QUESTIONS AND ANSWERS ON THE 2015 INVITATION
(November 24, 2014)

Schedule of Key Events

Posted 5/2/2014

Question: The Invitation requires the Participation Proposal to be submitted on June 1, 2014 and the provider networks submitted on May 26, 2014. June 1st is a Sunday and May 26th is Memorial Day. Will these dates be changed? Will there be any other changes in the Schedule of Key Events?

Answer: Yes. The Schedule of Key Events is hereby amended as follows (revisions shown in red):

- Invitation Released on April 25, 2014
- Letter of Interest due from Insurers on May 9, 2014
- Written Questions regarding the Invitation due on May 16, 2014
- **Provider Network Submissions due on May 27, 2014**
- Reponses to Written Questions regarding the Invitation due on May 30, 2014
- **Participation Proposal, Rates and Forms for Dental Pans due on June 2, 2014**
- **Participation Proposal, Rates and Forms for Qualified Health Plans due on June 13, 2014.**
- **SERFF Template ("binder") filings due to DFS for Qualified Health Plans and Dental Plans on June 16, 2014.**
- Anticipated Certification on September 15, 2014
- 2015 Open Enrollment begins on November 2, 2014 for Small Businesses and November 15, 2014 for Individuals and Families

Consumer Network Protections

Posted 5/2/2014

Question: The 2015 Invitation includes a new section on Consumer Network Protections, Section II.D.2, and cites the Out-of-Network bill that was recently passed. Please confirm that these provisions will take effect when the legislation takes effect on April 1, 2015.

Answer: The majority of the provisions will take effect on the same date as the Out-of-Network bill. However, the requirement that Insurers cover out-of-network providers at the in-network cost-share to the Marketplace consumer in instances where an in-network provider was not available to such consumer, has been in effect since January 1, 2014 for Marketplace

consumers and will continue to be in effect until the provisions of the Out-of-Network bill take effect on April 1, 2015.

New Post 5/23/14

Question: In a Point of Service (POS) product, if the in-network portion of coverage is offered through an Article 44 insurer and the out of network coverage is offered through an Article 42 or 43 insurer, which entity is required to offer the "make available" out-of-network product enacted as part of the 2014-15 state budget? Is there a different treatment for the Small Business Marketplace versus the off-Marketplace small group?

Answer: The "make available" out-of-network benefit can be made available through the Article 42 or 43 entity that normally provides the out-of-network portion of the coverage. This is true for both the Small Businesses Marketplace/Individual Marketplace and off-Marketplace small group.

Question: If an insurer choses to offer the "make available" out-of-network product enacted as part of the 2014-15 state budget available through the Small Business Marketplace, can it be attached to any product at any metal level for a given insurer?

Answer: The insurer can chose to offer the "make available" out-of-network product at any metal level in the Small Business Marketplace. Like other out-of-network benefits, the "make available" out of network coverage must be embedded in the product (i.e., it cannot be offered independently as a separate rider).

New Post 5/23/14

Question: Are insurers required to market or actively sell their marketplace products outside the Marketplace?

Answer: Under the guaranteed availability requirements in 45 CFR §147.104, insurers must make their Marketplace products available outside the Marketplace, but do not need to actively market the products.

Open Enrollment Period

Posted 5/6/2014

Question: Does NYSOH know how the member renewal process will work?

Response: NYSOH is developing an administrative renewal process for those QHP members that consented to allowing the Marketplace to access electronic records for the purpose of

determining eligibility in future years. Marketplace consumers will have the option during the open-enrollment period, which starts on November 15, 2014. Marketplace consumers will have the option to remain in their current qualified health plan for calendar year 2015. The Marketplace intends to provide a notice to current Marketplace members informing them of this option. This notice will be provided closer to the open enrollment period.

New Post 5/23/14

Question: What are the open enrollment dates for both Small Business Marketplace and the Individual Marketplace?

Answer: Open enrollment for January 1, 2015 coverage in the Small Business Marketplace begins on November 2, 2014 and open enrollment for the Individual Marketplace begins on November 15, 2014.

SERFF Submissions

Posted 5/6/2014

Question: Will the insurers be able to use the same HIOS ID's for 2015 that they're using for 2014.

Answer: Yes, plans SHOULD use the same 14 digit HIOS ID numbers in 2015 as 2014 as long as they offered the product(s) on the marketplace in 2014. The 14 digit HIOS ID numbers used for the products offered in 2014 cannot be used for brand new products offered in 2015.

Standard Products

Posted 5/6/2014

Question: The IRS released the 2015 maximum HSA limits of $6,420. Will there be a change to the catastrophic plan limit?

