2025 NYSOH QHP Rider Q&A

The following initiatives are pending federal approval, DOH will expand eligibility for existing cost sharing reduction (CSR) plans to individuals with higher incomes in order to increase the affordability of QHP coverage starting January 1, 2025.

Again, starting January 1, 2025, DOH will also reduce cost-sharing for non-hospital-based preventive diabetes-related services, supplies and prescription drugs, for all QHP consumers in individual direct payment coverage, (not small group coverage)in all metal levels, except catastrophic. We will also eliminate cost-sharing for certain services for pregnant and postpartum enrollees in Qualified Health Plans (QHPs), including (where applicable) deductibles, co-insurance, and co-payments for most services.

Q1 - The rider title "Cost-Sharing Reimbursement for Certain Covered Services" may be causing some confusion as it would seem to indicate the contract holder is being reimbursed for something.

Response - We have changed the Rider title to "Payment of Cost-Sharing for Certain Covered Services."

Q2 - How will providers be made aware they should not collect copayments/deductibles?

Response - In our conversations with issuers about these proposals they have said they have existing processes in place which can be customized and allows them to communicate variations in cost sharing to providers in their networks. We also recommend working directly with providers via newsletters, training/webinars and provider manual and portal updates. NYSOH will also disseminate information about these changes to providers through the MRT Listserv email and provider associations.

Q3 - How does NYSOH intend to implement funding mechanisms to satisfy the reimbursement of the eliminated cost-sharing?

Response – For the proposal to expand eligibility 87% AV and 73% AV silver plans to higher income consumers, NYSOH intends to implement the Cost sharing reduction reimbursement using the previously established CMS process. It will include advanced monthly payments (pm/pm), as well as a reconciliation process. Additional guidance forthcoming as the process develops. Since the population of consumers impacted by the higher AV plans will overlap with the Diabetes/Maternal health proposals, and these populations are also estimated to be relatively small, the state intends to reconcile payments for that population after the plan year ends.

https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20U%20-%20Cost%20Sharing%20Reduction%20Initiatives%202025.pdf

Q4 - Please confirm that the full scope of services excluded from cost-sharing will be eligible for reimbursement, without regard to whether the services relate to the pregnancy. For example, if a pregnant woman sprains an ankle, breaks a bone, or seeks treatment for a bad case of poison ivy, those office visits and any related services would be excluded from any cost-sharing.

Response – That is correct. The intent of the policy is to cover all services for pregnant and postpartum individuals except those specifically listed in the Rider as not covered. The cost-sharing waiver is not limited to services related to the maternity care. The approach was also informed by issuer input.

Q5 - The model language references that the waiver of cost-sharing is available to the extent of available funds. Please provide some context regarding whether plans should anticipate a shortfall and how the Department will ensure that health plans do not extend cost-sharing waivers that exceed the value of available funds.

Response - The reference to the availability of funding is included to provide notice to both the plan and the insured that in the unlikely case the federal waiver funding is no longer available the cost-sharing would no longer be waived, and the insured would be responsible for the cost-sharing included in the schedule of benefits. The State would provide notice well in advance of the plan year if there were insufficient funds to cover the policy changes.

Q6 - Drug coverage under the maternity care provisions will be difficult to manage since there is nothing communicated to a network pharmacy on a prescription about the pregnancy status for a member. Similarly, there are many services and drugs that may be ordered by a provider during the 12-month coverage period that are not specific to pregnancy (e.g., office visits with a mental health provider and/or drugs prescribed to treat post-partum depression that are also used to treat other types of depression).

Response – This implementation is similar to the Medicaid program before the prescription drug carve out. Claims should include a pregnancy indicator so pharmacies are aware that there should be no cost sharing. In addition, insurers are expected to notify their members that cost sharing is waived. The cost-sharing rider is for all prescription drugs obtained by the insured during their pregnancy and for 12 months after delivery.

Q7 - Plans also noted that implementing the benefits for "the 12 months following delivery" may require manual intervention to ensure plans do not over or under pay cost shares because the date is not configurable. It depends on the delivery date and the receipt of the claim. This is highly likely to require some kind of manual intervention to ensure accuracy following delivery. Additionally, If the services are not strictly related to maternity diagnosis it becomes more problematic since plans do not always know when a member is pregnant, and it would be difficult to define exactly what timeframe would need to be used. Plans would have the same dependency on the delivery claim to determine when exactly the member became pregnant, which also highly likely to be manual.

Response – In order to promote better maternal health, the State expects issuers to be able to provide their members adequate support and key information to promote healthy pregnancy and postpartum care.

NYSOH is looking into what can be added to the 834 to assist Issuers with this process, to the extent NYSOH may have information the issuer does not.

