



**Invitation and Requirements for Insurer
Certification and Recertification for Participation in
2024**

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

Table of Contents

| | |
|--|-----------|
| 2024 Schedule of Key Events | 5 |
| Section I: Introduction and Overview | 6 |
| A. Issuing Office and Purpose | 7 |
| B. Background | 7 |
| 1. NY State of Health, the Official Health Plan Marketplace | 8 |
| Section II: Qualified Health Plan and Stand-Alone Dental Plans – Individual and Small Business Marketplaces | 10 |
| A. Participation Requirements | 11 |
| 1. Licensure and Solvency | 11 |
| 2. Choice of Participation | 11 |
| 3. Service Area | 11 |
| 4. Public Health Emergencies and Unwind | 11 |
| 5. QHP Applicant Product Offerings | 12 |
| 6. Stand-Alone Dental Applicant Product Offerings | 19 |
| 7. Small Business Marketplace | 20 |
| B. Premium Rates and Policy Form Filings | 22 |
| 1. New York State Department of Financial Services (“DFS”) Statutory Authority | 22 |
| 2. Policy Form Filings | 23 |
| 3. Rate Filings | 23 |
| 4. Provisions Applicable to QHP Applicants | 24 |
| 5. Role of Brokers and Agents | 25 |
| Section III: Essential Plans | 27 |
| A. Essential Plan Participation Requirements | 28 |
| 1. Choice of Participation | 28 |
| 2. Service Area | 28 |
| 3. Public Health Emergencies | 29 |
| 4. Benefits, Cost-Sharing and Individual Premium Contributions | 29 |
| Section IV: Requirements Applicable to Qualified Health Plans, Stand-Alone Dental Plans, Essential Plans and Small Business Marketplace | 35 |
| A. Administrative Requirements | 36 |
| 1. Enrollment and Member Services | 36 |
| B. Marketing Standards | 39 |
| 1. New York State of Health Marketing and Outreach | 39 |
| 2. QHP and EP Applicant Responsibilities | 39 |
| C. Network Adequacy | 40 |
| 1. General Standards | 40 |

| | | |
|---------------------------------------|--|-----------|
| 2. | Specific Standards for QHP Applicants and EP Applicants | 40 |
| 3. | Sanctioned Providers Applicable to All Applicants | 43 |
| 4. | Method of Review | 44 |
| 5. | Frequency of Review | 44 |
| 6. | Submission of the Network | 44 |
| D. | Enhancements to Network Information | 44 |
| 1. | Provider Directories | 45 |
| 2. | Verification of Networks and Appointment Availability Standards/Monitoring | 45 |
| 3. | Addressing Provider Directory Disputes | 46 |
| 4. | Treatment Cost Calculators for Participating Providers | 46 |
| E. | Consumer Network Protections | 46 |
| 1. | Access to Out-of-Network Providers and Information | 46 |
| F. | Prescription Drug Benefits | 48 |
| 1. | Formulary Requirements | 48 |
| 2. | Pharmacy and Therapeutics Committee | 48 |
| 3. | Pharmacy Rules | 48 |
| 4. | Prescription Drug Co-payments | 49 |
| G. | Quality and Enrollee Satisfaction | 49 |
| 1. | QHP Applicant Requirements | 49 |
| 2. | EP Applicant Requirements | 53 |
| H. | Reporting | 55 |
| 1. | General | 55 |
| 2. | Timing and Instructions for Reporting | 55 |
| 3. | Encounter Data | 56 |
| 4. | Financial Reporting | 56 |
| I. | Certification, Recertification and Decertification Processes | 56 |
| 1. | Certification | 56 |
| 2. | Decertification | 56 |
| 3. | Non-Renewal | 56 |
| 4. | Suspension | 57 |
| J. | Federal and State Laws and Regulations | 57 |
| 1. | Federal Laws, Regulation and Guidance | 57 |
| 2. | State Laws and Regulations | 57 |
| 3. | Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations | 58 |
| 4. | Access to Care | 58 |
| 5. | Access to Information | 58 |
| 6. | Medicaid and Child Health Plus Programs | 59 |
| Section V: Application Process | | 60 |

| | |
|---|-----------|
| A. Issuing Agency | 61 |
| B. Letters of Interest | 61 |
| C. Inquiries | 61 |
| D. Changes to the Application | 62 |
| E. Submission of the Application | 62 |
| 1. Application Contents | 62 |
| 2. QHP, SADP, and EP Applicant Instructions | 63 |
| F. Public Information | 64 |
| G. Agreement with DOH | 65 |
| Section VI: Attachments | 66 |
| Section VII: Definitions | 68 |

2024 Schedule of Key Events

| EVENT | DUE DATE | QHP | SADP | EP |
|--|----------------------|-----|------|----|
| Dental Forms and Rate Filings Due to DFS in SERFF | May 2, 2023 | | X | |
| Invitation Released | May 5, 2023 | X | X | X |
| Medical Rate Filings Due to DFS in SERFF | May 10, 2023 | X | | |
| Letters of Interest Due to NYSoH | May 12, 2023 | X | X | X |
| Written Questions Accepted by NYSoH | May 5 – May 26, 2023 | X | X | X |
| Dental on Exchange Binders Due in SERFF | May 16, 2023 | | X | |
| Participation Proposals Due to NYSoH | May 26, 2023 | X | X | X |
| Medical Policy Form Filings Due to DFS in SERFF | May 31, 2023 | X | | |
| Medical On Exchange Binders are Due in SERFF | June 9, 2023 | X | | |
| Qualified Dental Plan Template Due to NYSoH | June 30, 2023 | X | X | |
| Provider Network Submission Due to NYSoH | July 21, 2023 | X | X | X |
| Essential Plan Templates Due to NYSoH | *July 28, 2023 | | | X |
| DFS Rate Decision Due Date | *July 31, 2023 | X | X | |
| Essential Plan Subscriber Agreements Due to NYSoH | August 31, 2023 | | | X |
| Plans Must Complete Approval of Information in Issuer Portal | *September 1, 2023 | X | X | X |
| Certification of Plans by NYSoH | September 15, 2023 | X | X | X |

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

*Date will be extended due to the 1332 waiver process, if necessary



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:

- i. Insurers offering Qualified Health Plans (“QHPs”), Stand-Alone Dental Plans (“SADPs”) and Essential Plans (“EPs”), through NY State of Health, the Official Health Plan Marketplace (“Marketplace”), in 2023, to apply for recertification for 2024; and
- ii. Other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs, SADPs, and EPs to be offered on the Marketplace in calendar year of 2024.

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, Applicants who sign a new Agreement with the DOH, will have products certified as QHPs, SADPs, or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of products to be offered on the Marketplace in 2024.

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.

PLEASE NOTE: important changes regarding Essential Plan in Section III of the Invitation.

NOTICE REGARDING ESSENTIAL PLAN CERTIFICATION:

As explained below, DOH has applied for a 1332 State Innovation Waiver, which will change the authority of the Essential Plan program from section 1331 of the Affordable Care Act to section 1332. The program will continue under its current Essential Plan branding even as the legal authority for the program may change. Unless DOH otherwise provides notice, DOH will approve insurers’ EP certifications or recertifications under the 1332 State Innovation Waiver program instead of the Basic Health Program. However, if New York’s 1332 State Innovation Waiver is not enacted or approved, insurers’ Essential Plans will be certified or recertified pursuant to the Basic Health Program.

B. Background

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

NY State of Health, the official health plan Marketplace of New York State, authorized by the Federal Patient Protection and Affordable Care Act of 2010 (the “ACA”), was established in April 2012 by Governor Cuomo’s Executive Order 42, and codified in the NY Public Health Law in 2019. The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York. As of January 31, 2023, more than 6.9 million New Yorkers were enrolled in coverage through the marketplace, an increase of just over 2 million people from 2020, in large part due to the COVID-19 pandemic.

As of January 31, 2023, over 5.2 million New Yorkers were enrolled in Medicaid through NY State of Health and over 1.7 million people enrolled in a non-Medicaid program through the Marketplace. This includes 214,052 people enrolled in a Qualified Health Plan, 377,598 enrolled in CHP, and 1,123,110 enrolled in the Essential Plan.