Answer: Yes, the maximum limit for the catastrophic plans has been raised to $6,600 for 2015 per the IRS regulation. The maximum out pocket for other qualified health plans remains the same. See Attachment B to the invitation.

New Post 5/23/14

Question: Are the product changes highlighted in the standard plan designs (ex. Silver CSR 1) for all members entering the 2015 Marketplace? In other words, will insurers have to "renew" current 2014 plans and offer new 2015 plans?

Answer: No, the revised 2015 standard plans (ex. Silver CSR 1) in effect replace the corresponding 2014 standard plan.

Essential Health Benefits

Posted 5/6/2014

Question: The list of Essential Health Benefits (EHB) released with the invitation last week doesn't include bariatric surgery, as it did last year. Is bariatric surgery no longer a covered benefit for 2015?

Answer: Bariatric surgery continues to be a covered EHB for 2015, but was not separately listed in Attachment A. A revised Attachment will be issued for consistency with 2014.

Invitation Responses

Posted 5/6/2014

Question: Why is pediatric listed twice in the table on page 2 of Attachment E?

Answer: Pediatric dental was listed twice because the Stand Alone Dental Applicants must offer one standard pediatric dental product, but are also allowed to offer a non-standard pediatric dental product. The purpose of listing it twice was to capture both versions of the product.

Posted 5/6/2014

Question: Is the County of New York missing from Addendum 3?

Response: NY County was inadvertently referred to as Manhattan County in Addendum 3. Addendum 3 will be revised to reflect NY County.

Posted 5/6/2014

Question: Why is the Silver Cost Sharing Reduction (CSR) not included in Addendum 1?

Answer: The Silver CSR product is automatically created by the insurers as a QHP offering for every silver product offered. There is no need to call it out when capturing the counties in which the products will be offered.

Posted 5/13/2014

Question: Will the formulary list be the same for 2015 as it was in 2014 for plans on the marketplace?

Answer: There is nothing in the federal rules that prohibit an insurer from making updates to its formulary, so long as it continues to meet the minimum requirements. Formularies will be reviewed during the review of a QHP filing and upon recertification each year. Both standard and non-standard plans must cover at least the greater of one drug in each category or class, or the number in each class the benchmark plan covers. Plans may designate which drugs are in each tier, as long as the cost sharing meets actuarial value requirements.

Posted 5/13/2014

Question: For the 2015 Plan Management Benefits template, have the benefit categories changed from 2014?

Answer: Yes, revisions have been made to the Plan Management Benefit template. DFS will post the QHP filing instructions on their website once the document has been finalized.

Posted 5/19/2014

Question: Will participating insurers be permitted to continue using FAIR Health's treatment cost calculator in 2015, as permitted to do so in 2014, in order to satisfy the requirement that the out-of-pocket costs be transparent?

Answer: The answer to this question is hereby amended on 11/24/14. Use of FAIR Health's treatment cost calculator for out-of-network services would satisfy the Invitation's requirement that out-of-pocket costs be transparent. Contact Fair Health if you wish to set up a link in order to establish an appropriate licensing arrangement.

Posted 5/19/2014

Question: Will Addendum 2 be used internally or for purposes of training and marketing?

Answer: The purpose of Addendum 2 is to identify how non-standard products differ from standard products. The primary purpose is for internal evaluation of offerings; however, the Addendum or the information contained in it may be used for other purposes deemed appropriate by the NYSOH including but not limited to training and consumer education.

Posted 5/19/2014

Question: The filing instructions for Addendum 2 states "fill out one form for each non-standard product." Does this mean that one form should be completed per metal level per product?

Answer: If there are no differences in the non-standard product among the metal levels, other than the AV value, please indicate on the form and submit one form.

Posted 5/19/2014

Question: What is the earliest date that QHP issuers offering plans in New York can begin to submit 2015 SERFF (binder) templates?

Answer: Refer to the FAQ's published on 5/6/14 for a schedule of key events. If you have further questions on the submission of the SERFF (binder) templates, please contact your reviewer at the Department of Financial Services.

Posted 5/19/2014

Question: When completing the question related to annual deductibles in Addendum 2, should the issuer include only the dollar difference from the standard plan or should insurers also include differences in the deductible accumulations?

Answer: Insurers should explain any and all differences from the standard product. This would include but not be limited to the dollar amount of the deductible and how it is accumulated.

Posted 5/19/2014

Question: Is NYSOH seeking a quality improvement strategy to be submitted with the application to participate prior to certification?

Answer: Yes, the quality improvement strategy must be submitted as part of 2015 Participation Proposal due by June 13, 2014.

