



**Invitation and Requirements for Insurer Certification and
Recertification for Participation in 2017**

**QUALIFIED HEALTH PLANS, STAND-ALONE DENTAL PLANS AND
ESSENTIAL PLANS**

Revised May 6, 2016

Deleted: April 11, 2016

Schedule of Key Events

| EVENT | DUE DATE | QHP | SADP | EP |
|--|-------------------------|-----|------|----|
| Invitation Released | April 11, 2016 | x | x | x |
| Letters of Interest Due | April 18, 2016 | x | x | x |
| Written Questions Accepted | April 12 – May 20, 2016 | x | x | x |
| Stand Alone Dental Policy Forms and Rates Due to DFS | April 25, 2016 | | x | |
| Medical Policy Forms and Rates Due to DFS | May 9, 2016 | x | | |
| Stand Alone Dental Binders are due in SERFF | May 13, 2016 | | x | |
| Participation Proposals Due to NYSoH | May 20, 2016 | x | x | x |
| Medical Binders are due in SERFF | May 27, 2016 | x | | |
| DFS Rate Decision Due Date | July 28, 2016 | x | x | |
| Essential Plan Subscriber Agreements due to NYSoH | July 29, 2016 | | | x |
| Essential Plan Templates Due to Plan Management | August 19, 2016 | | | x |
| Certification of Plans by NYSoH | September 9, 2016 | x | x | x |
| Approval of Plans in Issuer Portal Completed | September 23, 2016 | x | x | x |
| All Plan Information Final in NYSoH System | October 31, 2016 | x | x | x |

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

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PART 1

INTRODUCTION AND OVERVIEW

Section 1.1 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), Essential Plans (EPs), and Stand-Alone Dental Plans through the NY State of Health, the Official Health Plan Marketplace (Marketplace) in 2016 to apply for recertification for 2017; and
- (ii) to invite other insurers that are licensed or certified in New York State to apply to be certified as QHPs, SADPS, and/or EPs to be offered on the Marketplace in calendar year 2017.

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, who sign a new Agreement with the DOH, will be certified as QHPs, SADPs, and/or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of plans to be offered on the Marketplace in 2017.

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.

Section 1.2 Background

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

On March 23 and 30, 2010, President Obama signed The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as The Patient Protection and Affordable Care Act (ACA). The ACA authorized the creation of state-based and administered Health Benefit Exchanges. On April 12, 2012, Governor Cuomo issued [Executive Order No. 42](#) establishing the New York Health Benefit Exchange, now known as NY State of Health, the Official Health Plan Marketplace, within the DOH. NY State of Health opened on October 1, 2013 for coverage starting on January 1, 2014.

The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York and enrolled more than 2.8 million New Yorkers into comprehensive, affordable coverage.

As enrollment through NY State of Health increases each year, New York has seen a significant, corresponding reduction in the number of uninsured. Since the Marketplace opened in 2014, the number of uninsured New Yorkers has declined by nearly 850,000 and the rate of uninsured has declined from 10 percent to 5 percent between 2013 and September 2015.¹

The launch of the Essential Plan in 2016 for lower-income individuals and families has been very successful. The Essential Plan has provided New York's Marketplace with a unique opportunity to offer consumers the same or better benefits at a lower cost or no cost, and at the same time realize savings for state taxpayers. Starting on January 1, 2016, certain consumers who would have previously been eligible for a QHP were instead enrolled in the Essential Plan where they receive the same benefits as they otherwise would have, but with significantly lower cost sharing - saving the average Essential Plan consumer over \$1,100 a year. At the same time, implementation of the Essential Plan allowed New York to enroll most lawfully present non-citizens who were previously enrolled in state-funded Medicaid into the Essential Plan with federal financial participation.

Applicants can enroll in coverage through NY State of Health on-line, by telephone or with the help of an in-person assister. In 2016, there were more than 13,000 certified enrollment experts, including Navigators, Certified Application Counselors, and brokers.

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 get a personalized premium estimate before starting an application. Over 3.6 million people used this tool during the 2016 open enrollment period.

In 2016, NY State of Health further increased efforts to reach non-English speakers across the state. Consumer education materials are available in 23 languages, including five additional languages that were not available in 2015. The Marketplace again sponsored a comprehensive state-wide advertising campaign in English, Spanish, and Chinese and in an expanded number of ethnic community publications in order to reach a diverse range of eligible New Yorkers.