Consumers can enroll in coverage through NY State of Health online, by telephone, or with the help of an enrollment assister. Between November 16, 2022, and January 31, 2023, nearly 1.36 million New Yorkers visited the NY State of Health website, Customer Service answered over 596,589 telephone calls, and there were more than 7,200 certified enrollment experts, including navigators, certified application counselors, health plan facilitated enrollers and health insurance brokers who worked with consumers. Enrollment assistors helped about three-quarters (77 percent) of enrollees complete their Marketplace applications in 2023. Through its website, 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 to also receive a personalized premium estimate before starting an application. NY State of Health continues to promote the availability of affordable, comprehensive coverage through a multi-channel and multi-lingual statewide paid advertising campaign.

During the COVID-19 public health emergency, NY State of Health has served as a safety net where individuals who lost jobs and/or income can find and enroll in affordable, comprehensive health coverage. Recognizing the need to ensure that individuals could easily maintain their coverage during the pandemic, NYSOH adopted nearly every option made available by the federal government to eliminate barriers to coverage, including the expedited implementation of the American Rescue Plan Act of 2021 (ARPA) provisions to make commercial, Qualified Health Plan (QHP) coverage more affordable and opening a Special Enrollment Period for the duration of the PHE and “unwind” period. In addition, the passage of the Inflation Reduction Act (IRA) in August 2022 will enable New Yorkers to continue to receive expanded financial assistance for health insurance for an additional three years.

Throughout the PHE, and in alignment with federal Continuous Coverage requirements, NYSOH has been extending coverage without requiring renewal for individuals enrolled in Medicaid, Child Health Plus (CHP), and the Essential Plan (EP) since March 2020. This flexibility will end in Spring 2023, when NYSOH will begin sending renewal notices to enrollees in these programs and

redetermining eligibility. Each month between May 2023 and April 2024, a group of enrollees will receive their renewal notices, depending on their enrollment end date. As the Continuous Coverage Requirement comes to an end, NYSOH is committed to continuing to provide affordable health insurance to all New Yorkers in need.

1332 State Innovation Waiver:

The New York State Fiscal Year 2023 Enacted Budget authorizes the Commissioner of Health to seek a Section 1332 State Innovation Waiver to expand Essential Plan eligibility to additional low- and moderate-income individuals. Through this expansion of Essential Plan coverage, the State seeks to increase access to high quality, affordable health insurance for low- and moderate-income individuals.

The State’s draft waiver application is available online [here](#). The final waiver application, reflecting comments received during the public comment period will be submitted in early May. The state hopes to receive timely federal approval permitting implementation in January 2024.



Section II: Qualified Health Plan and Stand-Alone Dental Plans – Individual and Small Business Marketplaces

A. Participation Requirements

1. Licensure and Solvency

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

- i. Be licensed as an insurer under Articles 42 or 43 of NY Insurance Law or certified under Article 44 of NY Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or
- ii. Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to September 1, 2023, and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2023.

2. Choice of Participation

Applicants may apply to participate in the individual market and small business marketplace. They are not required to participate in both.

3. 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 and consumers. 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.

Applicants seeking to expand their QHP service area in addition to notifying DFS and DOH must file a service area expansion application with the Division of Health Plan Contracting and Oversight or DHPCO. This application should be sent to bmccsmail@health.ny.gov.

4. Public Health Emergencies and Unwind

In response to a public health emergency, in order to maintain and ensure access to health coverage, the State reserves the right to waive the following provisions, including retroactively:

Eligibility:

- Annual Re-certification: The state shall temporarily waive requirements related to the timely processing of annual recertifications.

Grace Periods:

- The State reserves the right to extend grace periods, as permitted by federal law and/or regulation, for payment of enrollee premium in order to avoid termination or cancellations for non-payment of premium, if applicable, to ensure access to health care services.

5. QHP Applicant Product Offerings

a. Essential Health Benefits

Applicants must agree to provide the Essential Health Benefits (“EHBs”) specified by the DOH for calendar year 2024, delineated in Attachment “A.” The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels

All products 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 U.S. Department of Health and Human Services (“HHS”) AV calculator.

| | |
|-------------|-----------------------|
| Bronze: | 60% AV |
| Silver: | 70% AV |
| Silver CSR: | 73% AV (200-250% FPL) |
| Silver CSR: | 87% AV (150-200% FPL) |
| Silver CSR: | 94% AV (100-150% FPL) |
| Gold: | 80% AV |
| Platinum: | 90% AV |

Consistent with current federal rules, the following *de minimis* variations from AV are permissible:

| | |
|--------------|--|
| Bronze: | 4%/+2% if no major service is covered before deductible -2%/+5% if one major service is covered before the deductible or is HSA qualified |
| Silver: | Individual – 0%/+2% Small Group –2%/+2% |
| Silver CSRs: | 0%/+1% |
| Gold: | -2/+2% |
| Platinum: | -2%/+2% |

Note that the minimum AV differential between the Silver plan (70%) AV and the Silver CSR (73%) is 2%.

c. Standard Products

QHP 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 QHP 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 market; there is no requirement to offer standard products for the small business marketplace. The standard products for 2024 are provided in Attachment “B.”

d. Standard Products with Visit(s) Pre-Deductible

The 2024 standard bronze product includes 3 visits to a primary care provider (PCP) or specialist that are not subject to the deductible; copayments are applicable for these visits.

The 2024 standard silver plan, silver 73 and 87 CSR plans include 1 visit to a primary care provider (PCP) or specialist not subject to the deductible; copayments are applicable for these visits.

e. Child-Only Offerings

In accordance with federal regulation, QHP Applicants must agree to offer a child-only product at each metal level described in Section II(A)(4)(b), above, in the individual market. 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 (A)(4)(b), above, offered at the child-only rate outlined in Section II(B)(4)(b). Only one child-only product is required per metal level. Please note that a QHP Applicant’s participation in the State’s Child Health Plus program does not satisfy this requirement.

f. Catastrophic Products

QHP Applicants must agree to offer at least one standard catastrophic product in each county of the Applicant’s service area in the individual market. The standard catastrophic product can be found in Attachment “B.” As part of the Participation Proposal, which is Attachment “F,” the DOH will require QHP Applicant’s affirmative intent to offer, or continue to offer, a catastrophic product.

If the DOH determines there is adequate catastrophic coverage in a particular county, the DOH may, in its sole discretion, allow other QHP Applicants, in the same county, the option of not offering the catastrophic product.

An Applicant’s decision not to offer catastrophic coverage will be for the entire plan year of 2024.

The DOH will inform the QHP Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the catastrophic product will be made by the DOH prior to certification. In the event there is not adequate coverage in a particular county, all QHP Applicants in that county will be obligated to offer the catastrophic product.

g. Out-of-Network Products

An “out-of-network” product is a product that provides coverage for services rendered by health care providers that are not in the health plan issuer’s network. QHP 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 the individual market only.

QHP 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. Non-Standard Products

QHP Applicants may opt to offer up to two (2) “non-standard” products per metal level, as described below, 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 Section II(A)(3), those stated below, and any applicable DFS instruction or guidance. This non-standard product limit only applies to the individual market; there will be no limit on the number of products offered by an insurer on the small business marketplace.

Non-standard products must allow consumers to easily identify the differences between non-standard products and standard products, so that consumers can determine which plan provides the highest value at the lowest cost to address their needs. All non-standard products must comply with federal and state laws, regulations and guidance and shall be subject to DFS and Marketplace review and approval. Non-standard silver level products, if offered by the issuers, must have an actuarial value of at least 70%, with a permissible *de minimis* variation of +2% AV.

Non-standard products do not have to be offered at all four metal levels. They must, however, be offered at a minimum of two metal levels of the issuer’s choosing (for example, silver and bronze). If the QHP Applicant elects to offer(a) non-standard product(s) at the bronze level, the Applicant must also offer at least the same number of non-standard products at one of the other metal levels.