New Post 5/23/14

Question: Will insurers be allowed to auto renew individuals in their individual products offered outside the Marketplace?

Answer: Questions related to off –Exchange renewals should be directed to the NYS Department of Financial Services.

New Post 5/23/14

Question: Can Insurers offer up to 3 non-standard products per metal tier, per county (as opposed to 3 total within the service area)?

Answer: Yes. Health Insurer Applicants may opt to offer up to 3 non-standard products at any metal tier per county of their service area subject to the permissible combinations in section II.D.1(g) of the Invitation.

New Post 5/23/14

Question: For the purposes of indicating new products in Addendum 1 of the QHP Invitation, would the addition of child/pediatric dental to an existing standard plan be considered a new plan? In other words, would a column need to be highlighted if the only change to an existing (i.e., 2014) standard plan is the addition/inclusion of pediatric dental?

Answer: No, this would be considered an existing plan, but please note the change in the Addendum.

New Post 5/23/14

Question: Will catastrophic products be counted towards the 3 non-standard products per metal tier limitation?

Answer: No. Catastrophic plans are not counted towards the number of non-standard products. See Section II.D.1(g)(iii) on page 11 of the Invitation.

Stand Alone Dental Plans

Posted 5/6/2014

Question: Under federal rules, every Stand-Alone Dental Plan (SADP) must contain the pediatric dental EHB. An adult plan that also offers the pediatric EHB is by definition a family plan. Please explain, as this is an issue that was identified last year. How does this differ for embedded dental in non-standard plans?

Answer: While every SADP must contain the pediatric dental EHB, not every adult will choose a family plan option. Therefore, an individual adult plan is an option with the pediatric dental EHB embedded in it.

Posted 5/6/2014

Question: In Section J on page 13, what constitutes “supplemental pediatric dental”?

Answer: Supplemental Pediatric Dental Benefits are benefits that QHP's or SADP's cover which are above and beyond the Essential Health Benefit requirements for pediatric dental (e.g., additional coverage for orthodontia). These additional benefits may be provided in accordance with invitation guidelines regarding Non-Standard Products (NSP’s). Refer to the Invitation Section II.D.1.g., for examples of NSP's.

Posted 5/6/2014

Question: Are Stand-Alone Dental Plan’s required to provide a Treatment Cost Calculator on their website?

Answer: Yes. Stand-alone dentals plans are required to provide a Treatment Calculator on their website to help consumer predict costs.

Posted 5/6/2014

Question: Does the QARR Section 2 of the Invitation apply to Stand Alone Dental Plans?

Answer: The Minimum Participation Standards set forth in Section II. E.2 and the Quality and Enrollee Satisfaction requirements in Section II.E. do not apply to Stand Alone Dental Plans.

Posted 5/13/2014

Question: When adding a pediatric dental benefit to an existing 2014 QHP product, is it necessary for insurers to create new HIOS ID's?

Answer: Yes, insurers will need to create new HIOS ID's when adding new benefits to any existing QHP's on the individual market.

Posted 5/19/2014

Question: Was there an elimination of high/low AVs and age alignment up to age 21 regarding the stand- alone dental requirement?

Answer: No. The final federal rules did not eliminate the high/low AVs. Dental insurers must continue to offer products with actuarial values of 70 and 85 percent. The Invitation does not change the age requirement for stand-alone dental. Pediatric dental products are offered to children 18 years or younger.

New Post 5/23/14

Question: Are the hard copies of the proposal due by June 2nd for Stand Alone Dental Plans, or is it sufficient for the electronic version to arrive on the 2nd, with the hard copies arriving thereafter?

Answer: Electronic submission of the proposal at the email noted in Section V.C by June 2nd is acceptable. However, Applicants must follow up this submission with two original, signed copies of the participation proposal by mail or hand deliver to the address listed in the Section V.C.

New Post 5/23/14

Question: Does the new naming convention apply to Stand Alone Dental Plans?

Answer: Referring to section II.D.1(h) of the Invitation at pages 11 and 12, the following fields apply to Stand Alone Dental Plans: Product Name, Standard/Non-standard, Network Coverage, Dental Coverage, Dependent Age Coverage.

New Post 5/23/14

Question: Is the statement on page 13 of the Invitation which states that "Federal Law requires coverage for pediatric dental services…" implying that individuals much purchase pediatric dental coverage or that it is only to be offered by the Marketplace as an option available to consumers to purchase?

Answer: Pediatric dental benefits must be made available to consumers on the Marketplace, but consumers do not need to purchase them.

Recertification Process

Posted 5/6/2014

Question: Does Section 4 on page 28 of the Invitation does not specially indicate the recertification process. Will the process differ from the certification process?