Q8 - [This rider amends the benefits of Your [Contract; Policy]. Due to federal waiver funding, You will not be responsible for Your [In-Network] Cost-Sharing for certain covered diabetic services and maternity care, while the funding is available. For the Covered Services listed below, the waiver funding will apply towards Your [[In-Network] Deductible] and [In-Network] Out-of-Pocket Limit.
{Drafting Note: Use this paragraph for coverage that is not a high deductible health plan. Insert the bracketed language for coverage with a deductible.}

I assume this is bracketed for Plans that don't have a network. Are there any on-exchange plans without a network?

Response - The bracketed reference to "In-Network" in the first paragraph is for inclusion when there is out-of-network coverage. We have added a drafting note to clarify.

Q9 - Diabetic self-management education services section of Rider - Isn't this info already in the contract? Would it be better to cross reference it?

Response - For clarity we are keeping the list of what specifically is covered in the diabetic proposal.

Q10 - Document circulated by NYSOH only included the following labs: "Lipid panel test, Hemoglobin A1C test, Microalbumin urine test, Basic metabolic panel, Liver function test." Is this the complete list?

Response - Yes. The lab services for which copays are waived for the diabetes initiative are limited to: Lipid panel test, Hemoglobin A1C test, Microalbumin urine test, Basic metabolic panel, Liver function test.. Please see Attachment U of the 2025 plan invitation.
https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20U%20-%20Cost%20Sharing%20Reduction%20Initiatives%202025.pdf

Q11 – Please explain the listing of equipment and related supplies for the treatment of diabetes found in the Rider language.

Response - This listing is comprised of EHB and the diabetic supply list in Ins. Law Section 4303(u) or in 10 NYCRR 60-3.1.

Q12 – Why is Insulin on the list of equipment and related supplies, as there is no cost share to start with?

Response -We have removed Insulin from the list and added language clarifying it is already covered in full under the Contract/Policy.

Q13 - Blood pressure monitors prescribed by Your Provider for use during Your pregnancy or within 12 months of delivery are not subject to Preauthorization - where is this coming from?

Response – The intent of this change is to alleviate barriers for individuals in need of key supplies for high-risk patients during prenatal and postpartum care. Providers have expressed concerns around wait times for approvals of prior authorizations for automatic blood pressure monitors, which are generally needed immediately. The policy change will allow monitoring to begin immediately.

Q14 - We strongly recommend not crediting member deductible or out of pocket max accumulators for dollar amounts that were not actually paid by the member. Crediting accumulators with forgone member liability would be difficult to impossible to configure and could further confuse members and/or providers.

Response - For crediting the cost-sharing to the insured's deductible and out-of-pocket limit, Insurance Law § 4303(tt) requires that for prescription drugs, financial assistance counts towards both the deductible and the out-of-pocket limit. Additionally, federal payment notices also permit the application of financial assistance towards deductibles and out-of-pocket limits. To avoid consumer confusion, we have applied the requirement uniformly. For HDHPs, the Insurance Law already includes the requirement to satisfy the "minimum deductible under 26 USC 223." The language included in the Rider is consistent with the couponing provision included in the Prescription Drug Coverage section of the model language.

Q15 - This configuration may not be achievable if the intention is to impose a lower deductible amount that is limited to the Internal Revenue Code minimum as opposed to imposing the plan deductible upon the member. For instance, if a plan is an HDHP and has a $3K single/$6K family deductible but the IRS minimum deductible amount for an HDHP is $1,650/$3,300 for 2025, is the intention to only enforce the deductible upon the member for the identified diabetic services in paragraph A or identified maternity services within paragraph B until the $1,650/$3,300 deductible is satisfied and then to have the member liability waiver apply to the remainder of the deductible (meaning from $1,650/$3,300 up to the $3K/$6K plan deductible amount)? I think it would be easier for plans to configure and for members to understand if the rule was simplified to state that the entire plan deductible will continue to be required of the member within HDHPs as opposed to trying to embed the IRC minimum deductible amounts within a larger plan deductible.

Response - For crediting the cost-sharing to the insured's deductible and out-of-pocket limit, Insurance Law § 4303(tt) requires that for prescription drugs, financial assistance counts towards both the deductible and the out-of-pocket limit. Additionally, federal payment notices permit the application of financial assistance towards deductibles and out-of-pocket limits. To avoid consumer confusion, we have applied the requirement uniformly so that co-pay subsidies will apply to all services, supplies and drugs. For HDHPs, the Insurance Law already includes the requirement to satisfy the "minimum deductible under 26 USC 223." The language included in the Rider is consistent with the couponing provision included in the Prescription Drug Coverage section of the model language.