QUESTIONS AND ANSWERS ON THE 2017 INVITATION
May 2, 2016

NOTE: The following changes were made to the attachments or addendum that Applicants submit to the NY State of Health as part of the Application:

- **Attachment F: year was changed to 2017**
- **Addendum F.2 – Changed title to ADDENDUM F.2**
- **Addendum F.3 – Changed title to ADDENDUM F.3**

QHP OFFERINGS

QUESTION: The Invitation seemed to indicate plans with OON benefits do not count towards the non-standard plan maximum of 3 plans. Does this mean we could offer more than 3 non-standard plans, so long as they all included OON benefits?

ANSWER: This is a limited exception to the 3 non-standard plan rule that is intended to provide the flexibility needed to add products with OON benefits to the Marketplace. It applies only if the insurer is offering a new OON product in 2017 outside the Marketplace which must also be offered on Marketplace under the invitation rules at the platinum and silver levels. This new OON product would not count toward the 3 non-standard product maximum. (See Section 2.1.D.1.h.iii.)

QUESTION: 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. Can this be embedded within the standard QHP plan?

ANSWER: No. The standard plans offered on the Marketplace must include New York's Essential Health Benefits as the benefit package for these products. Per 45 CFR 156.115(d) "An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB." Therefore, adult dental services cannot be included in the standard plans.

QUESTION: Regarding the 3 PCP Standard products, would we be able to offer those in lieu of the original Standard products, or do we have to offer the original Standard products no matter what but could additionally offer the 3 PCP standards on top of them?

ANSWER: The "original" standard products must be offered by all Health Insurer Applicants and the optional Standard with 3 PCP Visits products can be offered in addition to the Standard products.

QUESTION: In regards to the new Standard plans with the 3 PCP visits before the deductible apply. There are many services which require the PCP Copay; however, Note 3 indicates that the 3 visits in front of the Deductible are ONLY for services provided by a provider of family medicine, internal medicine, pediatric medicine, obstetrics/gynecology or outpatient mental health. Please confirm that for services identified as applying the PCP copay received at a provider other than those listed would take the Deductible + PCP Copay. Examples (Not an inclusive list): Chemotherapy, Radiation Therapy, Assistive Communication Devices for Autism Spectrum Disorder, etc.

ANSWER: The benefit applies to visits to a primary care provider, as defined in Attachment C, and does not apply to any visit to a provider or for any service where the copay is at the PCP copay amount.

QUESTION: Are we required to offer the following plans for each CSR version similar to what we do on the base versions: Child Only (for Standard Plans) and Native American Limited and/or Zero.

ANSWER: The Child Only plans are separate products and a version must be offered at every metal level. The Cost Share Variations must be included for each Child Only product offered. This includes the two Cost Share Variations for the American Indian/Alaska Native population for the Bronze, Silver, Gold and Platinum plans and the three additional silver Cost Share Variations.

QUESTION: The Invitation indicates that Child Only Plans are required for Standard Plans offered ON the Marketplace. Does that mean that we are not required to offer Child Only Plans OFF of the Marketplace?

ANSWER: The Invitation sets forth the requirements for on marketplace offerings. However, under federal guaranteed availability rules, all products offered on the Marketplace must also be offered outside of the Marketplace.

ESSENTIAL PLAN OFFERINGS

QUESTION: The Invitation mentions that EP Applicants "must apply to participate in their entire service area as approved by Department of Financial Services (DFS) or DOH" (page 26). If

related plans have more than one QHP service area, and a Medicaid Managed Care service area, would participating in the EP in the plan's Medicaid service area fulfill the requirement quoted above?

ANSWER: Yes. For the Essential Plan, Applicants have the option of choosing to use either their QHP service area or the Medicaid service area. If they choose the QHP service area, they must offer their EP products throughout all of the QHP service area. If they choose the Medicaid service area, they would need to offer their EP products throughout all of their Medicaid service area.

QUESTION: If we choose to participate with EP after rates are released, when would we need to execute the EP contract with NYS?

ANSWER: All new EP contracts must be executed prior to the beginning of the 2017 open enrollment on November 1, 2016.

QUESTION: EP plans require "incentives for the use of preventive services". Can NYS elaborate on this?

ANSWER: Incentives might include, but not be limited to, initiatives such as rewards for completing a health goal, finishing all prenatal visits, participating in a smoking cessation session, attending initial orientation sessions upon enrollment, and timely completion of immunization or other health related programs.

QUESTION: Can you please let us know if the state will be updating the Essential Plan model contract language, and if so when we can expect the updates to be completed.

ANSWER: The 2017 model language for the Essential Plan will be released shortly. The Essential Plan subscriber contracts are not due to the NY State of Health until July 29.

STAND ALONE DENTAL PLAN OFFERINGS:

QUESTION: Are Standalone Dental contracts required to be posted on our website for open enrollment? The Invitation only mentions Health Insurance Applicants

ANSWER: No

QUESTION: Does the Treatment Cost Calculator provision apply to only Health Insurance Applicants? Or does it also apply to Standalone Dental Applicants?

ANSWER: It applies to all applicants, QHP, SADP and EP.

QUESTION: In regards to each carrier's own marketing materials, do we have to have the name extension e.g. "ST OON Pediatric Dental Dep 19"?

ANSWER: No. However, the goal of the naming convention is to help consumers identify and link information about products when shopping. Thus, as a minimum, the product name should be consistent on both the NY State of Health site and in the plan's marketing materials. For example, if the plan name on the NY State of Health site is "ABC Plan, ST, OON, Pediatric Dental, Dep 19", at a minimum the marketing material should be marketed as " ABC Plan".

NETWORK SUBMISSIONS:

QUESTION: We are looking for clarification on section 4.1, F – Frequency of Review. This section states that "the DOH will review adequacy of an Applicant's network upon submission of the application and on a quarterly basis thereafter". So, is the expectation that we will be submitting our network with the application in addition to our quarterly submissions? Or, would the 2Q submission due on 5/25 be acceptable as part of our application?

ANSWER: Applicants do not need to submit their network with the application. The standard quarterly submissions will be used to evaluate network adequacy.

QUALITY REQUIREMENTS:

QUESTION: In the invitation, it lists Section 4.2(E)(1) that a QIS form (from CMS) needs to be completed and submitted with the participation proposal but then further into the invitation, it seems like that form is just for QHP. Can you clarify for me?

ANSWER: As stated in Section 4.2.E.1, 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 submit the QIS and follow the instructions in this section. All other Health Insurer and Essential Plan Applicants must follow the requirements in Section 4.2.E.2.

QUESTION: Our plan has QHPs offered in 2014 and 2015 that had more than 500 enrollees as of 7/1/15. For these plans, as instructed, will complete a QIS based on the federal requirements. However, for our other QHPs where we offered coverage in 2014 and 2015 that did not have 500 enrollees as of 7/1/15, are we required for those plans without the 500 enrollees to complete a separate quality strategy as described in the paragraph below or would we incorporate the QHPs without 500 enrollees in the QIS already being submitted based on the federal guidelines?

ANSWER: As stated in Section 4.2.E.1, 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 submit the QIS. The

requirement would apply to this applicant, and to all products, as it offered QHPs in 2014 and 2015 and had more than 500 enrollees in at least one of its QHPs.

QUESTION: Could you please confirm what office of the DOH we would submit the Quality Strategy, if applicable?

ANSWER: As indicated in Section 4.2.E.1, Applicants must submit the required QIS information as part of their participation proposal for the 2017 coverage year which is due on May 20, 2016. Submission instructions are included in the Invitation. NYSOH will distribute information within DOH for review as needed.

QUESTION: Quality section on E.1, starting on p. 43 - What is the due date for the initial submission of the QIS information for QHP?

ANSWER: Per Section 4.E.1, it is due with the participation proposal on May 20th.

QUESTION: Quality section on E.1, starting on p. 43 - Will we need to submit the QIS information utilizing the federal form?

ANSWER: Yes. Please see Section 4.E.1, of the Invitation.

QUESTION: Can a plan submit the QIS reporting for their Essential Plans instead of the general Quality Strategy required of Essential Plans?

ANSWER: No. Essential Plan Applicants must submit the Quality Strategy as indicated in Section 4.E.1 of the Invitation.

QUESTION: The Invitation did not provide a format for submission for the EP QIS submission, is there a desired format?

ANSWER: Per Section 4.E.1, "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."

QUESTION: I am writing to ask for a clarification on a requirement listed under the prescription drug formulary section (section 4.2D.1). 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: 2017 NYSOH Invitation to Participate 42; 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. Does the item c require a separate link to display the cost share

information for prospective members? If so, where will this URL be present to consumers during shopping experience? Will this link be provided on the NYSOH marketplace portal?

ANSWER: This federal requirement states that Applicants must make available for each separate product offered, a link to a list of all covered drugs with applicable cost sharing amounts. The link will be entered on the Prescription Drug template in SERFF in the "Formulary URL" field. It will appear on the Plan Detail page of the NY State of Health website.

ADMINISTRATIVE REQUIREMENTS:

QUESTION: When are URLs required to be LIVE for testing?

ANSWER: Issuers participating in the Marketplace for the first time or participating issuers with new URLs, must send screenshots of their URLs that indicate required functionality. URLs must be live for consumers on the first day of open enrollment which is November 1, 2016. Existing issuers must already have functioning URLs.

QUESTION: When are URLs required to be LIVE for consumers to start window shopping on the NY site?

ANSWER: URLs must be live for consumers on the first day of open enrollment which is November 1, 2016.

QUESTION: Section 4.2, paragraph E of the Invitation states: "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." Please explain what "in a manner consistent with Part 156" means. Specifically, please indicate the section of Part 156 the Invitation is referring to.

ANSWER: Several sections of Part 156 of the federal rules set forth reporting requirements for QHPs. Applicants should be prepared to submit any and all reports required by Part 156 upon request by DOH. Examples within Part 156 include sections 705, 715, 1110 and 1125.

NY STATE OF HEALTH WEBSITE:

QUESTION: Is the state of NY changing their site design for 2017? Or, will it remain as it is today?

ANSWER: The NY State of Health is not implementing a major redesign of the site for 2017.

ISSUER DATA SUBMISSION REQUIREMENTS:

QUESTION: What are the specific dates of the site testing window?

ANSWER: Issuer review of their plan data will begin September 12 and must be completed by September 23, 2016.

QUESTION: The FFM is no longer using the SERFF admin template. Do NY State of Health plans still need to submit it?

ANSWER: Yes. Per the DFS QHP Binder Filing Instructions, plans will still need to submit the admin template as part of the SERFF Binder filing as a supporting document. Plan Managers will provide the plans with the Admin Template for 2017.