Answer: No, the recertification process is the same as the certification process.

QHP Naming Convention

Posted 5/6/2014

Question: Is the expectation that the new Qualified Health Plan (QHP) naming convention will be used only for the purposes of displaying plan names on the NYSOH portal? Or, will insurers be required to use the new plan names on printed materials, ID cards, etc.

Answer: The central purpose of the new QHP naming convention is for consumers to easily identify products displayed and sold on the NYSOH Marketplace portal. Pursuant to Section II.D.h., Insurers are given guidelines for displaying the products they plan on providing. Unless the Department of Financial Services requires otherwise on its subscriber agreements, summaries of benefits, etc., insurers will not be required to use the new plan names on printed materials, ID cards, etc. However, to the extent possible, the NYSOH encourages insurers to use the same name to help consumers link the materials to the product purchased on the Marketplace.

Posted 5/19/2014

Question: The SERFF (binder) templates do not permit product names to be added to the silver cost-share variations. Will NYSOH still require the Applicants to use the Silver CSR1, Silver CSR2, and Silver CSR3 naming conventions, and if so, how will this be done if it cannot be entered into the SERFF template that way?

Answer: No, the NYSOH will not require the Applicants to use such naming conventions since the information cannot be entered into the SERFF templates. The Invitation, Section II.D.1 (h), is hereby amended to remove the Silver CSR1, Silver CSR2 and Silver CSR3 values.

New Post 5/23/14

Question: How is the naming convention delineated for a child only product?

Answer: A child only product is one of the permitted values under the metal tier field. See section II.D. 1(h) of the Invitation.

New Post 5/23/14

Question: There appear to be errors in the naming convention instruction or the examples provided. Can you please provide clarification and can you please clarify the naming convention for the catastrophic plans?

Answer: The examples in the Invitation for the naming convention did not follow the instruction and are hereby amended as set forth below. In addition, the instructions have been modified to remove the silver cost-share variations in the values below, per the question above, dated 5/19/2014; to add the instruction that the catastrophic plans do not need to include the value of Dep25 and Dep29; and to remove the values of catastrophic and child only in the Small Business Market. The naming convention instructions are hereby amended as follows:

Individual Market:

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	
Metal Tier	Bronze, Silver, Gold, Platinum, Child Only, Catastrophic	Indicate metal tier using entire word for metal level;
Standard/Non-Standard	ST or NS	Indicate Standard or Non-standard by using “ST” for

		standard and "NS" for non-standard
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded within the QHP
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29; do not add to catastrophic plans
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other	List the general categories of variances from standard benefits in alphabetical order separated by commas. Do not enter for Standard Plans

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

Small Business Marketplace:

Field Name	**Values**	**Instructions**
Product Name	To be assigned by Applicant	
Metal Tier	Bronze, Silver, Gold, Platinum	Indicate metal tier using entire word for metal level
Standard/Non-Standard	ST or NS	Indicate Standard or Non-standard by using "ST" for standard and "NS" for non-standard
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.

Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded in the QHP
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other	List the general categories of variances from standard benefits in alphabetical order separated by commas. Do not enter for Standard Plans
Domestic Partner	DP	Include only if domestic partners are eligible for coverage
Family Planning	FP	Include only if the family planning benefit is covered

Examples of permissible QHP names are shown below:
ABC product, Platinum, ST, INN, Dep25
ABC product, Platinum, ST, INN, Dep29, FP
ABC product, Gold, OON, NS, Adult Dental, Dep29, DP, FP

New Post 5/23/14

Question: While the New York State QHP Naming Convention requires the use of commas to separate the different categories (e.g. ST, INN), the SERFF Plan and Benefits Templates prohibit the use of special characters—including commas. Can commas be omitted from the naming convention to ensure proper validation through SERFF?

Answer: Yes, commas should be omitted.

Provider Network Submission

Posted 5/13/2014

Question: Is there an Essential Community Provider template to be used for the QHP filing?

Answer: Yes, a template will be distributed to all Medical Insurers applicants requesting information on all Essential Community Providers, FQHC's, Tribal Clinics, and Specialty Clinics

with which the Insurer is contracted for QHPs. Insurers will be required to submit this template along with provider networks on a quarterly basis. The initial template will be distributed in the next few weeks, and we will give 15 days to respond to the initial request.

Posted 5/13/2014

Question: Could NYSOH please clarify the requirement related to the inclusion of essential community providers in provider networks. Specifically, provide guidance as to what "a sufficient number and geographic distribution" means in this context? In addition, how would an insurer know if a clinic is a *tribal-operated* health clinic?

