

**Invitation to Participate
in the
New York Health Benefit Exchange**

January 31, 2013

NEW YORK STATE DEPARTMENT OF HEALTH

Office of the New York Health Benefit Exchange

Schedule of Key Events

Invitation Released.....	January 31, 2013
Letter of Interest Due.....	February 15, 2013
Written Questions re: Invitation Due	March 1, 2013
Response to Written Questions re: Invitation	March 15, 2013
Participation Form Submission Due Date.....	April 5, 2013
Provider Network Submission Date.....	April 12, 2013
Submission of Rates and Forms.....	April 15, 2013
Anticipated Notification of Certification.....	July 15, 2013

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Section I. Introduction and Overview

A. Issuing Office and Purpose

This Invitation is issued by the New York State Department of Health (DOH) to invite insurers that are licensed or certified in New York State to apply for certain health insurance plans to be qualified as eligible for certification as Qualified Health Plans (QHPs) to be offered through the New York Health Benefit Exchange (Exchange). Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and individual health plans meet all federal minimum participation standards and other requirements necessary for certification as a QHP. After Applicants and individual plans have been (i) reviewed and found to satisfy all minimum standards and requirements, and (ii) an Agreement is signed with the DOH, such health plans will be certified as QHPs available through the Exchange. This will be the only opportunity for insurers to apply for certification to participate in calendar years 2014 and 2015, unless the DOH, in its sole discretion, determines that it is in the best interest of consumers for the DOH to invite new applicants to participate in calendar year 2015 to ensure adequate choice for consumers and small businesses, to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs, and for other reasons determined by the DOH.

B. Background

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 Exchange within the DOH. On December 14, 2012, the United States Department of Health and Human Services (HHS) granted New York [conditional approval](#) to operate a state based Exchange.

Starting on October 1, 2013, the Exchange will begin accepting applications for health insurance coverage from individuals and small employer groups for coverage effective on January 1, 2014.

The implementation of the Exchange will allow individuals and small businesses to shop and purchase health insurance coverage through the Exchange; will allow individuals to receive federal premium tax credits and cost sharing reduction benefits; enable small business to qualify for federal tax credits; and result in lower premiums for individuals and small businesses. Based on simulation modeling conducted by the Urban Institute, over 1 million people will enroll in health insurance coverage through the Exchange when it is fully implemented, including 615,000 individuals who purchase coverage directly and 450,000 employees of small businesses who purchase coverage through the Exchange. Additionally, the

value of the federal premium tax credits and cost sharing reduction benefits for individuals are estimated to be \$2.4 billion per year and the federal tax credits for small business are valued at an estimated \$200 million per year. For more information on the anticipated impact of the Exchange, see the Urban Institute's reports found on the Exchange information [web site](#).

New York's Child Health Plus program will continue to cover eligible children in families with incomes up to 400% of the federal poverty level. Effective on January 1, 2014, New York intends to expand Medicaid to cover adults up to 138% of the Federal Poverty Level.

Section II. Participation Requirements

For purposes of this Invitation, references to "Applicant" or "Applicants" shall mean all eligible entities that, through this Invitation, may apply for QHP Certification, including health insurers, stand-alone dental carriers, and Consumer Operated and Oriented Plans (CO-OPs); references to "Health Insurer Applicants" means only health insurers applicants that offer medical benefit coverage, including CO-OPs; and references to "Stand-Alone Dental Applicants" refers to only dental carriers that are applying to offer stand-alone dental coverage. Unless expressly stated otherwise, all requirements set forth in this Invitation apply to all Applicants.

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 October 1, 2013 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by October 1, 2013.

B. Choice of Individual Exchange or SHOP Exchange

Applicants may apply to participate in both the Individual Exchange and Small Business Health Options Program (SHOP) Exchange, 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. 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 Exchange. 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 specified by the DOH for calendar years 2014 and 2015, and delineated on Attachment A. The Essential Health Benefits must be included in the calculation of the actuarial values of the products.

b. Metal Levels. Except for the impact of cost-sharing reduction subsidies, 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 HHS AV calculator found at <http://www.cciio.cms.gov/resources/regulations/index.html#hie>:

Bronze :	60% AV
Silver:	70% AV
Gold:	80% AV
Platinum:	90% AV

A de minimus variation of +/- 2% AV is permissible.