Examples of permissible and non-permissible combinations:

| | Platinum | Gold | Silver | Bronze |
|-------------------------|----------|------|--------|--------|
| Permissible: | 0 | 0 | 2 | 2 |
| Permissible: | 1 | 2 | 0 | 2 |
| Permissible: | 0 | 1 | 0 | 1 |
| | Platinum | Gold | Silver | Bronze |
| Non-Permissible: | 0 | 0 | 1 | 2 |
| Non-Permissible: | 2 | 0 | 0 | 3 |
| Non-Permissible: | 0 | 0 | 0 | 1 |

QHP Applicants that offered a Bronze QHP that was HSA eligible in 2023, will be permitted to offer the HSA Compliant Bronze set forth in Attachment “B” in 2024, to ensure the HSA can carry over for their respective enrollees.

Child-only products, catastrophic products, out-of-network products, and the HSA Compliant Bronze product set forth in Attachment “B” will not be counted towards the two (2) non-standard product maximum.

i. Prescription Drug Coverage

As required under the federal rules, prescription drug coverage must cover at least the greater of:

- (1) One drug in every United States Pharmacopeia (“USP”) category and class; or
- (2) 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 review. This requirement is not intended to limit the number of drugs that the QHP Applicant may cover in a drug category or class. QHP 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. QHP 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 county, all QHP Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

QHP Applicants will also have the option of offering adult/family dental, and/or supplemental pediatric dental benefits, as an additional benefit per Section II(A)(4)(h), above. If the QHP Applicant offers a family dental benefit, the pediatric component must include at least the same pediatric dental benefits as outlined in Attachment “A.” These requirements apply to the individual and small group marketplace.

QHP Applicant’s product descriptions must include a plain language description of what services are included within “Basic” and “Major” dental services and must include information about any waiting periods, benefit maximums, any limits on services and benefits that do not count toward the max-of-pocket limit.

To assist the DOH in providing meaningful, detailed benefit and cost sharing dental information to consumers we will be requesting Applicants to complete a Qualified Dental Plan (QDP) Benefit and Cost Sharing Template which will be used to populate the NY State of Health Dental Comparison Tool.

Attachment “S” outlines the QDP instructions and Attachment “T” is the QDP template which

Applicants are required to complete. The data submission due date is outlined in the 2024 Schedule of Key Events.

The Dental Comparison Tool can be found here:

<https://info.nystateofhealth.ny.gov/resource/dental-plan-comparison-tool>

The Dental Comparison Tool assists consumers in review and comparison of dental plans offered on the marketplace. The purpose of the new data collection template is to ensure consistency in dental benefit information across insurers and to facilitate consumer comparisons across insurers.

k. QHP and SADP Naming Conventions

To assist consumers in identifying products and differences between products, QHP and SADP Applicants must use the following naming conventions to identify all QHPs and SADPs offered on the Marketplace, in the order as presented below. Insurers will be required to add the network name associated with each product in the naming convention to assist consumers in identifying the specific network associated with the product. Please 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 the word for metal level. |
| Standard/ Non-Standard | ST or NS | Indicate standard or non- standard by using “ST” for standard and “NS” for non-standard. ST or NS must immediately follow the Metal Tier. |
| Network Coverage | INN or OON | Indicate network type using “INN” for in-network and “OON” for out-of-network coverage. |
| Network Name | To be assigned by Applicant | Indicate the network name associated with each Product |
| 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 benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank. |
| Dental Coverage | Pediatric Dental, Adult/Family Dental | Specify the type of dental coverage embedded in the QHP. If none, leave blank |
| Dental Coverage Waiting Period | WP | Include "WP" to indicate any waiting periods for adult dental services. |

Examples of permissible QHP Individual Market names are shown below:

ABC Product, Platinum, ST, INN, 123 Network, Dep25 , ABC

Product, Gold, ST, INN, XYZ Network, Dep29

ABC Product, Silver, NS, OON, Main St Network, Dep29, Family Vision, Family Dental, WP

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 the entire word for metal level. |
| Network Coverage | INN or OON | Indicate network type using "INN" for in-network and "OON" for out-of-network coverage. |
| Network Name | To be assigned by Applicant | Indicate the network name associated with each Product |
| 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 benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank. |
| Dental Coverage | Pediatric Dental, Adult/Family Dental | Specify the type of dental coverage embedded in the QHP. If none, leave blank. |

| | | |
|---------------------------------------|-----|---|
| Dental Coverage Waiting Period | WP | Include “WP” to indicate any waiting periods for adult dental services. |
| Domestic Partner | DP | Include only if domestic partners are eligible for coverage. |
| Family Planning | FP | Include only if the family planning benefit is covered. |
| Healthy NY | HNY | Include if the product is a Healthy NY product. |

Examples of permissible QHP Small Business Market names are shown below:

ABC product, Platinum, ST, INN, 123 Network, Dep25

ABC product, Gold, NS, OON, Adult Dental, XYZ Network, Dep29, DP, FP ABC product, Silver, OON, Main ST Network, Dep25

ABC product, Gold, ST, INN, EFG Network, Dep 25, HNY

I. Effective Dates

All certified and recertified products offered through the Marketplace will have effective dates of January 1, 2024, in the individual market. Small group coverage runs on a plan year.

Qualified employers will be able to purchase Marketplace certified products directly from the plan issuer at any point during the year.

QHP 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 2024 must be established and submitted to DOH and DFS through this Invitation.

6. Stand-Alone Dental Applicant Product Offerings

SADP Applicants shall offer products through the Marketplace in accordance with federal and state laws and regulations, and in accordance with the participation requirements set forth below.

SADP Applicant’s product descriptions must include a plain language description of what services are included within “Basic” and “Major” dental services and must include information about any waiting periods, benefit maximums, any limits on services, benefits that do not count toward the max-of-pocket limit and whether a deductible is applicable for adult dental care benefits.

a. Essential Health Benefits

The SADP Applicant must agree to provide the pediatric dental benefits outlined Attachment “A.” The pediatric dental benefits are minimum benefits and the SADP Applicant may add additional benefits.

b. The Standard Product

The SADP Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the SADP 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 the individual market.

c. Non-Standard Products

The SADP Applicant may opt to offer up to three (3) non-standard products for the individual market. The SADP Applicant may opt to offer unlimited non-standard products for the small business marketplace.

The non-standard product(s) may be a(n) adult/family dental product or additional pediatric dental product offering(s). These requirements apply to both the individual market and the small business marketplace.

d. Other Applicable Provisions

SADP Applicants must meet the requirements set forth in Section II(A)(4)(I) above and Section II(B)(5), below.

7. 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 a group that meets the definition of “small group” in the NY Insurance Law and regulations, which is currently defined as a group of one hundred (100) or fewer full time equivalent employees (“FTEs”) over the prior calendar year with at least one common law employee enrolled as defined by federal regulation, (see 26 CFR § 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor’s spouse. 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: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

b. Employer Choice

Qualified employers will have the flexibility to offer their employees any SHOP certified product(s) offered by health plan issuer(s).

c. Product Offerings

Issuers proposing to no longer offer products in 2024 that were certified in 2024 on the small business marketplace, must inform the NY State of Health by the date Medical Policy Forms and Rates are due to DFS as indicated in the 2024 Schedule of Key Events, explaining the reason for the removal.

There will be no designation of “standard” and “non-standard” products in the small business marketplace. That is, Applicants applying for the small business marketplace in 2024 are not required to offer the standard benefits shown in Attachment “B.” Applicants must, however, adhere to metal level actuarial value requirements and must agree to offer at least one product at each metal level on the small business marketplace.

There will be no limit on the number of products offered by an insurer on the small business marketplace. Insurers are encouraged to offer all small group market products approved for offer

in the outside market to increase the availability of tax credits to small employers.

For Plan Year 2024, Healthy NY issuers will continue to have the option of seeking SHOP-certification. This will allow HNY employers to access the Federal small business health care tax credit, if otherwise eligible.

d. Minimum Participation

While insurers in the small business marketplace and the off-marketplace small group insurance market are discouraged from imposing minimum participation requirements, non-HMO insurers are permitted to impose minimum participation requirements. However, if a small group cannot meet the insurer’s minimum participation requirements, an insurer must still permit the group to enroll during an annual small group market open enrollment period that begins November 15 and extends through December 15 of each year.