B. The Essential Plan, New York's Basic Health Program

The ACA provides states with the option to establish a Basic Health Program. New York has elected this option as authorized by Section 369-gg of the Social Services Law, and received approval from the federal government on March 27, 2015 to administer this program.

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

¹ CDC/NCHS, National Health Interview Survey, 2015, Family Core component. "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2015" <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf>

- 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 incomes between 138%-200% of the FPL or less than 138% and be ineligible for Medicaid due to immigration status.

Individuals eligible for the Essential Plan are not eligible to receive Advance Premium Tax Credits, but will have the option of purchasing a full pay QHP if they elect not to apply for financial assistance on their application.

The federal government provides states with funding in an amount equal to 95 percent of the amount that it would have spent on Advanced Premium Tax Credits and Cost Sharing Reductions had the individuals who enrolled in the Essential Plan been enrolled in the Individual Marketplace. Insurers must provide health care services as detailed in the attachments to this Invitation. Monthly premium contribution is set in NYS Social Services Law and cost sharing cannot exceed the amount the individual would have paid for QHP coverage in the Marketplace.

More detail about the Essential Plan can be found in Attachments G and H.



PART 2

Qualified Health Plan and Stand-Alone Dental Plans: Individual Market and Small Business Market

Section 2.1 Participation Requirements

For purposes of this Invitation:

“Applicant” and Applicants” means insurers applying to offer medical coverage or dental coverage and applying for QHP certification or recertification.

“Health Insurer Applicant” means health insurers applying for QHP certification or recertification that offer medical coverage,

“Stand-Alone Dental Applicants” refers to insurers applying for QHP certification or recertification that offer only stand-alone dental coverage.

A. Licensure and Solvency

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

- Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or
- Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 1, 2016 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2016.

B. Choice of Participation

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

C. Service Area

Applicants must apply to participate in their entire service area as approved by the Department of Financial Services (DFS) or the DOH at the time of application, provided all requirements of this Invitation are met. Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception. The

DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace. Pursuant to 45 CFR § 155.1055, Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

D. Applicant-Specific Requirements

1. Health Insurer Applicant Product Offerings

a. Essential Health Benefits. Health Insurer Applicants must agree to provide the Essential Health Benefits (EHB) specified calendar year 2017, and delineated on Attachment A. The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels. Each product in each metal level must meet the following specified actuarial value (AV) levels based on the cost-sharing features of the product and determined using the 2017 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 federal rules, a *de minimus* variation of +/- 2% AV is permissible, except with respect to the Silver CSR (cost-share reduction) variations, which only permits a variation of +/- 1% AV. Notwithstanding the implementation of the EP, there are a limited number of people who will be eligible for CSR variations of 87% AV and 94% AV because they are 65 or older but not eligible for Medicare. Thus, Health Insurer Applicants must offer, at a minimum, Standard Products as described below at these AV levels.

c. Standard Products. Health Insurer Applicants must offer one (1) standard product in each metal level and in every county of its Marketplace service area. The standard product offered by Health Insurer Applicants must include the benefits and visit limits as delineated in Attachment A and the cost-sharing limitations delineated in

Attachment B, with the exception that the wellness benefit may be substituted for a different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DFS review and approval. This requirement applies to the Individual Marketplace and the Small Business Marketplace. The Standard Products for 2017 are listed in Attachment B.

Note on Standard Product Changes for 2017: HHS has updated the enrollment and utilization data included in the AV calculator. As a result, the actuarial values of certain standard products increased from 2016 because fixed deductibles and cost sharing would satisfy a smaller share of total charges. This change in the AV calculator required New York to revise the Silver, Silver 73% AV, Silver 87% AV and Bronze Standard products.

d. Standard with 3 PCP Visits. In order to align the goals of encouraging appropriate use and access to primary care, Health Insurer Applicants may also offer a standard product with 3 visits to a primary care provider as defined in Attachment C that are not subject to the deductible. Copayments will apply. This additional plan will not count towards the number of non-standard plans offered by the Health Insurer Applicant and can be offered in the Individual or Small Business Marketplace. If the Health Insurer Applicant opts to offer this product, it must:

i. be offered at the Gold, Silver, Silver CSR 73% AV, Silver CSR 87% AV, and Silver CSR 94% AV* metal levels in every county of its QHP service area: and