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

d. 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 II.D.1.b., above, in the Individual Exchange. 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 II.D.1.c., above, offered at the child-only rate outlined in Section III.C.6.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.

e. 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 Exchange. The standard catastrophic plan can be found in Attachment B. As part of the Participation Proposal, which is attached as Attachment E, the DOH will require Health Insurer Applicant's affirmative intent 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.

f. Nonstandard Products. Health Insurer Applicants may opt to offer up to three (3) "non-standard" products at any metal level, and in all or any part of its service area. In proposing non-standard products, Health Insurer Applicants may either (i) substitute benefits within certain categories listed below, (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including higher visit limitations; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance, as well as DFS review.

The categories of benefits that may be substituted are:

- A. Preventive/Wellness/Chronic Disease Management
- B. Rehabilitative and Habilitative

If affiliated entities of the Health Insurer Applicant apply to participate in the Exchange, the limitation of three (3) non-standard products per metal level in each Exchange will apply to the Health Insurer Applicant and its affiliates collectively. Child-only products, catastrophic products and required out-of-network products will not be counted towards the three (3) non-standard product maximum.

g. 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.

h. 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 must propose to offer pediatric dental benefits as a separately priced benefit for each standard and non-standard product proposed for the Exchange. In the event the DOH determines that there is adequate pediatric stand-alone coverage available in a particular county by a stand-alone dental carrier, the Health Insurer Applicant offering a QHP product in that county will have the option of including the pediatric dental benefit or deferring the offering to such stand-alone dental carrier. The DOH will inform the Health Insurer Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the pediatric dental benefit must be made by the Health Insurer Applicant prior to receiving certification.

Health Insurer Applicants will also have the option of offering adult dental, family dental, and/or supplemental pediatric dental benefits as an additional benefit per Section II.D.2.f., 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.

i. Out-of-Network Offerings. To ensure that the consumers purchasing coverage have the same array of choices in the Exchange that they will have outside the Exchange, for 2014, a Health Insurer Applicant that offers an out-of-network product outside the Exchange in a county, must also offer an out-of-network product through the Exchange in that same county. 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 required to offer an out-of-network product must offer the out-of-network product on the Exchange at the silver and platinum levels. This requirement applies to both the Individual Exchange and the SHOP Exchange.

j. New Products. All initial products offered through the QHP certification process will have effective dates of January 1, 2014 in the Individual Exchange and SHOP Exchange. Qualified Employers will be able to purchase coverage through SHOP 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 2015, must be established and submitted to DOH and DFS through the 2014 recertification process.

k. 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 Exchange, provided that they have entered into an agreement with the Exchange. Such agreements will require Producers to be licensed and in good standing with the DFS.

In addition, Producers seeking to assist small businesses and/or individuals will be required to complete an Exchange-approved training program and pass a test to certify completion of the program. 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 Exchange and must have required privacy and security measures in place.

All of Health Insurer Applicants' compensation arrangements with Producers must be the same inside and outside of the Exchange, and must comply with all applicable provisions of State law. For example, the commission for a small group product offered on the SHOP Exchange must be the same as the commission for a small group product offered outside of the Exchange. In addition, for the sale of Exchange products, the Applicant must contract with Producers that have successfully completed the required training program and have entered into agreements with the Exchange.

I. Navigators/In-Person Assistors. Consistent with the federal law, the DOH provides grants to qualified organizations to act as Navigators and In-Person Assistors for the Exchange. Navigators and In-Person Assistors will provide in-person, linguistically and culturally appropriate assistance to those applying for coverage through the Individual Exchange and/or SHOP Exchange. Health Insurer Applicants must cooperate with Navigators and In-Person Assistors that have contracts with the Exchange.

2. Stand-Alone Dental Applicants

Stand-Alone Dental Applicants shall offer products through the Exchange 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 outlined in Attachment A. The Standard product can be offered at either a high level (85% AV) or a low level (75% AV), but not both. This requirement applies to both the Individual Exchange and the SHOP Exchange.

c. Non-Standard products. The Stand-alone Dental Applicant may opt to offer up to two (2) non-standard products. The non-standard product may be adult dental, family dental or a second pediatric dental product offering. This requirement applies to both the Individual Exchange and the SHOP Exchange.

d. Other Applicable Provisions. Stand-Alone Dental Applicants must meet the requirements set forth in Section II.D.1.k. and II.D.1.l., above.