The annual open enrollment period applies to coverage issued or renewed between November 15 and December 15 and coverage applied for between November 15 and December 15 with an effective date of January 1. Insurers may impose minimum participation

requirements on renewal outside of the open enrollment period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

For coverage issued by the small business marketplace prior to April 1, 2018, insurers were not permitted to impose minimum participation requirements. Therefore, insurers may not impose minimum participation requirements upon renewal for small business marketplace employer groups who were issued small business marketplace coverage prior to April 1, 2018.

e. 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, please visit <https://www.irs.gov/forms-pubs/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.

f. Non-Discrimination

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

B. Premium Rates and Policy Form Filings

1. New York State Department of Financial Services (“DFS”) Statutory Authority

Pursuant to Sections 3201, 3231, 4235, and 4308 of the NY 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 NY 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 to issuing or delivering such contracts and prior to QHP certification or recertification.

2. Policy Form Filings

All policy forms for QHP products and SADPs shall be submitted to DFS by the date shown in the 2024 Schedule of Key Events, for approval through the System for Electronic Rate and Form Filing (“SERFF”) in accordance with instructions established by DFS and HHS.

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.

DFS will develop updated model language for the Subscriber Agreements to all QHP products and SADPs, which will be available on the DFS website. All QHP Applicants and SADP Applicants must use the model language.

3. Rate Filings

All premium rate applications for Marketplace products must be received by DFS on or before the due date shown in the 2024 Schedule of Key Events for SADP Applicants and QHP Applicants.

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

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.

QHP 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 must rerun their products through the updated AV calculator to ensure that all proposed products meet the required 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 <https://www.cms.gov/ccio/resources/regulations-and-guidance/index#plan-management>.

4. Provisions Applicable to QHP Applicants

a. Rating Tiers

Individual and small group products in New York State are community rated in accordance with state law, regulations, and guidance. QHP Applicants cannot consider age, sex, health status, occupation or tobacco use when establishing premium rates.

All products shall be initially priced to reflect five 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 |
| Child only | 0.412 |

These relativities shall apply to 2024 rates in the individual market and the small business marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-Only Products

QHP 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 Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

c. Federal Risk Adjustment

QHP Applicant's premium rates should reflect the federal risk adjustment as directed by DFS.

d. Single Risk Pool Inside and Outside of the Marketplace

Under the ACA and applicable regulations, QHP 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 business marketplace, respectively. This requirement applies to products offered both inside and outside of the Marketplace, for each market. Consequently, if the QHP Applicant offers a small group or individual product on the Marketplace, it should submit one rate adjustment filing per market containing the non-grandfathered products offered inside and outside the Marketplace. DFS will issue instructions as to how to submit the rate adjustment filings. Catastrophic products will have their own risk pool.

e. Premium Rate Periods

- i. Small Group Products: Applicants may use quarterly rolling rates for Marketplace products offered through the small business marketplace, with a 12-month guarantee for the employer.

For example, if the employer’s plan year begins April 1, 2023, the rate provided to that employer will be guaranteed for all employees through March 31, 2024, as well as new employees or special enrollments that occur during the plan year, through March 31, 2024.

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

f. Rating Regions

When submitting products for rate review, Applicants must adhere to the rating regions set forth in Attachments “C” and “D”.

5. 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 groups and individuals in purchasing coverage through the Marketplace.

a. Producer Certification

Producers who have successfully completed the training certification program for each applicable market 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.

b. Producer Compliance

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

c. Producer Compensation

All QHP and Essential Plan Applicants' must comply with all applicable provisions of New York State insurance law. In addition, all QHP Applicants' compensation arrangements with Producers must be the same for products sold inside and outside of the Marketplace. For example, compensation for a policy sold on the Marketplace must be the same as the compensation for a policy sold outside of the Marketplace. In addition, if compensation is provided, QHP Applicants must provide the same compensation (i.e., the same (1) flat percentage of premium; (2) flat amount per person; or (3) flat dollar amount per policy) at all metal levels.

Essential Plan compensation arrangements must follow the same requirements as in the individual market. Essential Plan producer compensation schedules will be requested during the Essential Plan rate setting process.



Section III: Essential Plans

A. Essential Plan Participation Requirements

New York elected to establish a Basic Health Program, an option provided to states in the ACA, in April 2015. New York has branded its Basic Health Program the “Essential Plan.” The Essential Plan is authorized by Section 369-gg of the NY State Social Services Law and was approved by the Centers for Medicare and Medicaid Services on March 27, 2015.

Additionally, New York is in the process of submitting a draft application to the Centers for Medicare and Medicaid Services (“CMS”) and the U.S. Department of Treasury for a 1332 State Innovation Waiver (“1332 Waiver” or “Waiver”), an option provided to states in section 1332 of the ACA. The Waiver application seeks authority to operate the Essential Plan pursuant to section 1332 of the ACA and (proposed) section 369-ii of the NY Social Services Law (“SSL”) in lieu of the authority under the Basic Health Program [set forth in section 1331 of the ACA and NY SSL 369-gg.] The transition to 1332 Waiver authority would permit NYSOH to extend eligibility for Essential Plan to individuals with income between 138 and 250 percent of FPL, as outlined below. This transition is intended to be seamless to consumers, as under the 1332 State Innovation waiver the program will continue to be branded as the “Essential Plan”. The target implementation date is January 1, 2024, pending federal approval.

If New York’s 1332 State Innovation Waiver is not approved in 2023, insurers’ Essential Plans will be certified or recertified pursuant to the Basic Health Program.

Essential Plan applicants must demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2023.

1. Choice of Participation

Applicants that apply to participate in the With Waiver Essential Plan may also apply to participate in both the QHP individual market and the QHP 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.

2. 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.

Applicants seeking to expand their EP service area in addition to notifying DFS and DOH must file a service area expansion application with the Division of Health Plan Contracting and Oversight or DHPCO. This application should be sent to bmccsmail@health.ny.gov

DOH reserves the right to negotiate service area with EP Applicants, to ensure choice of EP insurer in each county of the state, consistent with federal requirements.

3. Public Health Emergencies

In response to a public health emergency, to maintain and ensure access to health coverage, the State reserves the right to waive the following provisions, including retroactively:

Eligibility:

- Annual Re-certification: The State shall temporarily waive requirements related to the timely processing of annual recertifications.

4. Benefits, Cost-Sharing and Individual Premium Contributions

a. Standard Essential Plans

EP Applicants must agree to offer five variations of EP products (pursuant to the 1332 Waiver authority) based on enrollee income as a percentage of FPL and other factors as described below (here in after 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 2024, with the following exceptions: pediatric services, will not be included in the benefit, the wellness benefit may be substituted for a different wellness benefit or benefits in accordance with federal and state regulations, guidance and DOH review and approval.

The Standard EPs shall include adult vision and dental benefits as part of the health care services with no premium or cost sharing. EP 1, EP 2, and EP 200-250 will include the Vision and Dental benefit set forth in Attachment K. EP 3 and 4 shall include the adult dental and vision benefits equivalent to those provided under NY Medicaid. All EPs offered shall include only in-network options and at no time shall an EP Applicant impose cost-sharing with respect to preventive health services, or items, as defined in 45 CFR § 147.130.

- i. Pending federal approval of the 1332 waiver: For individuals with incomes greater than 200% and less than or equal to 250% of FPL

("Essential Plan 200-250" in Attachment "G"), EP Applicants must provide the Standard EP. Individual enrollees will have a \$15 monthly premium for Essential Plan 200-250 coverage. 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. For 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 have no monthly premium for Essential Plan 1 coverage. 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.
- iii. For 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 have no monthly premium for Essential Plan 2 coverage. EP Applicants must also offer a version of this product for the AI/AN population with no cost-sharing for any services.
- iv. For individuals with incomes greater than 100% and less than or equal to 138% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 3" in Attachment "G"), EP Applicants must provide the Standard EP.

Pursuant to Section 369- gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of the federal poverty level, and who previously would have qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include but are not limited to the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, and adult vision and dental services equivalent to the NY Medicaid benefit.

Non-emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 3 coverage.

- v. For individuals with incomes at or below 100% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 4", in Attachment "G"), EP Applicants must provide the Standard EP.

Pursuant to Section 369-gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 100% of the federal poverty level, and who would have previously qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include but are not limited to the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, and adult vision and dental services equivalent to the NY Medicaid benefit.