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, Health Insurer Applicants must agree to offer a child-only product at each metal level described in Section 2.1(D)(1)(b), above, in the Individual Marketplace. The child-only product must conform to the benefits and visit limits delineated in Attachment A and the same cost sharing limitations delineated in Attachment B. In other words, it must be the Standard Product required in Section 2.1(D)(1)(c), above, offered at the child-only rate outlined in Section 2.2(c)(5)(b). Only one child only product is required per metal level. Health Insurer Applicants' participation in the State's Child Health Plus program does not satisfy this requirement.

*All variations of the silver plans must be offered therefore Applicants will need to include the Silver CSR 94% AV variation in their submissions. As the Silver CSR 94% AV variation does not have annual deductible, the design would be the same as the standard plan.

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

g. Out-of-Network Offerings. An "out-of-network" product is a product that provides coverage for services rendered by health care providers that are not in the health insurer's network. Health Insurer Applicants that offer an out-of-network product outside the Marketplace must offer the out-of-network product on the Marketplace at the silver and platinum levels. This requirement applies to both the Individual Marketplace and the Small Business Marketplace. Health Insurer Applicants that do not offer an out-of-network product outside the Marketplace are strongly encouraged to offer a QHP on the Marketplace with an out-of-network benefit, so consumers have an option to purchase such a product should they chose to do so. An Applicant may use an additional or different license to offer an out-of-network QHP, provided the different or additional license is for an entity within the same family of companies.

h. Nonstandard Products. Health Insurer Applicants may opt to offer up to three (3) "non-standard" products at any metal level 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 2.1.C, those stated below, and any applicable DFS instruction or guidance.

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

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

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

B. At least one and not more than 3 non-standard products. However, the number of Bronze non-standard products may not exceed the number of non-standard products at any other metal tier, except that Health Insurer Applicants that offered a Bronze QHP that was HSA eligible in 2016 will be permitted to offer the HSA Compliant Bronze set forth in Attachment B in 2017 to ensure the HSA can carry over for their respective enrollees

(iii) Child only products, catastrophic products, out of network offerings, 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 plans offered in prior years to determine whether they should continue to be offered.

i. QHP Naming Convention. To assist consumers in identifying products and differences between products, Health Insurer Applicants must use the following naming conventions to identify all QHPs offered on the Marketplace in the order as presented below. 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 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, and "NS" for non-standard |
| Network Coverage | INN or OON | Indicate network type using "INN" for in-network and |

| | | |
|------------------------|---|--|
| | | "OON" for out-of-network coverage. |
| Dental Coverage | Pediatric Dental, Adult/Family Dental | Indicate the type of dental coverage embedded within the QHP |
| Dependent Age Coverage | Dep25, Dep29 | Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29 |
| Non-Standard Details | Adult Vision, Family Dental, Family Vision, Wellness, other significant details | 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 | This should be the same product name the Applicant uses to market the product |
| Metal Tier | Bronze, Silver, Gold, Platinum, | Indicate metal tier using entire 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, 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 significant details | 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, NS, OON, Adult Dental, Dep29, DP, FP
- ABC product, Silver, ST3PCP, ONN, Dep25

i. Prescription Drug Coverage. As required under the federal rules, prescription drug coverage must cover at least the greater of (i) one drug in every United States Pharmacopeia (USP) category and class; or (ii) the same number of prescription drugs in each category and class of the benchmark plan chosen by the State. All prescription drug information must be submitted to DFS for its review. This requirement is not intended to limit the number of drugs that the Health Insurer Applicant may cover in a drug category or class. Health Insurer Applicants are encouraged to develop formularies that exceed the federal requirements when it is determined to be in the best interest of their members.