3. Consumer Operated and Oriented Plans (CO-OPs)

The DOH is partnering with the Center for Consumer Information and Insurance Oversight (CCIIO) with respect to participation of CO-OPs. Applicants designated as CO-OPs must adhere to the standards and processes set forth in this Invitation. Once a CO-OP has met all the standards set forth in this Invitation, DOH will make a recommendation to CCIIO to certify the CO-OP. CCIIO will determine whether to adhere to DOH's recommendation and notify the CO-OP and DOH of its decision. Once the CO-OP is certified, federal regulations require it to be deemed certified for two (2) years, with recertification determined by CCIIO in partnership with the DOH every two years. The CO-OP entity will be subject to the DOH decertification criteria, however, and any recommendation of decertification will be made to CCIIO, which will make the final decertification decision and communicate this to the CO-OP and DOH.

4. Small Business Health Options Program (SHOP) Exchange

In addition to the above participation requirements, Applicants seeking to participate in the SHOP exchange agree to adhere to the following requirements:

a. Definition of a Small Group. For calendar year 2014 and 2015, the definition of a small group shall mean a group of fifty (50) or fewer employees.

b. Employer Choice. Through the SHOP Exchange, Qualified Employers will have flexibility of choice when determining the products to offer their employees, including the following options:

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

The SHOP will also permit the ability 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 Standards. Consistent with State law and regulation, in order to enroll in non-HMO options offered through the Exchange, at least 50% of a Qualified Employer’s employees must have health insurance coverage. Employees that enroll in any product count towards meeting this participation requirement. If the employer still cannot meet the 50% participation requirement, the employer will be re-directed towards HMO options only.

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

5. 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 or health insurer) on behalf of individuals. HRAs are accounts held solely by an employer on behalf of an employee. Both types of accounts require the individual/employee to be enrolled in a high-deductible health plan that meets IRS out-of-pocket limits. For more information, visit <http://www.irs.gov/uac/Publication-969,-Health-Savings-Accounts-and-Other-Tax-Favored-Health-Plans>.

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.

6. 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.

E. Quality and Enrollee Satisfaction

The DOH monitoring of the quality of care delivered by entities whose products are certified as QHPs (Exchange Participants), will be ongoing and determined through use of a variety of quality, utilization and satisfaction metrics that have been validated, have clinical relevance to the populations served, and are widely in use by health plans serving other populations in New York State. Measuring performance across a wide range of quality metrics will assure Exchange

members across the age spectrum and with various health conditions are included in this assessment. This process will also help to establish the DOH's active agenda for improvement and re-measurement. Public reporting of Exchange Participant performance will also be a central feature of the DOH plan for quality oversight.

Outlined below are the DOH expectations related to quality of care and enrollee satisfaction for which the Applicant must adhere:

1. Develop and Maintain a Quality Strategy

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) improving health outcomes through the implementation of 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 patient safety and 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.

2. Quality Assurance Reporting Requirements

All 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 (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 Exchange Participant quality rankings that will appear on the Exchange 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 Exchange Participants will also be posted on the DOH website in eQARR and related publications.

The QARR technical specifications are typically released during the fall season of the measurement year, with reporting of QARR data due on or about the following June 15. The current QARR specifications for reporting year 2013 are posted on the DOH webpage and can be viewed at the following link:

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2013/docs/qarr_specifications_manual_2013.

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

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

QARR submissions with respect to Exchange enrollment is anticipated to begin on or around June 2015 for calendar year 2014.

3. Consumer Assessment of Health Care Providers and Systems (CAHPS)

All Exchange Participants will also be required to annually survey a sample of their Exchange 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 Exchange Participants may be required to 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 demographic or clinical detail. 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.

The initial CAHPS survey for Exchange Participants is anticipated to be scheduled on or around fall of 2014.

4. Quality Improvement Initiatives

The DOH will require Exchange Participants to have the infrastructure in place (or the ability to contract for such services) which allows them to implement their Quality Strategy and related improvement activities as well as participate in a variety of DOH sponsored quality improvement work. This could include administration of member's surveys, offering member education/outreach or incentive programs, offering physician training and/or incentive programs, supporting systematic changes at the practice level and practice level assessments among other things. The Exchange Participants will also be welcome to participate in DOH sponsored statewide improvement initiatives that target issues of importance such as readmissions, coordinated care for members with chronic disease, and other topics.