Non-emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 4 coverage and will have no cost-sharing on benefits.

b. Standard Essential Plan Plus Adult/Vision/Dental Benefits

Adult vision and dental benefits are included in the health care services in the Standard EP.

c. Additional Features of Essential Plans

EP Applicants must include in the Standard EP, the following features per 42 CFR § 600.410(d):

- i. Care coordination and care management for enrollees, with a 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;
- iii. Incentives for the use of preventive services.

d. Essential Plan Naming Conventions

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 insurer. The EPs must be labeled as follows

- i. Essential Plan 200 - 250
- ii. Essential Plan 1
- iii. Essential Plan 2
- iv. Essential Plan 3
- v. Essential Plan 4

e. Effective Dates

Starting January 1, 2024, individuals who are determined eligible to enroll in the Essential Plan offered through the Marketplace shall have a coverage effective date of the first of the month in which an Essential Plan is selected. Plan selection may occur manually, or via auto-assignment. For example, an individual who selects an Essential Plan on February 20, 2024, will have coverage in the Essential Plan starting February 1, 2024.

Individuals who enroll in the Essential Plan will have the following effective dates:

- i. For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status (Essential Plan 3 and 4), and are newly enrolling in coverage, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2024, will have coverage starting February 1, 2024.
- ii. For individuals who have incomes above 138% of the FPL (Essential Plan 200 – 250, 1, and 2), and are newly enrolling in coverage, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2024, will have coverage starting February 1, 2024.
- iii. For individuals who have incomes at or below 138% of the FPL (Essential Plan 3 and 4), and do not qualify for Federal Medicaid due to immigration status, and are renewing coverage, the effective date will be the first of the following month.
- iv. For individuals who have incomes above 138% of the FPL (Essential Plan 1 and 2), and are renewing coverage, the effective date shall be the first of the following month.

Note that EP enrollees who renew coverage after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin the first of the following month and they will be enrolled into their same plan. Consumers who change plans at renewal and renew after the fifteenth of the month will be enrolled into their same plan the first of the following month and then transitioned to their new plan the first of the next month.

For example, an enrollee whose coverage ends December 31, 2023, returns on December 25, 2023, and completes necessary updates and remains eligible for the Essential Plan will be enrolled in their same plan beginning January 1, 2024. If the enrollee is changing plans, coverage in their new plan will begin February 1, 2024.

Additionally, beginning in 2024, EP members who fail to renew before their eligibility end date, but who then complete a late renewal the following month and remain eligible for the same program and health plan, will have their enrollment backdated so there are no gaps in coverage.

For example, a consumer fails to complete their EP renewal and their EP enrollment is terminated 6/30/2024. They then come in on 7/12/2024 and renew and re-enroll with the same EP Issuer; they will be given a 7/1/2024 enrollment start date.

f. Compensation

EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP. Upon approval of the 1332 waiver for 200% - 250% FPL EP applicants will separately collect the applicable premium made from enrollees. The capitation payments made to the issuer must be used in accordance with federal and state laws and regulations, including New York's approved 1332 Waiver State Innovation Waiver application. EP Applicants will be informed of their monthly capitation payment amount around August 31, 2023.

EP Issuers are subject to the Medical Loss Ratio (MLR) of at least eighty-six percent (86%) and to rebating provisions. (See ACA § 1331(b)(3); 45 CFR § 158.210(c), 45 CFR § 158.240(b)).

g. Rating Regions and Risk Adjustment

Capitation payments will be made to EP Applicant on a county basis and in accordance with the nine rating regions set forth in Attachments "H" and "I" to this Invitation. The DOH currently risk adjusts for all rating groups within the Essential Plan rating structure except for the new 200% - 250% FPL EP applicants.

h. Subscriber Agreements and Template Submissions

EP Applicants must use the subscriber agreements that will be provided to them shortly after the release

of this Invitation. Revisions to the model language contained in the subscriber agreements will be limited to the bracketed sections of the subscriber agreements. EP Applicants can include their logos and numerical contract-identifying information on agreements. The subscriber agreements must be submitted to the DOH by the due date shown in the 2024 Schedule of Key Events.

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 the due date shown in the 2024 Schedule of Key Events.

i. Non-Discrimination

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



Section IV: Requirements Applicable to Qualified Health Plans, Stand-Alone Dental Plans, Essential Plans and Small Business Marketplace

A. Administrative Requirements

1. Enrollment and Member Services

a. Enrollment Periods for QHPs and Stand-Alone Dental Plans

QHP Applicants and SADP Applicants must adhere to the open enrollment periods and special enrollment periods established under applicable law and guidance. 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.

b. Enrollment Period for the Essential Plan

Enrollment in the Essential Plan will be open all year. Eligibility for the Essential Plan will be recertified every twelve (12) months. If the enrollee is determined to remain eligible for EP, a new 12-month enrollment period will begin.

c. 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:

- i. Transaction files, including maintenance and termination transactions, must be picked up daily;
- ii. Acknowledgement transactions (999 transactions) must be sent within 24 hours of picking the files up;
- iii. Effectuation transactions, which are the basis of Federal Advance Premium Tax Credit (APTC) payments to issuers, must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned member identification number;

- iv. Terminations and cancellations must be sent within five (5) business days of the grace period end date;
- v. Error files are sent to insurers daily; error files must be reviewed and corrected on a regular basis, but no less frequently than once per week.

d. 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.

e. Subscriber Contracts

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

f. 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 websites 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.

The Applicant and its contractors 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 font 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, 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 enrollees speak;
- iii. Pursuant to 45 CFR § 155.205(c)(2)(iii), before the beginning of the 2021 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 languages 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>);
- iv. Make verbal interpretation services available 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;
- v. 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; and
- vi. 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.

g. 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 twenty-four (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. New York State of Health Marketing and Outreach

The DOH intends to continue its 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 enrollment through the Marketplace.

2. QHP and EP Applicant Responsibilities

Applicants are encouraged to conduct advertising campaigns, including but not limited to television, radio, digital, billboards, subway, and bus posters. The Applicants are encouraged to distribute marketing materials in local community centers, health fairs and other areas where potential enrollees are likely to gather. Distribution of NY State of Health developed public education campaign materials associated with the end of the COVID-19 Public Health Emergency is strongly encouraged.

The Applicant shall use the NY State of Health 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.

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.

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.

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.

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

C. 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, Applicants must adhere to the following:

1. General Standards

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.

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.

2. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP 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 use providers, allied health professionals, ancillary providers, durable medical equipment (“DME”) providers,

home health providers, and pharmacies. Specifically, the Applicant’s network must meet the following minimum standards:

- i. Each county network must include at least one (1) hospital; however, for the following counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan, and Queens;
- ii. Each county network must include the core provider and service types established in the Data Dictionary through the Provider Network Data System (“PNDS”) website;
- 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:

Primary Care Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and
- In rural areas, transportation requirements may exceed these standards if justified.

Dental Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and
- A time and distance standard of 45 minutes/45 miles may be used in the following rural counties and provider types, where a lack of providers has been demonstrated to DFS:
 - Pedodontics: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins.
 - Oral Surgeons: Essex, Franklin, Lewis, Schoharie and Steuben.
 - Orthodontics: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.

Other Provider Types

- It is preferred, that the Applicant meet the 30-minute or 30-mile standard, unless justified.
- vi. QHP 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;
- vii. QHP Applicants 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 QHP Applicants' and EP Applicants' service area;
- viii. The QHP 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 clinic, to the extent such providers are available;
- ix. January 1, 2023, an update to the public health law will be effective, that requires Medicaid managed care, Qualified Health Plans and Essential Plans to contract with National Cancer Institute (NCI) designated cancer centers, licensed by the department within the health plan's service area that is willing to agree to provide cancer-related inpatient, outpatient, and medical services to the plan's enrollees.

Such contract would be under the prevailing terms and conditions that the plan requires of other similar providers included in the plan's provider network but must include reimbursement of at least the fee for service Medicaid rate and methodology applicable to the center's inpatient and outpatient services. (See, Chapter 57 of the Laws of 2022).

Additional information regarding NCI-Designated Cancer Centers can be found

here: <https://www.cancer.gov/research/infrastructure/cancer-centers/find>

- x. QHP Applicants and EP Applicants are 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.

