Invitation for Health Insurer and Dental Plan Participation in the New York Health Benefit Exchange:

Questions and Answers (as of June 3, 2013)

QHP and Dental Plan Invitation:

New – Posted 6/3/2013

Q. Could you provide additional guidance on the treatment cost calculator? Beyond the information offered in the invitation, would a link to the Fair Health cost calculator satisfy this requirement?

A. Use of a link to the Fair Health cost calculator would be sufficient to meet the treatment cost calculator requirement. **Contact FAIR Health if you wish to set up a link in order to establish an appropriate licensing arrangement.**

New – Posted 6/3/2013

Q. Section II.G.2(b)(2) of the Invitation requires the Applicants to use the logo and branding designated by the Department of Health on their marketing and outreach materials, as well as the Exchange website and toll-free telephone number. When can Applicants obtain this information?

A. The Department of Health is unable to provide a date certain when such information will be available for use by Applications. Accordingly, the Invitation is hereby amended to state that the Applicants *may*use the logo and branding designated by the Department of Health, and *may*use the Exchange website and toll-free telephone number, on their marketing and outreach materials. The Department of Health will provide such information to the Applicants as soon as it becomes available.

Posted 4/16/2013

This is to clarify the number of non-standard products that may be offered by Applicants. This clarification supersedes all prior instructions, including the January 31, 2013 Plan Invitation and previous Questions and Answers issued by the DOH.

Applicants may elect to offer:

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

(2) At least one and not more than 3 non-standard products at each metal level subject to the following:

(a) The number of non-standard products at any metal level may not exceed the number of non-standard products at any other metal level by more than one; and
(b) The number of non-standard bronze products may not exceed the number of non-standard products of at least one other metal level.

Permissible combinations under 2 above include:

1 bronze, 2 silver, 1 gold, 1 platinum
1 bronze, 1 silver, 2 gold, 1 platinum
1 bronze, 1 silver, 1 gold, 2 platinum
1 bronze, 2 silver, 1 gold, 2 platinum
2 bronze, 2 silver, 1 gold, 1 platinum
2 bronze, 2 silver, 2 gold, 1 platinum
3 bronze, 3 silver, 2 gold, 2 platinum
3 bronze, 3 silver, 3 gold, 2 platinum
3 bronze, 2 silver, 3 gold, 2 platinum
3 bronze, 2 silver, 3 gold, 3 platinum

We will permit the participation proposals to be modified only as a result of the above modification. To meet the above requirement, insurers can either remove non-standard products or submit additional non-standard products. We will be contacting each insurer directly by the end of the week to see how they would like to proceed. In the event, an insurer chooses to add non-standard products to conform to the above, DFS will permit the insurer to submit such additional Exchange non-standard products no later than May 15.

Posted 4/2/2013

Q. Has New York modified the deadlines for QHP and Dental Plans to submit the participation proposal, addenda, networks, and SERFF Plan Management templates?

A. The following modifications have been made.

- QHP and Dental Plan participation proposals and the supporting addenda are due on April 15th. Applicants will be able to revise proposals and addenda throughout the certification process as needed.
- Health Insurer Applicant and Dental Insurer Applicant SERFF form and rate filings are due on April 15. However, DFS is willing to entertain requests for extensions, and filings must be made no later than April 30.
- Health Insurer Applicant SERFF Plan Management Binder filings containing the CCIIO data templates are due April 30th.

- Provider network submissions are due on April 30th.

- Dental Plan Applicant SERFF Plan Management Binder filings containing the CCIIO data templates will be due after they are released, likely at the end of May.

However, we encourage Applicants to submit filings as early as possible, which will facilitate DFS and DOH review.

Posted 3/6/2013

Q. Given that the federal government updated the Actuarial Value (AV) Calculator last week, will the State be revising the standard benefits included in the Application? If so, when will plans receive updated guidance?

A. The Department of Financial Services is in the process of reviewing the standard benefits based on the revised AV Calculator. Updated guidance, if needed, will be available during the week of March 11th.

Posted 3/6/2013

Q: Given that final regulations were promulgated by CCIIO last week, will the DOH be extending the deadline for submission of questions?

A: Yes, the DOH will be extending the deadline for submission of questions from March 1, 2013 to March 29, 2013.