Answer: The Invitation requires the Applicant to make every good faith effort to include in its network the Essential Community Providers (ECPs) defined under federal regulation and, at a minimum, include in each county network a Federally Qualified Health Center and a tribal operated health clinic, to the extent such providers are available. In addition to this requirement, Applicants should take into consideration its geographic service area, expected enrollment and other relevant factors in determining what constitutes a sufficient number and geographic distribution of ECPs.

Information about American Indian Nations Health Clinics can be found at: http://www.health.ny.gov/community/american_indian_nation/

Posted 5/19/2014

Question: Please clarify the timing of the provider network (PNDS) submissions. Does the provider network submission on May 27th, need to contain network composition for the beginning of the 2015 plan year? Or, would participating providers have to submit the Q2 2014 HPN submission as usual.

Answer: The quarter 2 2014 PNDS submission due on May 27 should include the providers with whom the insurer has a contract at the time of submission. The third quarter PNDS submission, which will be due at the end of August, will be the submission that is used for display on the Marketplace during the open enrollment period which begins on November 15, 2014. Per the Invitation, Section II.F.6, as changes in the network occur, the insurer is required to submit such changes to the NYSOH within 15 business days of the change.

Posted 5/19/2014

Question: Are letters of intent acceptable when submitting the provider network on a quarterly basis?

Answer: No, letters of intent are not acceptable. The PNDS submission should include only those providers with whom the health plan has an executed contract.

Posted 5/19/2014

Question: Are insurers required to submit a full file or a change file to report network changes?

Answer: Insurers are required to submit only a change file. Insurers are required to submit files to the Marketplace for changes to their network as soon as they occur (i.e., addition or termination of a hospital or large physician practice) but no later than 15 business days from the effective date of the change.

Posted 5/19/2014

Question: Section II (D) (2) Please clarify if the "submission deadline for the URL Link to Provider Directory" needs to be active on the filing date for certification purposes?

Answer: The DOH will begin evaluating Applicant Proposals for certification as soon as they are received and anticipates that the certification process will completed around September 15, 2014. The URL's must be functional by September 15, 2014.

Posted 5/19/2014

Question: In Attachment F of the Invitation to Participate, is a notarized attestation required with each provider network submission?

Response: The notarized attestation required in Attachment F is required with each quarterly network submission. It will be required with monthly submissions in the future.

Posted 5/19/2014

Question: When will plans need to start making monthly network submissions through the HPN?

Response: We anticipate that the Marketplace will begin requiring monthly submissions in the second quarter of 2015.

New Post 5/23/14

Question: What is the minimum requirement for Essential Community Providers in New York State for Stand Alone Dental Plans?

Answer: While Essential Community Providers are not specifically required in the description of the network standards related to dental benefits and stand-alone dental carriers, the New York State of Health encourages the stand-alone dental carriers applying for participation in the Marketplace to establish a diverse network of health care providers in order to meet the widest variety of consumers' health care needs.

New Post 5/23/14

Question: What is required percentage of Essential Community Providers to meet network adequacy standards for 2015?

Answer: There are no required percentages. See the questions above related to Essential Community Providers.

Operational Guidance

New Post 5/23/14

Question: Have the NYSOH brand guidelines changed from last year?

Answer: No. The co-branding guidelines have not changed from last year. Please see NY State of Health - cobranding@health.state.ny.us or visit http://info.nystateofhealth.ny.gov/resource/ny-state-health-brand-guidelines

New Post 5/23/14

Question: If a dependent who was once a part of an enrolled family leaves the family and becomes his/her own subscriber, will their HX ID number stay the same?

Answer: Yes, their individual HX ID number will remain the same.

Small Business Marketplace

New Post 5/23/14

Question: Please define, per NYSOH, what is a “small group”?

Answer: For calendar year 2014 and 2015, the definition of a small group shall mean a group of fifty (50) or fewer employees with at least one common law employee as defined 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. See page 17 of the Invitation.

New Post 5/23/14

Question: On page 18 of the Invitation, please provide examples the four options fundamentally available to employers within SHOP with regard to "employer choice".

Answer:

1) Selecting one metal level and all products within that metal level.

Example: Employees have the option of enrolling in a platinum plan offered by Insurer A, Insurer B or Insurer C.

2) Selecting one specific health insurer and one specific metal level offered

Example: All employees must enroll in the same platinum plan from Insurer A.

3) Selecting one specific health insurer and offering multiple products from such insurer;

Example: Employees can select a bronze, silver, gold or platinum plan from Insurer A.

4) Selecting all metal levels and all health insurer products

Example: Each employee can select any bronze, silver, gold or platinum plan from any Insurer A, Insurer B or Insurer C.