Pursuant to applicable law, QHP Applicants and EP Applicants are required to notify enrollees of significant changes in their networks which will be effective in the 2023 plan year. Applicants are required to submit disruption analysis reports to the NY State of Health, when a network is scheduled to have a hospital disenroll, an IPA or major medical group, or is scheduled to lose or change their pharmacy carrier.

- xi. DOH requests Applicants to conduct additional outreach to their enrollees in advance of significant network changes as indicated above, to ensure their awareness. Applicants are required to inform DOH of such outreach plans.

b. Specific Standards for 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 two (2) orthodontists, 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).

In addition to these requirements, the Applicant's dental network must meet the time and distance standards set forth above in Section IV(C)(2)(a)(v).

3. Sanctioned Providers Applicable to All Applicants

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

- i. Been sanctioned or prohibited from participation in Federal Health Care Programs under either Section 1128 or Section 1128A of the SSA; or
- ii. Had their license suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

4. 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 the DOH 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, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

5. 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. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law §4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDIS submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

6. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, <https://pnds.health.ny.gov>, in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "P". Submissions 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.

a. Identification and Use of Existing Essential Plan Network for Current and New Issuers

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 the Marketplace or DOH.

D. Enhancements to Network Information.

In addition to the Network Adequacy requirements set forth in Section IV(C), all Applicants shall adhere to the following, unless otherwise specified:

1. Provider Directories

The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the products 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 NY Insurance Law § 3217- 1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), 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, SADPs or EPs.

If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace 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 individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates. Applicants should include the word ‘NYSOH Marketplace’ on their internal provider directory websites to assist consumers with identifying which networks belong to Marketplace products.

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.

2. Verification of Networks and Appointment Availability Standards/Monitoring

- 1 The Applicant shall provide their process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process 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 processes are to validate participation by providers and to make sure providers are aware of their participation in Marketplace networks.

2 Applicants and their contractors must submit for review appointment availability standards established for office hours and after office hours. Access standards should include but not be limited to routine care, follow up visit for emergency/hospital discharge, urgent care and emergency care for medical, behavioral health and substance use appointments. Applicants and their contractors must explain the health plan process to ensure compliance with these standards including frequency of review and advise where appointment availability standards may be found by consumers, such as, memberhandbook or Applicant’s website.

3. 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.

4. Treatment Cost Calculators for Participating Providers

The QHP Applicant and EP Applicant must have in place a treatment cost calculator available through an internet website and such other means for individuals without access to the internet. Such treatment cost calculators must be able to demonstrate enrollee cost-sharing using current price data 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.

E. Consumer Network Protections

1. Access to Out-of-Network Providers and Information

Consistent with Financial Services Law Article 6, QHP Applicant and EP Applicants must adhere to the following:

- i. QHP Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency (“ER”) bills. In addition, QHP Applicants and EP Applicants must hold their member harmless

from liability for non-emergency (“non-ER”) surprise out-of-network bills: (a) 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 (b) whenever a participating physician refers a member to an out-of-network provider without the member’s written consent.

- ii. QHP Applicants and EP Applicants shall allow their 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.
- iii. QHP 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.
- iv. QHP 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.
- v. QHP 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 Part H of Chapter 60 of the Laws of 2014 (the “Out-of-Network Law”).

QHP 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 by the Out-of-Network Law. Upon request, QHP Applicant and EP Applicant will provide a URL link to its out-of-network treatment cost calculator.

F. Prescription Drug Benefits

1. Formulary Requirements

QHP 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 a minimum, the following must be met:

- i. The link(s) must provide an up-to-date listing of all covered drugs;
- ii. Separate links must be provided for each product offered on the Marketplace and the formulary or formularies must clearly identify the product(s); and
- iii. 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.

QHP Applicants and EP Applicants must comply with NY Public Health Law § 4406-c, and NY Insurance Law § 3216(i)(27), (28), § 3221(a)(16), § 3221 (l) (18), and § 4303(jj), (kk). Formularies will be reviewed to ensure the intent of the state law is being followed. QHP 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 QHP 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

Pursuant to 45 C.F.R. § 156.122 (e)(1), QHP Applicants and EP Applicants 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.

4. Prescription Drug Co-payments

QHP and EP Applicants must comply with: (i) NY Insurance Law § 4325(h) and NY Public Health Law § 4406-c(6) to assure that enrollee co-payments do not exceed the usual and customary cost of a prescribed drug, and (ii) NY Insurance Law § 3217-b(a)(2) and 4325(a)(2), and NY Public Health Law § 4406-c(2) to ensure that contracts with pharmacies, whether negotiated directly or through a pharmacy benefit manager, do not contain “gag clauses” or other provisions in violation of (i) NY Insurance Law § 4325(h) and NY Public Health Law § 280-a, NY Public Health Law § 4406-c(6) or NY Education Law § 6826- a.

G. Quality and Enrollee Satisfaction

1. QHP Applicant Requirements

a. Quality Rating System

New York will use U.S. Centers for Medicare and Medicaid Services (“CMS”) generated quality ratings in 2024, which is based upon data provided to CMS by health insurers in 2023. Each rated health plan has an “overall” quality rating, ranging from 1 to 5 stars, which accounts for member experience, medical care and health plan administration.

More information about these ratings is available at <https://www.healthcare.gov/quality-ratings/>

b. Quality Improvement Strategy (“QIS”) or Quality Strategy (“QS”)

QHP Applicants must submit either a Quality Improvement Strategy (“QIS”) or a Quality Strategy (“QS”), as determined below.

We strongly recommend Applicants post the content of their QIS and QS information on their public website in a form that is appropriate for the public to review.

c. Quality Improvement Strategy (“QIS”)

QHP Applicants that offered QHP coverage through the Marketplace in 2021 and 2022, and continues operating in the Marketplace through 2023, and had more than 500 QHP

enrollees in a “product” (defined by CMS for this purpose as insurer model, including HMO, EPO, PPO, POS, etc.) as of July 1, 2022, must submit at least one QIS Implementation Plan form. When a QHP Applicant is continuing a QIS the applicant must submit a QIS Progress Report Form for the 2024 Plan Year.

QHP Applicants that meet the eligibility criteria to submit a QIS are required to use the QIS Implementation Plan form for the 2024 Plan Year if: implementing a QIS for the first time; discontinuing a current QIS and implementing a new QIS; or if implementing an additional QIS. If a QHP Applicant is continuing their current QIS either with or without modification, they do not need to submit a new QIS Implementation Plan Form for the 2024 Plan Year.

The QIS Progress Report Form for the 2024 Plan Year should be submitted for: QHP Applicants who are continuing their current QIS, with or without modifications; and QHP Applicants who are discontinuing their current QIS and implementing a new QIS.

The Modification Summary Supplement for the 2024 Plan Year should be submitted for QHP Applicants to indicate any modifications to an existing QIS Implementation Plan for the upcoming Plan Year (making changes to goals activities, measures, performance targets, and/or the product types). In addition, Applicants are required to use the Quality Improvement Strategy Technical Guidance and User Guide for the 2024 Plan Year resource for completion of the applicable forms.

These resources are available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Improvement-Strategy/QIS-General>. This website contains the 2024 Plan Year QIS forms and instructional documents regarding QIS implementation and reporting.

Applicants that submitted a new QIS Implementation Plan Form in Plan Year 2023 and have not made any changes to the QIS do not need to resubmit the QIS Implementation Plan Form for the 2024 Plan Year. The Applicant would be required to submit a QIS Progress Report Form for the 2024 Plan Year and if applicable a Modification Summary Supplement for the 2024 Plan Year.

Applicants must:

- i. Implement a QIS, described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- ii. Implement a QIS that includes at least one of the following:
 - Activities for improving health outcomes;
 - Activities to prevent hospital readmissions;
 - Activities to improve patient safety and reduce medical errors;

- Activities for wellness and health promotion; and/or
- iii. Implement at least one QIS that includes activities to reduce health and health care disparities.
- iv. Adhere to guidelines, including the QIS Technical Guidance and QIS User Guide established by Health and Human Services (“HHS”), in consultation with experts in health care quality and interested parties.
- v. Report on progress implementing the QIS to the DOH on a periodic basis.

QHP Applicants must submit the required QIS information as part of their participation proposal for the 2024 coverage year by completing the required parts of the 2024 Plan Year applicable forms including: the QIS Implementation Plan Form, the QIS Progress Report Form and the QIS Modification Summary Supplement.

The submitted QIS appropriate forms for the 2024 plan year will be evaluated by the NY State Department of Health (NYS DOH) Office of Quality and Patient Safety, in consultation with the NY State of Health. Based upon the results of the QIS evaluation, an overall outcome of “meets” or “does not meet” will be assigned to the QIS submission. QHP Applicants will be notified in writing regarding any corrective actions required.

a. Quality Strategy (“QS”)

QHP Applicants that did not offer QHP coverage through the Marketplace in 2021 and 2022 or did not have more than 500 enrollees enrolled in a product as of July 1, 2022, must develop a Quality Strategy (“QS”) that encompasses all the requirements set forth in 1311 (g) of the Affordable Care Act (“ACA”). This strategy must be implemented and updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

- 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 the medical home model, for treatment or services under the plan or coverage;
- 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;

- 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;
- The implementation of wellness and health promotion activities;
- The implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, social determinants of health, and cultural competency trainings; and including evaluation of such activities.
- 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.

b. Quality Reporting System (“QRS”)

QHP Applicants must submit quality data collected as part of the Quality Reporting System (“QRS”) and QHP enrollee survey requirements to NYS DOH. QHP Applicants should follow the 2024 Quality Rating System Measure Set Technical Specifications. These quality indicators 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”).

Applicants must report quality measures such as satisfaction data, birth files and optional enhancement files. All Applicants will be using one tool, the National Committee for Quality Assurance (“NCQA”) Interactive Data Submission System (“IDSS”) to submit to both NYS DOH and NCQA. All quality measures will be reported via the NCQA IDSS tool. CMS-QRS reporting will require Applicants to have:

- HEDIS Volume 2;
- NCQA IDSS tool;
- Programming for all required measures (either in house capability or via a vendor);
- A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to NCQA; and
- A certified and HHS approved survey vendor to administer enrollee experience surveys.

To reduce disparities across patient groups, health plans must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their member population. As a first step towards stratification of quality data by

patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self-reported race and ethnicity information that consumers provide as part of the NY State of Health application. All plans must provide this data as part of the patient record with their QARR submissions.

c. Enrollee Satisfaction Survey

QHP Applicants must annually survey a sample of their Marketplace eligible members to allow the DOH to assess members' experience of care, including their access to care as well as their interactions with their providers and health plan. This information will be collected through the enrollee satisfaction survey under CMS guidelines. The NYS DOH will use the experience of care information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies.

2. EP Applicant Requirements

a. Quality Strategy ("QS")

EP Applicants must comply with the Quality Strategy ("QS"), as outlined above.

b. Quality Reporting

EP Applicants will be required to participate in the NYS 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") and the 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 Technical specifications are released annually during the Spring of the measurement year, with reporting of QARR data due on or about the following June 15.

Applicants must report quality measures such as satisfaction data, birth files and optional enhancement files. All Applicants will be using one tool, the National Committee for Quality Assurance ("NCQA") Interactive Data Submission System ("IDSS") to submit to both NYS DOH and NCQA. All quality measures will be reported via the NCQA IDSS tool. CMS-QRS reporting will require Applicants to have:

- HEDIS Volume 2;
- NCQA IDSS tool;
- Programming for all required measures (either in house capability or via a vendor);
- A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to NCQA; and
- A certified and federally approved CAHPS vendor to administer satisfaction surveys.

To reduce disparities across patient groups, health plans must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their member population. As a first step towards stratification of quality data by patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self-reported race and ethnicity information that consumers provide as part of the NY State of Health application. All plans must report this data with their QARR submissions. Essential Plan Applicants should have reached 80% completeness for data on race and ethnicity in the measurement year 2022 submission which will be due to NCQA and the NYS DOH in the Spring of 2023.

c. Screening for Social Determinants of Health

EP Applicants will be required to screen 85% of their members for social determinants of health in their preferred language at enrollment or re-enrollment. The data will be collected via the Social Needs Screening-Electronic HEDIS measure which is required for aggregate and patient level detail reporting in NYS' QARR 2024 specifications.

It is highly encouraged that the EP Applicants use the Center for Medicaid and Medicare (CMS)'s Accountable Health Communities Health Related Social Needs Screening Tool to align with current screening for Health Home members and potential future screening requirements for Medicaid members.

EP Applicants may use health care providers or other tools to help complete screenings but will be responsible for submission as outlined by the HEDIS specification for the measure. This limits the provision of data to members continuously enrolled as defined by the measure. Screened for social determinants of health is defined as that a screening for food, housing, and transportation was conducted and that a positive or negative finding of the screen was captured.

The NY State Department of Health has established an EP Quality Incentive Pool which shall provide incentive payments to health plans that achieve specified levels of performance on quality and consumer satisfaction measures and such other factors, including but not limited to reducing

health care disparities, as determined by the NYS DOH.

d. Satisfaction Survey (“CAHPS”)

EP Applicants will be required to annually survey a sample of their eligible members to allow the DOH to assess many aspects of the member’s experience of care, including their access to care and services, their interaction with their providers and health plan.

For EP, this information will be collected using a national satisfaction survey methodology called Consumer Assessment of Healthcare Providers and Systems (“CAHPS”).

The DOH will use the experience of care information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies

e. Accreditation

The DOH will not require Applicants to be accredited as a condition of participation in 2024.

H. 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, the number of claims that are denied, customer service information, rating of provider practices, information on cost-sharing and payments with respect to any 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 the site of service and may also include diagnosis information. Each encounter must be recorded in an information system as each unique occurrence between recipient and provider. Encounters must 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 also 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.

I. Certification, Recertification and Decertification Processes

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 plan issuer certified by the Marketplace 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 applicable law. Decertification of individual products 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

Plan issuers may opt not to renew participation or products in the Marketplace. The issuer must notify DOH of its decision not to renew, no later than thirty (30) days prior to the start of Open Enrollment. The Issuer shall cooperate with DOH in the development of a plan to facilitate the orderly transition of its members, including, but not limited to, notification to consumers and providing DOH with member specific information to the extent permitted by law. In addition, per Executive Order 167, an issuer that withdraws from the Qualified Health Plan market cannot participate in Medicaid, Child Health Plus or the Essential Plan.¹

4. Suspension

The DOH may suspend enrollment in a health plan in the event a 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.

J. Federal and State Laws and Regulations

1. Federal Laws, Regulation and Guidance

The Applicant shall always 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, as amended. The two laws are collectively referred to as the Affordable Care Act (“ACA”);
- American Rescue Plan Act of 2021
- 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; and
- 42 CFR Part 600 and other related guidance and instruction;

2. State Laws and Regulations

¹ Executive Order No. 167, issued June 9, 2017 [9 NYCRR 8.167], and continued through Executive Order [Hochul] No. 6 [9 NYCRR 9.6].

The Applicant shall always 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:

3. 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 § 4308 (Supervision of Superintendent);
- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance);
- Executive Order No. 167, issued June 9, 2017 [9 NYCRR 8.167], and continued through Executive Order [Hochul] No. 6 [9 NYCRR 9.6].

4. 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>);
- Discrimination Based on Sexual Orientation, Gender Identity and/or Gender Dysphoria, DFS Insurance Circular Letter No. 9 (2018), June 25, 2018

5. 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 § 4909 (Prescription Drug Formulary Changes);
- N.Y. Insurance Law § 4909 (Prescription Drug Formulary Changes);
- N.Y. Public Health Law § 4910 (Right to External Appeal);
- N.Y. Insurance Law § 4323 (Marketing Material); and
- N.Y. Insurance Law §§ 3217-a and 4324 (Disclosure of Information).

6. 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 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 2024 Schedule of Key Events, 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.

A form Letter of Interest is attached to this Invitation as Attachment “E” for QHP Applicants, EP Applicants, SADP Applicants and Small Business Market (SHOP) Applicants. Please indicate which offerings you are interested in participating in for 2024.