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

Health Insurer Applicants will also have the option of offering adult/family dental, and/or supplemental pediatric dental benefits as an additional benefit per Section 2.2(D)(1)(g), above. In the event the Health Insurer offers a family dental benefit, the

pediatric component must include at least the same pediatric dental benefits as outlined in Attachment A.

k. Effective Dates. All initial and recertified products offered as a result of this Invitation will have an effective date of January 1, 2017 in the Individual Marketplace and Small Business Marketplace. Qualified Employers will be able to purchase coverage through the Small Business Marketplace at any point during the year, and may modify the effective date of coverage for any 12-month period. Health Insurer Applicants, however, will not be able to establish and offer new products at any time during the year. Products to be offered during calendar year 2017, must be established and submitted to DOH and DFS through this Invitation.

2. Stand-Alone Dental Applicants

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

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

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

c. Non-Standard products. The Stand-alone Dental Applicant may opt to offer up to three (3) non-standard products. The non-standard product may be an adult/family dental plan or a second pediatric dental product offering. This requirement applies to both the Individual Marketplace and the Small Business Marketplace.

d. Other Applicable Provisions. Stand-Alone Dental Applicants must meet the requirements set forth in Section 2.1(D)(1)(k) and 2.2(D), below.

3. 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 defined as a group of one hundred (100) or fewer FTE employees with at least one common law employee enrolled as defined by federal regulation, (see 26 CFR 31.3121(d)-1(c)). The term 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: http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

b. Employer Choice. Through the Small Business Marketplace, Qualified Employers will have the flexibility to offer their employees:

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

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

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

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

4. Health Savings Accounts and Health Reimbursement Accounts

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

5. Non-Discrimination

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

Section 2.2 Premium Rate and Policy Form Filing

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

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

B. Policy Form Filings

1. All policy form filings for 2017 Marketplace products must be received by DFS by April 25, 2016 for Stand-Alone Dental Applicants and May 9, 2016 for Health Insurer Applicants.

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

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

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

C. Rate Filings

1. All premium rate applications for Marketplace products must be received by DFS by April 18, 2016 for Stand-Alone Dental Applicants and May 9, 2016 for Health Insurer Applicants.

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

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

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

5. Provisions Applicable to Health Insurer Applicants

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

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

These relativities shall apply to 2017 rates in the Individual Marketplace and Small Business Marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-only Products. In addition to the tiers specified above, Health Insurer Applicants must offer child-only products in conjunction with the standard product designs. Only one child-only product is required per metal level. Separate policy forms

must be created and provided to enrollees of child-only products. The child-only rate must be set at 41.2% of the corresponding single rate product. The Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

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

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

6. Premium Rate Periods

a. Small Business Products. Applicants may use quarterly rolling rates for Marketplace products offered through the Small Business Marketplace, with a one year guarantee for the employer. For example, if the employer's plan year begins April 1, 2017, the rate provided to that employer will be guaranteed for all employees through March 31, 2018, as well as new employees or special enrollments that occur during the plan year through March 31, 2018.

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

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

D. Role of Brokers and Agents

To maximize access to health insurance coverage for residents of New York State, brokers and agents (collectively, "Producers") will be permitted to assist both small businesses and individuals in purchasing coverage through the Marketplace.

1. Producer Certification. Producers who have successfully completed the training certification program for each applicable marketplace and entered into an agreement with the

Marketplace will be deemed certified to conduct business in the Marketplace. Such agreements will require Producers to be licensed and in good standing with the DFS. For the sale of Marketplace products, the Applicant must contract with Producers that have successfully completed the required training program and have entered into agreements with the Marketplace.

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

3. Producer Compensation. All of Health Insurer Applicants' compensation arrangements, including bonus arrangements and all other arrangements that relate to compensation to Producers must be the same inside and outside of the Marketplace, and must comply with all applicable provisions of State law. For example, the commission for a small group product offered on the Small Business Marketplace must be the same as the commission and bonuses for a small group product offered outside of the Marketplace. In addition, if compensation is provided, Health Insurer Applicants must provide the same compensation at all metal levels.



PART 3

Essential Plans

Section 3.1 Participation Requirements

For the purposes of this Invitation, “EP Applicant” or “EP Applicants” means an insurer that is applying to offer the Essential Plan.

A. Licensure and Solvency

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

- Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or
- Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 1, 2016 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2016.

B. Choice of Participation

Applicants that apply to participate in the Essential Plan may also apply to participate in both the Individual Marketplace and 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.