For Exchange Participants with performance that falls outside normal ranges for quality or satisfaction performance, a barrier analysis and an improvement plan will need to be developed and operationalized once approved by the designated DOH office.

5. Accreditation

For calendar years 2014 and 2015, the DOH will not require Applicants to be accredited as a condition of participation. This requirement will be reviewed for calendar year 2016.

F. 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:

1. 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.

2. Specific Standards Applicable to Health Insurer Applicants

a. Network Composition. The Health Insurer Applicant's network must contain all of the provider types necessary to furnish the Exchange 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:

- (i) Each county network must include a hospital;
- (ii) Each county network must include the core provider types and ratios established through the Provider Network Data System (PNDS);
- (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

b. Essential Community Providers. Health Insurer Applicant is 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 the Health Insurer Applicant's service area. The Health Insurer 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 is required to include individual providers, outpatient 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 abuse services. Facilities providing inpatient alcohol and substance abuse services must be capable of providing detoxification and rehabilitation services.

3. 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).

4. Sanctioned Providers

The Applicant shall not include in its network any provider who

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

5. 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.

6. 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 will make available to the DOH a URL link that provides an up-to-date online directory of providers. The DOH will make such link publicly available on the Exchange web site.

7. 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 F. 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.

G. Administrative Requirements

1. Enrollment and Member Services

a. Enrollment Periods. The Applicant 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 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.

b. Enrollment Transactions. In addition, the Applicant must be able to obtain 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.

c. Member Services General Functions. The Applicant must agree to operate a Member Services Department during regular business hours, which must be accessible to Exchange 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.

d. 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 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 must:

(i) 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.

(ii) 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, provide taglines in common non-English languages indicating the availability of written translation of materials in any language the prospective or current enrollee speaks.

(iii) 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.

(iv) Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include Braille or audio tapes 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 Exchange that provides greater protections than the standards set forth above, Applicant shall adhere to such HHS standards.

e. Treatment Cost-Calculators for Participating Providers. Prior to January 1, 2014, the 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.

f. Treatment Cost-Calculators for Out-of-Network Providers. The Applicant will provide the DOH with information on cost-sharing and payments with respect to any out-of-network coverage pursuant to 45 CFR §156.220(a)(7). The Applicant will provide a URL link to its out-of-network treatment cost calculator that will be made available during the open enrollment periods in the event the DOH does not maintain an out-of-network calculator on the Exchange web site.

2. Marketing Standards

a. Exchange Marketing and Outreach. The DOH is implementing a multi-faceted marketing and outreach campaign focused on connecting New Yorkers with quality, affordable health insurance through its user-friendly website. The DOH will engage in targeted outreach to consumers through navigators, consumer advocates, small businesses, brokers, Regional Advisory Committee members and other stakeholders to promote the use of the Exchange. The DOH will also initiate an advertising campaign designed to publicize the access to quality, affordable health insurance.

b. Applicant Responsibilities

1. Applicant may conduct advertising campaigns, including television, radio, 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.

2. The Applicant shall use the logo and branding designated by the DOH in referring to Exchange products in marketing and outreach activities including any printed materials. Such materials must prominently display the Exchange 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 Exchange products.

3. 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 Exchange products.

4. 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 an Exchange Enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives of any kind to potential enrollees to enroll in an Exchange product or renew their coverage.

5. 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.

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

3. Reporting

a. 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, 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.

b. 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.

c. Encounter Data. Exchange Participants 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.

For more information on current encounter data reporting requirements *for plans serving Medicaid recipients*, Applicants may visit the DOH website at the following address:

http://www.health.ny.gov/health_care/managed_care/docs/dictionary_meds3.pdf

d. 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.

4. Certification, Recertification and Decertification Process

a. Certification. The subject matter of this Invitation is strictly related to the initial application for participation. The Exchange will grant certification through SERFF and an email notification. All Applicants that meet the requirements set forth in this Invitation and enter into an Agreement with the DOH, will have their health plans certified to be offered through the Exchange.

b. Recertification. Except with respect to Consumer Operated and Owned Plans (CO-OPs), notification of the opportunity for recertification will be provided to Exchange Participants no later than May 1st each year. Rates and forms must be filed in accordance with DFS processes and timelines. The Exchange will complete recertification on an annual basis on or before September 15 of each year. Further details of the recertification process will be established by the DOH and made available on its informational web site.

c. Decertification. An Exchange Participant 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. Decertification shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees. In the event that the DOH determines that an Exchange Participant must be decertified, the Exchange Participant will receive written notice of this determination and the opportunity for a hearing prior to decertification. The hearing will be before the Commissioner of Health or his designee. Further details on the decertification process and appeals process will be established by the DOH and made available on its information web site.

d. Non-renewal. Exchange Participants may opt not to renew participation in the Exchange. The Exchange Participant must notify DOH of its decision to not renew in a manner and timeframe that consistent with existing state law. The Exchange Participant must follow applicable laws and regulations in terminating the respective Exchange Participant from the Exchange, including notification to enrollees. The DOH will monitor the transition process, coordinating processes with Exchange Customer Service and DFS to facilitate transition.

e. Suspension. The DOH may suspend enrollment in a QHP 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 III. 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 and premium rates 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 Exchange products and obtain the Superintendent's approval of such policy forms and premium rates prior to delivering or entering into such contracts and prior to QHP Certification.

B. Policy Form Filings

1. All policy forms for Exchange products submitted for 2014 offerings will be considered new products.
2. All policy form filings for Exchange products must be received by DFS by April 15, 2013.
3. All policy forms for Exchange 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.
4. DFS will develop 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.
5. DFS will develop model policy form language for Exchange products, which will be available on the [DFS website](#). All Applicants must use the model language.

C. Rate Filings

1. All premium rates for Exchange products submitted for 2014 will be considered new products.
2. All premium rate applications for Exchange products must be received by DFS by April 15, 2013.

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

4. 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.

5. Applicants must use the federal AV calculator when determining whether the Exchange products meet the actuarial values required for the respective products. 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 Exchange 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>

6. 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 2014 rates in the Individual Exchange and SHOP Exchange. 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. For 2014 and 2015, the Exchange 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 Exchange. 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 Exchange for each market. Consequently, if the Health Insurer Applicant offers a small group or individual product on the Exchange, it should coordinate its rate application filings with the rate filings for non-grandfathered small group or individual products outside the Exchange. DFS will issue instructions as to how to coordinate the filings. Catastrophic plans will have their own risk pool.

7. Premium Rate Periods

a. SHOP Products. Applicants may use quarterly rolling rates for Exchange products offered through SHOP, with a one year guarantee for the employer. For example, if the employer's plan year begins April 1, 2014, the rate provided to that employer will be guaranteed for all employees through March 31, 2015, as well as new employees or special enrollments that occur during the plan year through March 31, 2015.

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

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

SECTION IV. 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 (2012) Exchange 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

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)

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 V. Application Process

A. Issuing Agency

As stated in Section I.A., 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 Exchange informational [website](#).

DOH shall review Applications in an objective, comprehensive manner designed to benefit both the Exchange 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. Letter of Interest

Prospective Applicants are requested to submit a non-binding Letter 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 a prospective 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 prospective Applicant may include such request in their Letter of Interest. A Form Letter of Interest is attached to this Invitation as Attachment D.

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 website in Section V.A., above, unless the party submitting a question maintains that the question/answer will contain confidential and/or proprietary information.

CONTACT

NAME: Invitation Administrator

EMAIL: nyhxpm@health.state.ny.us

ADDRESS: New York Health Benefit Exchange
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. Participation Proposal
- b. Submission of Policy Form and Rates
- c. Submission of Provider Network Information

Each of the three 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 V.C. Electronic submissions are also required and can be sent to the email address noted in Section V.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.

b. Submission of Policy Form and Rates. As set forth in Section III, Exchange products, rates and policy forms must be submitted to DFS per DFS instruction, which will be available on the [DFS website](#).

c. Submission of Provider Network Information. As set forth in Section II.F.7, Applicants shall submit their network through the Health Commerce System (HCS) in accordance with the Provider Network Submission Instructions contained in Attachment F to this Invitation.

d. Vendor Responsibility. On or around the same time Applicants submit Forms and Rates, Applicants 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.

VI. 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 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 as QHPs and to offer such QHPs through the Exchange.

It is expected that the Agreement will be for the period commencing on or around August 1, 2013 and extending for a twenty year period, subject to the approvals of the OAG and OSC.