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 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. 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 demonstrates 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:

- Withdraw the Invitation at any time, at the DOH’s sole discretion;
- Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation;
- 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; and
- At any time during the Invitation process, amend the Invitation to correct errors or omissions, 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 the PNDS website 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 Contents

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

For QHP Applicants and Stand-Alone Dental Plan Applicants:

- i. Participation Proposal;
- ii. Submission of Policy Form, Rates, and Binders to DFS for QHP and SAD Applicants;
- iii. Submission of Provider Network Information, Verification of Networks and Appointment Availability Standards/Monitoring;
- iv. QIS Implementation Plan and Progress Report Form or Quality Strategy (QHP Applicants Only).
- v. Submission of QDP Benefit Cost Sharing Template to DOH

For EP Applicants:

- i. Participation Proposal;
- ii. Submission of Subscriber Agreements to DOH for EP Applicants;
- iii. Submission of EP Information Templates to DOH;
- iv. Submission of Provider Network Information, Verification of Networks and Appointment Availability Standards/Monitoring and
- v. Quality Strategy.

Each of the component parts must be received by the due dates set forth in the 2024 Schedule of Key Events, listed in this Invitation. Late submissions may not be accepted.

2. QHP, SADP, and EP Applicant Instructions

a. Participation Proposals

Applicants shall submit one electronic signed copy of the Participation Proposal 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 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 "F" (QHP Applicants and SADP Applicants) and Attachment "J1" (EP Applicants). Applicants applying to offer both QHPs and EPs must complete **both** Attachments.

b. Submission of Policy Forms and Rates to DFS for QHP Applicants

As set forth in Section II(B), 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 Subscriber Agreements and Templates to DOH for EP Applicants

As set forth in Section II (B), EP Applicants will be required to submit EP Subscriber Agreements to DOH. EP Applicants will also be required to submit plan information via DOH required templates. Policy forms and templates must be sent directly to the Applicant's assigned Plan Manager by the due date indicated in the 2024 Schedule of Key Events.

d. Submission of Provider Network Information

As set forth in Section IV (C)(6), Applicants shall submit their network through the Provider Network Data System ("PNDS") in accordance with the Provider Network Submission Instructions contained in Attachment "P" to this Invitation.

e. Submission of Quality Improvement Strategy or Quality Strategy

As set forth in Section IV (G), QHP Applicants and EP Applicants shall submit their QIS or QS as part of the Participation Proposal.

f. Vendor Responsibility

On or around the same time that 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 questions about the VendRep System contact 866-370-4672 or 518-408-4672 or ITServiceDesk@osc.state.ny.us

g. Submission of HHS Form 690, Assurance of Compliance

Applicants shall, as a condition of certification pursuant to 45 C.F.R. Part 92.5, submit an original, signed copy of HHS Form 690, Assurance of Compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act.

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 NY 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.

G. 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 provide Applicants with an Agreement. The Agreement resulting from this Invitation will be effective only upon approval by 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 for their products to be certified and offered through the Marketplace.



Section VI: Attachments

| Attachment Designation | Attachment Name |
|-------------------------------|---|
| Attachment "A" | 2024 QHP Essential Health Benefits |
| Attachment "B" | 2024 Standard Products Cost-Sharing Chart |
| Attachment "C" | QHP and SADP Rating Regions by County |
| Attachment "D" | QHP and SADP Rating Regions Map |
| Attachment "E" | 2024 Letter of Interest |
| Attachment "F (1)" | 2024 QHP and SADP Participation Proposal |
| Attachment "F (2)" | 2024 QHP Products Offered by County and Market |
| Attachment "F (3)" | 2024 SADP Products Offered by County and Market |
| Attachment "G" | EP Benefits and Cost-Sharing Chart |
| Attachment "H" | EP Rating Regions |
| Attachment "I" | EP Rating Regions Map |
| Attachment "J (1)" | 2024 EP Participation Proposal |
| Attachment "J (2)" | 2024 EP Products Offered by County |
| Attachment "K" | 2024 EP Template Instructions |
| Attachment "L" | 2024 EP Admin Template |
| Attachment "M" | 2024 EP Plans Template |
| Attachment "N" | 2024 EP Rates Template |
| Attachment "O" | 2024 EP Service Area Template |
| Attachment "P" | 2024 Provider Network Submission Instructions |
| Attachment "Q" | 2024 URL Template Instructions |
| Attachment "R" | 2024 URL Template |
| Attachment "S" | 2024 QDP Template Instructions |
| Attachment "T" | 2024 QDP Template |



Section VII: Definitions

For purposes of this Invitation:

"Affordable Care Act ("ACA")" shall mean the Federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152).

"Applicant" and **"Applicants"** shall mean health plan issuers applying to offer medical or dental coverage and applying for certification or recertification.

"Certification" shall mean the Marketplace's authorization of a Qualified Health Plan, Stand-Alone Dental Plan or an Essential Plan to be offered on the Marketplace based on verification that a Plan complies with the requirements of the Invitation, as modified by the Marketplace.

"Cost-Sharing Reduction (CSR)" shall mean the Federal Program pursuant to 45 C.F.R. § 155.305(g), which provides federal reductions to cost-sharing on Essential Health Benefits for an Enrollee with a household income at or below a specified percent of the federal poverty level.

"Essential Plan" or "EP" shall mean a health benefit plan that has been certified by the state as an Essential Plan pursuant to NY Social Services Law § 369-gg(1)(e), to be offered through the Marketplace in accordance with NY State Social Services Law § 369-gg(1)(a).

"Essential Plan Applicant" or "EP Applicant" shall mean an insurer that is applying to offer the Essential Plan.

"Enrollee" shall mean an Eligible Individual enrolled in a Qualified Health Plan, Stand-Alone Dental Plan or an Essential Plan offered through the Marketplace.

"Invitation" shall mean the Invitation and Requirements for Insurer Certification and Recertification for Participation and the attachments thereto, issued by the Marketplace to health plan issuers to participate in Qualified Health Plans, Essential Plans and Stand-Alone Dental Plans, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website.

"Marketplace" shall mean NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange or Exchange) established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012 and codified in the NY Public Health Law in 2019.

"Non-Participating Provider" shall mean a provider of health care services or dental services with which the Applicant has no provider agreement.

"Participating Provider" shall mean a provider of health care services or dental services that

has a provider agreement with the Applicant.

"Personally Identifiable Information" ("PII") shall mean information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information" ("PHI") shall refer to individually identifiable health information as defined in 45 CFR 164.402.

"Qualified Employee" shall mean an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the small business marketplace, in accordance with 45 C.F.R. § 155.20 and Marketplace policies and procedures.

"Qualified Employer" shall mean an employer that (i) has 100 or fewer employees; (ii) small business marketplace(a) has its principal business address in the Marketplace service area small business marketplace or (b) offers coverage to each eligible employee through the small business marketplace serving that employee's primary worksite.¹ An employer that meets these criteria and which has at least one employee that is not the owner's spouse enrolled in coverage shall be authorized to offer Qualified Employees the ability to purchase Qualified Health Plans through the small business marketplace.

"Qualified Health Plan" or "QHP" shall mean a health benefit plan that has received the Marketplace's certification to be offered through the Marketplace, including a Stand-Alone Dental Plan except where otherwise noted.

"QHP Applicant" shall mean a health insurer that is applying for QHP certification or recertification that offers medical coverage.

"Qualified Individual" shall mean an individual that is eligible, pursuant to the ACA and federal regulation, to enroll in a QHP through the Marketplace.

"Recertification" shall refer to the Marketplace's annual review and verification of a Qualified Health Plan's compliance with the requirements for certification and the provisions of applicable law regarding Qualified Health Plans.

"Service Area" shall mean the geographic area(s) designated by the NY State Department of Health or NY State Department of Financial Services ("DFS") in which an Applicant's Qualified Health Plan(s) shall be offered.

"Small Business Marketplace" (a/k/a the "Small Business Health Options Program, or SHOP") shall mean the Small Business Health Options Program, as defined at ACA § 1311 (b)(1)(B) and 45

C.F.R. Part 155.

"Small Employer" shall mean an employer with 1-100 FTE employees.

"Special Enrollment Periods" shall, as described in 45 C.F.R. § 155.420, and applicable law and guidance, mean the periods during which a qualified individual or enrollee who experiences certain qualifying events as set forth in federal regulation, may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual open enrollment periods.

"Stand-Alone Dental Plan" or "SADP Applicants" shall mean a dental services plan that has received the Marketplace's certification to be offered through the Marketplace.