C. 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.

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

D. Applicant-Specific Requirements

1. EP Benefits, Cost Sharing and Individual Premium Contributions

a. Standard EPs. 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 G (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 2017, with the following exceptions: pediatric dental will not be included in the benefit, and the wellness benefit may be substituted for a different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DOH review and approval. All EPs offered shall include only in-network options, and at no time shall EP Applicant impose cost-sharing with respect to preventive health services or items, as defined in 45 CFR 147.130.

(i) Individuals with Incomes greater than 150% and less than or equal to 200% of FPL (“Essential Plan 1” in Attachment G). EP Applicants must provide the Standard EP. Individual enrollees will pay \$20 per individual per month for the Standard EP. 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) Individuals with Incomes greater than 138% and less than or equal to 150% of FPL (“Essential Plan 2” in Attachment G). EP Applicants must provide the Standard EP. Enrollees will not have a monthly premium for the Standard EP 2. EP Applicants must also offer a version of this product for the AI/AN population with no cost sharing for any services.

(iii) Individuals with Incomes greater than 100% and less than or equal to 138% of FPL Not Eligible for federal Medicaid due to Immigration Status (“Essential Plan 3” in Attachment G). EP Applicants must provide the Standard EP. As required under Section 369-gg of the NY State Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of federal poverty, and who previously qualified for NY Medicaid benefits, EP Applicants must 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. Individuals will not pay any monthly premium for EP 3 coverage.

(iv) Individuals with Incomes at or below 100% of FPL Not Eligible for federal Medicaid due to Immigration Status (“Essential Plan 4” in Attachment G). EP Applicants must

provide the Standard EP. As required under Section 369-gg of the NY State Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of federal poverty, and who previously qualified for NY Medicaid benefits, EP Applicants must 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. Individuals will not pay any monthly premium for EP 4 coverage **and will have no cost-sharing on benefits.**

b. Standard EP Plus Adult Vision/Dental. For individuals who qualify for an EP in Sections 3.1(D)(1)(a)(i) and (ii), 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 G (“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 J 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 of the income levels set forth in Section 3.1(D)(1)(a)(i) and (ii), above.

c. Additional Features of EPs. 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 particular 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; and
- (iii) Incentives for the use of preventive services.

d. EP Naming Convention. 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 particular insurer. The EPs must be labeled as follows (see Attachment G):

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

2. Effective Date

Essential Plan Effective dates. Individuals who enroll in the Essential Plan for 2017 will have the following effective dates:

a. individuals who have incomes at or below 138% of the FPL, and do not qualify for federal Medicaid due to immigration status, the effective date of EP coverage will be the first of the month in which they selected an EP health plan. For example, an individual who enrolls in an EP health plan on February 15, 2017, will have coverage in the EP starting February 1, 2017.

b. individuals who have incomes above 138% of the FPL, the effective date shall follow the “15th of the month” rule, which means these individuals who select an EP health plan between the first and the 15th of the month will have coverage that begins the 1st of the next month; and individuals who select a plan between the 16th and the last day of the month, will have coverage on the first day of the second month following the month in which they select an EP health plan.

3. Compensation

a. Capitation Payment. EP Applicants will receive from DOH a monthly capitation payment for each member that has enrolled in its EPs, and will separately collect the applicable premium payment due 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 July 31, 2016. 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 EP in 2017.

b. Premium Payment. EP Applicants must accept premium and cost-sharing payments made from third party entities on behalf of the 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.

c. Rating Regions and Risk Adjustment. Capitation payments will be made to EP Applicants on a county basis and in accordance with the nine rating regions set forth in Attachment H to this Invitation. The DOH will begin risk adjusting the capitation payments for applicable rate groups beginning in 2017.

4. Non-Discrimination.

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

E. Policy Form Filings and Plan Information Submissions

1. **Policy Form Filings.** EP Applicants must use the model policy forms that will be provided by DOH to EP Applicants shortly after the release of this Invitation. Revisions to the model language will be limited to the bracketed sections of the model policy forms. However, EP Applicants can include their logos and numerical contract-identifying information on the policy forms. The policy forms must be submitted to the DOH by July 29, 2016.

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2. **Plan Information.** 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 August 19, 2016.

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PART 4

Requirements Applicable to Qualified Health Plans, Stand-Alone Dental Plans and Essential Plans

For purposes of this Part 4, “Applicant” and “Applicants” shall refer to all Health Insurer Applicants, Stand-Alone Dental Applicants, and EP Applicants. Every section below applies to all Applicants, unless otherwise expressly stated.

Section 4.1 Network Adequacy

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

A. General Standards

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

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

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

B. Specific Standards Applicable to Health Insurer Applicants and EP Applicants

a. Network Composition. The Health Insurer 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 abuse providers, allied health professionals, ancillary providers, Durable Medical Equipment (DME) providers, home health providers, and pharmacies. Specifically, the Health Insurer Applicant’s network must meet the following minimum standards:

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

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

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

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

(v) meet the following time and distance standards:

A. Primary Care Providers

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

B. Other Providers

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

(vi) per 45 CFR 156.1110, Health Insurer 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.

b. Essential Community Providers. Health Insurer Applicant 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 Health Insurer Applicants' and EP Applicants' service area. The Health Insurer 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 clinics, to the extent such providers are available.

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

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

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

D. Sanctioned Providers

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

- a) been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA; or
- b) had his/her licensed suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

E. Method of Review

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

F. Frequency of Review

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

G. Submission of the Network

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

H. Identification and Use of Existing Network for the Essential Plan

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 NYSOH or DOH.

Section 4.2 Administrative Requirements

A. Enrollment and Member Services

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

2. Enrollment Period for the Essential Plan. Enrollment in EPs will be open all year. Eligibility for EP will be recertified every 12 months.

The EP Applicant must provide a 30-day grace period 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. 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.

3. 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:

- a. Transaction files, including maintenance and termination transactions, must be picked up daily.
- b. Acknowledgement transactions (999 transactions) must be sent within 24 hours of picking the files up.
- c. Effectuation transactions must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned Member Identification number.
- d. Terminations and Cancellations must be sent within five (5) business days of the grace period end date.
- e. Error files are sent to insurers on a daily basis; error files must be reviewed and errors corrected on a regular basis, but no less often than once a week.

4. 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.

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

6. 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 Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. In particular, the Applicant and its contractors must:

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

b. 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 enrollee speaks.

c. Pursuant to 45 CFR 155.205(c)(2)(iii) before the beginning of the 2017 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>.)

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

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

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

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

B. Marketing Standards

1. Marketplace Marketing and Outreach. The DOH intends to use a 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 the Marketplace.

2. Applicant Responsibilities

a. 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.

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

c. 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.

d. 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.

e. 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.

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

C. Consumer Network Protections

1. Access to Out-of-Network Providers and Information. Consistent with Part H of Chapter 60 of the Laws of 2014 (“2014 Out-of-Network Bill”), Health Insurer Applicants and EP Applicants must adhere to the following:

a. Health Insurer Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency (ER) bills. In addition, Health Insurer Applicants and EP Applicants must hold its member harmless from liability for non-emergency (non-ER) surprise out-of-network bills: (i) for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center where an in-network provider is unavailable, or a non-participating physician renders services without a member’s knowledge, or unforeseen medical circumstances arise (unless a participating physician is available and the member chose to obtain services from a non-participating physician); or (ii) whenever a participating physician refers a member to an out-of-network provider without the member’s written consent.

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

c. Health Insurer 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.

d. Health Insurer 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.

e. Health Insurer 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 the 2014 Out-of-Network Bill. Health Insurer 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 in 2014 Out-of-Network Bill. Upon request, Health Insurer Applicants and EPs Applicant will provide a URL link to its out-of-network treatment cost calculator.

2. Enhancements to Network Information. In addition to the Network Adequacy requirements set forth in Section II.F., 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 QHPs offered through the Marketplace (the “Marketplace Provider Directory”). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with NYS law, such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer’s network or a change in a physician’s hospital affiliation.

The Applicant must make available to DOH a URL link that provides access to the Applicant’s Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs or EPs. If multiple network configurations are offered by the Health Insurer Applicant, the directories must clearly identify the network(s) for the particular QHP product(s). For example, if one network is

used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non-standard product must be distinct and identifiable to a consumer. The directories must distinguish this network(s) from other networks offered by the Applicant so a consumer using the directory can clearly and easily access the correct directory via the URL link provided to the Marketplace. 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. The Applicant shall implement a system to periodically verify the accuracy of its reported Marketplace provider network(s). Such system may include, but not be limited to, direct outreach to providers listed by the Applicant as participating in Marketplace networks. The Applicant shall provide to the DOH the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of such system are to validate participation by providers and to make sure providers are aware of their participation in Marketplace network(s).

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

D. Prescription Drug Benefit

1. Formulary requirements. Health Insurer 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 minimum, the following must be met:

- a. The link must provide an up-to-date listing of all covered drugs;
- b. Separate links must be provided for each product offered on the Marketplace and clearly identified by product;
- c. 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

Health Insurer Applicants and EP Applicants must comply with NY State Public Health Law Section 4406-c, and Insurance Law Sections 3216(i)(27), 3221(a)(16) and 4303(jj) Formularies will be reviewed to ensure the intent of the state law is being followed. Health Insurer 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.

2. Pharmacy and Therapeutics Committee. The Health Insurer 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).

3. Pharmacy rules. Per 45 C.F.R. § 156.122 (e)(1), The Health Insurer Applicant and EP Applicant 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.

E. Quality and Enrollee Satisfaction

1. Federal Requirements for Quality Improvement Strategy (applies to certain QHPs).

In accordance with federal requirements, Health Insurer Applicants that offered QHP coverage through the Marketplace in 2014 and 2015, and had more than 500 QHP enrollees in a product as of July 1, 2015, must:

- (1) Implement a Quality Improvement Strategy (“QIS”), described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- (2) Implement a QIS that includes at least one of the following:

- i. Activities for improving health outcomes;
 - ii. Activities to prevent hospital readmissions;
 - iii. Activities to improve patient safety and reduce medical errors;
 - iv. Activities for wellness and health promotion; and/or
 - v. activities to reduce health and health care disparities.
- (3) Adhere to guidelines, including the QIS Technical Guidance and User Guide for the 2017 Coverage Year, established by Health and Human Services (HHS), in consultation with experts in health care quality and stakeholders.
- (4) Report on progress implementing the QIS to the New York State of Health on a periodic basis.

Health Insurer Applicants should review the [QIS Technical Guidance and User Guide for the 2017 Coverage Year](#) and the [QIS Implementation Plan and Progress Report form](#) in order to assist with the development and assure compliance of its QIS prior to beginning the initial submission. Applicants must submit the required QIS information as part of their participation proposal for the 2017 coverage year by completing parts A through E of the QIS Implementation Plan and Progress Report form.

The submitted QIS Implementation Plan and Progress Report form will be evaluated by the DOH Office of Quality and Patient Safety, in consultation with the NY State of Health. Based on the results of the QIS evaluation, an overall outcome of “meets” or “does not meet” will be assigned to the QIS submission and will be notified in writing regarding any corrective actions required.

2. DOH Required Quality Improvement Strategy (applies to QHPs not meeting criteria in E.1. above and all EP Applicants)

Health Insurer Applicants that did not offer QHP coverage through Marketplace in 2014 and 2015, or did not have more than 500 enrollees enrolled in a product as of July 1, 2015, and EP Applicants must develop a quality strategy that encompasses all the requirements set forth in 1311(g) of the ACA. This strategy must be implemented, updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

- a. The implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
- b. The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education

and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

- c. The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
- d. The implementation of wellness and health promotion activities;
- e. The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings; and
- f. A description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in children and adults.

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

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

Applicant will be required to report quality measures as well as all other required member-level files. QARR reporting will require all Applicants to have:

- (a) HEDIS Volume 2
- (b) Programming for all required measures (either in-house capability of through a vendor)
- (c) A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to the DOH.

(d) A certified and federally approved CAHPS vendor to administer CAHPS

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

5. Accreditation. The DOH will not require Applicants to be accredited as a condition of participation in 2017.

E. Reporting

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

2. 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.

3. 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 site of service and may also include diagnosis information. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Encounters are

to be submitted on at least a monthly or more frequent basis through the DOH designated vendor in a format and manner to be prescribed by the DOH.

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

F. Certification, Recertification and Decertification Process

1. 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.

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

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

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

SECTION 4.3 Federal and State Laws and Regulations

A. Federal Laws, Regulation and Guidance

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

- The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as the Affordable Care Act (ACA).
- 45 C.F.R. Parts 155 and 156 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
- 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:

- a) Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations
 - N.Y. Insurance Law § 3201, 11 N.Y.C.R.R. 52.1, et. seq. (Approval of policy forms)
 - N.Y. Insurance Law § 3231 (Rating of individual and small group health insurance policies; approval of superintendent)
 - N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance)
 - N.Y. Insurance Law § 4308 (Supervision of Superintendent)

- b) Access to Care
 - N.Y. Public Health Law § 4403(5)(a), 10 N.Y.C.R.R. 98-1.13(b) (Health Maintenance Organizations, network adequacy)
 - N.Y. Public Health Law § 4403(6)(a), 10 N.Y.C.R.R. 98-1.13(a)(Health Maintenance Organizations, access to appropriate providers)
 - N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.13(j)(Health Maintenance Organizations, emergency health services)

- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.6, 10 N.Y.C.R.R. 98-1.12 (Health Maintenance Organizations, quality management program)
- N.Y. Insurance Law § 4325 (Prohibitions)
- N.Y. Insurance Law § 3224-a (Standards for prompt, fair and equitable settlement of claims for health care and payments of health care services)
- 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>)

c) Access to Information

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

C. Medicaid and Child Health Plus Programs

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

Section 4.4 Application Process

A. Issuing Agency

As stated in Part 1, 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 Schedule of Key Events timetable contained on page 2 of this Invitation, via electronic or regular mail at the addresses set forth in paragraph C below. Submission of the Letter of Interest does **not** bind a prospective Applicant to submit an Application. If an Applicant would like to receive e-mail notification of updates/modifications to the Invitation, including the issuance of DOH responses to questions raised regarding the Invitation, the Applicant may include such request in their Letter of Interest. Form Letters of Interest are attached to this Invitation as Attachment E (Health Insurer Applicants and Stand-Alone Dental Applicants) and Attachment I (EP Applicants). Applicants intending to offer both QHPs and EPs must submit both Attachments.

C. Inquiries

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

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

E. Submission of the Application

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

a. For Health Insurer Applicants and Stand-Alone Dental Plan Applicants:

- (i) Participation Proposal
- (ii) Submission of Policy Form and Rates to DFS for QHP Applicants
- (iii) Submission of Policy Forms and SERFF Binders to DOH for EP Applicants
- (iv) Submission of Provider Network Information
- (v) QIS Implementation Plan and Progress Report Form or Quality Strategy (Health Insurer Applicants Only)

b. For EP Applicants:

- (i) Participation Proposal
- (ii) Submission of Policy Form
- (iii) Submission of EP Information Templates to DOH
- (iv) Submission of Provider Network Information
- (v) Quality Strategy

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

2. Instructions:

a. Participation Proposals. Applicants shall submit two (2) original, signed copies of the Participation Proposal by mail or hand delivery to the address listed above in Section 4.4 (c). Electronic submissions are also required and can be sent to the email address noted in Section 4.4 (c). Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with capacity and legal authority to bind the Applicant to the authenticity of the information provided. The Participation Proposal Form to be completed and submitted by Applicants is attached to this Invitation as Attachment E (Health Insurer Applicants and Stand-Alone Dental Applicants) and Attachment I (EP Applicants). Applicants applying to offer both QHPs and EPs must complete both Attachments.

b. Submission of Policy Form and Rates to DFS for QHP Applicants. As set forth in Section 2.2, 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 Policy Form and Plan Information to DOH EP Applicants. As set forth in Section 3.1 (E), EP Applicants will be required to submit EP Policy Forms to DOH. EP Applicants will also be required to submit Plan Information via DOH required templates. Policy Forms and Plan Information must be sent directly to the Applicant's assigned Plan Manager by July 29, 2016.

d. Submission of Provider Network Information. As set forth in Section 4.1(G), Applicants shall submit their network through the Health Commerce System (HCS) in accordance with the Provider Network Submission Instructions contained in Attachment J to this Invitation.

e. Submission of Quality Improvement Strategy or Quality Strategy. As set forth in section 4.2(E)(1), Health Insurer and EP Applicants shall submit their QIS or Quality Strategy as part of the Participation Proposal.

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

F. Public Information

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

Section 4.5 Agreement with DOH

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