Posted 3/6/2013

Q: Section II.G.1.d of the Invitation references the Participation Form Submission Due Date. Is Attachment E - Participation Proposal of the Invitation the Participation Form that is due on April 5th?

A: Yes, Attachment E - Participation Proposal is the Participation Form that is due on April 5, 2013.

<u>QHP and Dental Plan Proposal Submission:</u>

Posted 5/7/2013

Q: Must all stand-alone dental QHPs offered within the Health Benefit Exchange include coverage of the pediatric essential health benefit?

A: Yes. According to 45 CFR 155.1065(a)(2), stand-alone dental plans certified to be offered within the Health Benefit Exchange must cover at least the pediatric dental essential health benefit. Accordingly, the Invitation is amended to require the following for stand-alone dental plans:

- One standard pediatric dental plan that includes only pediatric dental benefits; the standard pediatric dental plan must include the pediatric dental benefits set forth in Attachment A, Essential Health Benefits, and may include additional benefits. The standard pediatric dental plan may be offered at either 85% actuarial value or 70% actuarial value, but not both.

- Up to 2 additional non-standard dental plans in each county of the service area; the non-standard dental plans can consist of either another pediatric dental plan at a different AV level and/or another dental product that includes the required pediatric dental benefits. Such non-standard products can be offered at various rating tiers (ie, individual, couple, parent/child(ren), couple/child(ren)) and can include adult benefits. The non-standard products must include the pediatric dental benefits set forth in Attachment A, Essential Health Benefits.

Given the above change, stand alone dental carriers may resubmit their Participation Proposals only to conform to the above guidance and will have until May 15, 2013 to make such modifications. If a modification is needed to the Participation Proposal, submit the entire revised Participation Proposal and Addendums 4 and 5 to nyhxpm@health.state.ny.us. Please be sure the Addendums are sent in Excel.

Posted 5/7/2013

Q. The most recent amendment to the Notice of Benefit and Payment Parameters provides an exception for State Based exchanges regarding requiring issuers to develop plan variations for all QHPs offered on the Exchange (regardless of metal level) for applicants that are American Indians (AI) or Alaska Natives (AN). Will New York require Health Insurer Applicants to offer zero cost share products for eligible AI/AN customers at each metal level?

A. Yes, all Health Insurer Applicants must offer a zero cost share product for eligible AI/ANs at each metal level.

Posted 5/7/2013

Q. Are we correct in assuming that we can add out-of-network benefits to the Standard Plans, and those plans will still be considered "Standard"?

A. Yes, out-of-network benefits may be a component of Standard Plans.

Posted 5/7/2013

Q. Are we understanding correctly that if benefits (such as adult dental) are added to the standard plans, the plan would then be considered "non-standard", even if the cost sharing for all identified, covered benefits remains the same, or would that be classified as a "standard" plan? Does the answer change depending upon whether or not the added benefit is part of an EHB category?

A. Per Section II.D.1.c of the Invitation, the standard product offered by Health Insurer Applicants must include the same benefits and visit limits as delineated in Attachment A and the same cost-sharing limitations delineated in Attachment B. This requirement applies to the Individual Exchange and the SHOP Exchange. Therefore, adding benefits to the Essential Health Benefits would create a Non-Standard product. Applicants can choose to offer benefits such as the adult dental benefit in non-standard plans.

Posted 5/7/2013

Q. Attachment B of the Participation Proposal has a line item for Pediatric Dental Services and states: 50% cost sharing for Bronze, 0% cost sharing for catastrophic and 0% cost sharing on sharing variation less than or equal to 300% FPL. Can you please clarify how we are supposed to interpret this with regards to Stand-alone dental plans?

A. The most recent version of Attachment B states: "Note: The pediatric dental cost sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan will have its own deductible and cost sharing arrangements and associated premium."

Revised – Posted 4/3/2013

Q. Which specific federal templates will be required to be submitted with the proposal in April? What specific Riders are Applicants required to file with Exchange products for Individual and SHOP products, Standard and Non-Standard products, and Catastrophic and Child only products?

A. The following plan management templates will be required upon the **April 30th** Submission:

- Administrative Template
- Plan/Benefit Template
- Prescription Drug Template
- Network Template
- Service Area Template
- Rate Data Templates
- Uniform Rate Review Template
- