite an Employer to Access their Account
- How to Delete an Employee from the Roster
- How to Add a New Hire/Newly Eligible Employee
- How to Search Provider Networks
- How to Upload Documents if EIN Verification is Required
- How to Renew a Small Group Client
- How to Terminate Employer Account
- How to Manage COBRA Enrollment Opportunities
- How to Enter Loss of Coverage for Employees

Video Demonstrations

[Broker Registration and Account Set-up](#) (video)

[Employer Group Account Set-up & Enrollment 1](#) (video)

[Employer Group Account Set-up & Enrollment 2](#) (video)

Webinars

[Webinars for Agents and Brokers on Informational Website](#)

Broker Support

Customer Service Call Center

All employers, employees, and authorized representatives such as brokers will be able to contact the NY State of Health’s customer service center at (855) 355-5777 to speak with a Consumer Support (CSS) Specialist regarding the following:

- General assistance navigating the NYSOH website and enrollment portals
- Telephonic Enrollment application assistance
- Assistance with technical issues while working within the website
- Identity proofing issues
- Enrollment questions or concerns

When calling the customer service center, it is important to listen carefully to the menu prompts in order to make the appropriate selection. The customer service center operating hours are:

- 8am-8pm, Monday – Friday
- 9am-1pm, Saturday

Broker Responsibilities

Brokers have their own “Broker Portal” in the NYSOH web portal, which allows them to assist small employers and their employees with the registration, application and plan selection process through their broker “Dashboard”. The following is a list of responsibilities and capabilities that the broker has when representing a small employer.

- Account Maintenance – Additions, Terminations and Renewals

- Communicate fully with the employer and respond to communications received
- Employer Enrollment
- Employer Group Set Up
- Issue Resolution Liaison with the NYSOH
- Maintain ethical behavior
- Maintain private/secure records
- Manage Qualifying Events
- Obligation to know the employer's needs
- Obligation to know the NYSOH plans available and make appropriate recommendations
- Special Enrollment Requests
- Understand and communicate fully the appeals and complaints process
- Work with the Health Plan regarding Coverage Issues

Brokers can call the NYSOH Customer Service Center to ask general policy questions, ask specific employer or employee account questions, file a complaint, or request an appeal on behalf of the employers they represent.

Security and Privacy

The NY State of Health works to ensure the protection of protected health information (PHI) and personally identifiable information (PII) in both internal and external communications. Assistors such as agents and brokers and are required to ensure the protection of PHI and PII.

Personally Identifiable Information (PII): Information that can be used to distinguish a person's identity, such as their name, social security number or date of birth, when standing alone or when combined with other personal information, such as mother's maiden name.

Protected Health Information (PHI): Under HIPAA, PII combined with "Health Information" (information about a person's health care, including payment for health care) is Protected Health Information or "PHI."

Encrypting Emails – PII and PHI must not be transmitted via standard e-mail, such as Outlook. If it is necessary to transmit PII or PHI electronically to NYSOH staff or business associates, it must be compressed and sent as an encrypted file using approved encryption software.

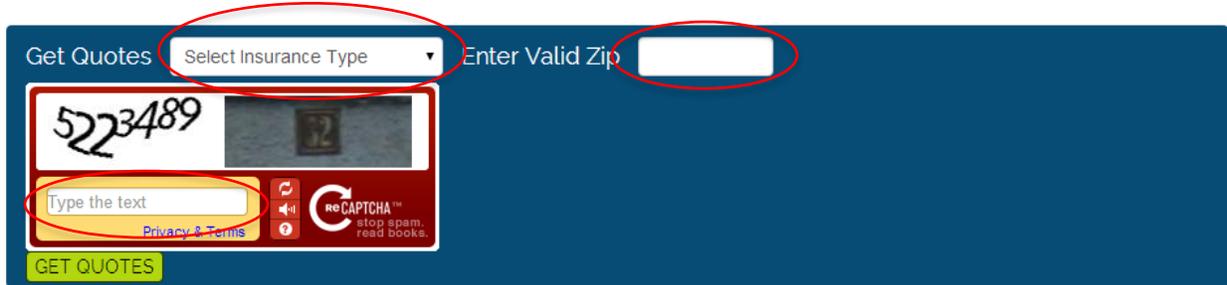
The following document provides a set of guidelines and best practices to help producers ensure that PHI and PII are protected in the course of their work:

[Privacy and Security Guidelines](#)

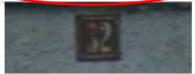
Anonymous Shopping or "Get a Quote" Function

From the Employer landing page on NYSOH website, you can "shop" for medical or dental plans in a specific zip code without signing into your account.

By selecting either medical or dental from the “Select Insurance Type” dropdown, entering your client’s zip code and the CAPTCHA code, you can pull up all the qualified health plans, including benefit details and premium rates, for a specific zip code.



Get Quotes Enter Valid Zip





[Privacy & Terms](#) [GET QUOTES](#)

You can print this and any following pages displaying plan choices. You can filter by carrier and metal levels or sort by premium. You can also estimate the small business health care tax credit. Clicking on the name of any plan will display the plan benefit details, which may also be printed (see following screen captures).

You can also compare up to three plans at a time by selecting the “Add to Compare” box for each plan you want to compare and selecting the “Compare Plans” function.

Plan List

The following plans are available based on the zip code you entered.

- You can filter your plans by Metal level or Carrier.
- You can compare up to three plans at a time by selecting the check box "Add to Compare", then select the "Compare Plans" button.
- To view the plan details/benefits, click on the Plan Name to access the hyperlink.

Filter Options: --Select Carrier--

Compare 0 Plans --Sort By-- 21 - 30 of 31  

 ★★☆☆☆	PLATINUM MA, ST, OON, DEP25, DP, FP HIOS ID: 36346NY0470050 PLATINUM <input type="checkbox"/> Add to Compare			
	County: RENSSELAER			
	Employee	Employee+Spouse	Employee+Child	Employee+Family
New Premium:	\$572 ⁸²	\$1,145 ⁶⁴	\$973 ⁷⁹	\$1,632 ⁵⁴
 ★★★★★	EPO COPAYMENT 200 GOLD ST INN DEP25 DP FP 			
	HIOS ID: 92551NY0380667 GOLD <input type="checkbox"/> Add to Compare			
County: RENSSELAER				
	Employee	Employee+Spouse	Employee+Child	Employee+Family
New Premium:	\$588 ²⁸	\$1,176 ⁵⁷	\$1,000 ⁰⁸	\$1,676 ⁰¹
 ★★☆☆☆	MVP PREMIER PLUS PLATINUM 1 NS INN DEP25 DP FP HIOS ID: 56184NY0170037 PLATINUM <input type="checkbox"/> Add to Compare			
	County: RENSSELAER			
	Employee	Employee+Spouse	Employee+Child	Employee+Family
New Premium:	\$640 ¹²	\$1,280 ²⁴	\$1,088 ²⁰	\$1,824 ³⁴

You can see all the plan details for a particular plan and you can print this page (continued on next page).

Plan Details

[Print Page](#)

You can see premiums co-pays, deductibles and covered services for the plan you chose for employees. For additional information on this plan, click on the right arrow symbol below for detailed coverage information for the benefit category or go to the Get More Information link.

[Back to Plan List](#)


EPO Copayment 200 Gold ST INN Dep25 DP FP

Metal Level	Gold	Quality Rating	★★★★★	
HSA Creditable	No	HIOS ID	92551NY0380667	
New Premium -Employee	\$588.28	New Premium -Employee+Spouse	\$1176.57	
New Premium -Employee+Child	\$1000.08	New Premium -Employee+Family	\$1676.61	
Annual Deductible - Individual	\$600	Annual Deductible - Family	\$600 per person \$1200 per group	
Out of Pocket Maximum - Individual	\$4,000	Out-of-Network Coverage	No	
Out of Pocket Maximum - Family	\$4000 per person \$8000 per group			

Plan Summary

Benefit	In Network Cost Share Tier1	Description
Urgent Care Centers or Facilities	\$60 Copay after deductible	A licensed facility (except Hospitals) that provides care for an illness, injury or condition serious enough to require care right away, but not so severe as to require emergency room care.
Emergency Room Services	\$150 Copay after deductible	Healthcare services you get in an emergency room.
Well Baby Visits and Care	No Charge	Routine doctor visits for comprehensive preventive health services that occur when a baby is young.
Laboratory Outpatient and Professional Services	\$40 Copay after deductible	Professional fees and services associated with laboratory work for diagnostic and treatment purposes.
Generic Drugs	\$10 Copay before deductible	Cost-share represents Tier-1 prescription drugs. Generic = A prescription drug that has the same active-

Additional benefit detail sections are available, including “More Information”, which will display links to the plan’s provider network, formulary, and Summary of Benefits and Coverage.

Plan Summary

Benefit	In Network Cost Share Tier1	Subject to Deductible	Description
Well Baby Visits and Care	\$0	No	Routine doctor visits for comprehensive preventive health services that occur when a baby is young.
Chiropractic Care	50%	Yes	Care performed by a Doctor of Chiropractic (Chiropractor).
Urgent Care Centers or Facilities	50%	Yes	A licensed facility (except Hospitals) that provides care for an illness, injury or condition serious enough to require care right away, but not so severe as to require emergency room care.
Emergency Room Services	50%	Yes	Healthcare services you get in an emergency room.
Laboratory Outpatient and Professional Services	50%	Yes	Professional fees and services associated with laboratory work for diagnostic and treatment purposes.
Inpatient Hospital Services (e.g., Hospital Stay)	50%	Yes	Health care you get when you're admitted as a patient to a health care facility, like a hospital or skilled nursing facility.
Generic Drugs	\$10	Yes	A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs.
Non-Preferred Brand Drugs	\$70	Yes	Brand drugs are sold by a drug company under a specific name or trademark and is protected by a patent. Non-preferred drugs may or may not be included on a plan's covered drug list or formulary and have higher cost-share.
Specialty Drugs	\$70	Yes	Specialty drugs are used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. The drugs are often self-injected or administered in a physician's office or through home health services.
Preferred Brand Drugs	\$35	Yes	Brand drugs are sold by a drug company under a specific name or trademark and is protected by a patent. Preferred drugs are included on a plan's covered drug list or formulary.
Primary Care Visit to Treat an Injury or Illness	50%	Yes	Visit to a clinician for health services that cover a range of prevention, wellness, and treatment for common illnesses.
Specialist Visit	50%	Yes	Visits to a physician to diagnose, manage, prevent or treat certain types of symptoms and conditions related to a specific disease or condition.

- ☑ Preventive and Wellness Services and Chronic Disease Management
- ☑ Rehabilitative and Habilitative Services and Devices
- ☑ Other Services
- ☑ Mental Health and Substance Abuse Services
- ☑ Emergency Services
- ☑ Laboratory Outpatient and Professional Services
- ☑ Pediatric Vision
- ☑ Hospitalization
- ☑ Prescription Drugs Other
- ☑ Outpatient Services
- ☑ More Information

Company Website: <http://www.mvphealthcare.com>
 Summary of Benefits and Coverage: <http://www.discovermvp.com/ny/st/shop/bronze/> ←
 Prescription Drug List: <http://www.discovermvp.com/ny/indiv/rx1> ←
 Provider Network: <http://mvp.primisp.com/#guest> ←
 Plan Brochure: <http://www.discovermvp.com/ny/st/shop/bronze/>

Small Business Health Care Tax Credit

A tax credit is available to eligible small businesses that offer insurance coverage to employees. This tax credit is only available to qualifying businesses through the NYSOH Marketplace.

In general, to be eligible for this credit, a business must:

- Have fewer than 25 full-time equivalent (FTE) employees
- Have employees with average annual salaries of \$50k or less
- Contribute at least 50% of lowest cost employee only premium offered

Business owners, their spouses and their family members are not included for purposes of determining FTEs and average annual wages.

Seasonal workers are not included for purposes of determining FTEs unless the seasonal worker is employed for more than 120 days during the taxable year. However, part-time workers who are employed throughout most of the year are counted in the FTE and average annual wages calculation for the credit.

NYSOH and the Small Business Marketplace do not calculate the Small Business Health Care Tax Credit for employers who offer insurance to their employees through the enrollment portal. An estimator is available through the enrollment portal; employers are advised to work with a tax professional to determine eligibility for and to claim this credit.

Tax credits are reconciled at the end of each tax year. Visit the IRS page, “Small Business Health Care Tax Credit for Small Employers” for more eligibility criteria, step-by-step instructions, forms and online tax credit estimator:

<http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>

[Broker Contacts for Participating Carriers](#)

The following spreadsheet provides broker support contact information for each carrier as well as information regarding commissions.

[Broker Contacts for Participating Carriers](#)

[Co-Branding Guidelines](#)

Use of the NY State of Health trademark logo is permitted by authorized partners including Brokers and Agents for the purpose of advertising and promoting the NYSOH and the public programs and qualified health plans available through the NYSOH. The logo must be used in accordance with these Guidelines:

[NY State of Health Brand and Co-Branding Guidelines](#)

PLEASE NOTE: Authorized partners must receive prior approval of co-branded marketing materials developed by authorized partners prior to distribution.



For questions about using the NYSOH trademark logo and for review of your documents, materials, websites, etc. showing intended logo use prior to dissemination or publication, please contact:

NY State of Health
cobranding@health.state.ny.us

Billing Policies

Premium payments and aggregated billing:

The NYSOH Small Business Marketplace will perform the following functions related to premium payment administration:

- Provide a bill each month that identifies the employer contribution, the employee contribution and the total amount that is due to the health plan issuers from the qualified employer.
- Collect from the employer/billing administrator the total amount due and make payments to the health plan issuers in the SHOP for enrollees.
- Producers will not be required to collect premiums including the initial binder.
- Maintain books, records, documents and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

Invoicing timeline –

Employers of participating small businesses will be billed *a month in advance* for all plan policies on the 1st of each month, beginning at the start of their selected plan year. For example, billing for September will be generated on the first of August for September 1st – September 30th coverage.

Employer bills from NYSOH are due on the last day of the billing month. So, for the example above, the due date on the invoice is August 31st.

Invoice changes will be accepted until the 15th of each month, at which time a new invoice will be generated only for groups that have made enrollment changes between the 1st and 15th of the month. This second invoice will represent the current invoice, replacing the previous invoice from the 1st of the month.

On the first day of the coverage month, if payment has not been received, a robo call is generated to the employer group alerting that payment has not been received. If payment has not been received as of the 16th day of the coverage month, a reminder letter is generated to the employer group stating that payment must be received by the last day of the coverage or the insurance will be terminated. If there is a broker attached to the group, a copy of this letter is also sent to their attention.

If payment in full is not received by the last day of the coverage month, insurance will be terminated back to the last month the premiums were paid in full. The SBM will send out notification of termination to employees and render the employer account inactive. Partially paid months will result in termination for non-payment and the partial payment will be refunded to the employer group. The effective date of termination of coverage will be the last day of the last month paid in full.

Also, the group is alerted that if the carrier has made any payments to providers for any dates of service during this period, they will take back the payments and the employees will be responsible.

Full month coverage and partial billing –

Coverage in the Small Business Marketplace is generally a full month of coverage. When an employer or employee initiates or terminates coverage, the system will begin coverage on the first of the month and end coverage on the final day of the month. Exceptions to this include life status changes due to:

- Birth – coverage begins on date of birth
- Adoption – coverage begins on date of adoption
- Death – coverage ends on date of death
- New hire enrollment – coverage begins on the date of hire per employer new hire policy
- Legal orders – coverage begins on date of legal order
- Loss of coverage for a qualified dependent - coverage begins on the day after the loss of coverage
- Loss of Coverage (for Employee) – coverage begins the day after the loss of coverage.

Premium payments for these events will be prorated to the exact date of the event and the employer will be responsible for any partial month premium amount(s).

Reinstating terminated coverage –

If an employer group is terminated for non-payment, they may reinstate coverage by contacting NYSOH to request reinstatement and paying all premiums up through the current coverage month.

If an employer group voluntarily terminates their SBM coverage and then decides that they want to re-enroll in the Marketplace, they may do so by creating a new enrollment; however, this group's plan year will "start over", meaning that they will have a new coverage effective date and they will be at the beginning of any deductible or cost-sharing arrangements for the plan(s) selected. They will also lock in to the quarter rate for which the effective date of coverage begins.

NYSOH allows employers to view invoice and payment activity through their online account, under the "Messages and Notices" tab.

Click [here](#) to see a sample invoice from NYSOH.

COBRA

The acronym COBRA refers to the health benefit provisions of the Consolidated Omnibus Budget Reconciliation Act passed by Congress in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.² COBRA gives employers and their families who lose their health benefits due to voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events, the right to choose to continue group health benefits provided by their group plan for limited periods of time under certain circumstances.

Small Business Marketplace participating groups can:

- Make COBRA available to employees
- Record qualifying events establishing COBRA Eligibility
- Submit changes for COBRA enrollees

Employees who elect COBRA will pay the premium to their employer and the employer will be responsible for paying NYSOH, as with regular coverage premiums. COBRA coverage will be included on the employer's monthly invoice from NYSOH and will be identified with an * to indicate COBRA enrollment.

For detailed information about COBRA accommodations including qualifying events, open enrollment, qualified beneficiaries, benefit requirements and timelines, see "[COBRA Guidelines](#)" on the NYSOH website.

2017 Plan Invitation

NY State of Health has issued its invitation to insurers to participate for the 2017 plan year. The invitation and related documents can be found [here](#).

² United States Department of Labor: http://www.dol.gov/ebsa/FAQs/faq_compliance_cobra.html accessed on 5-7-14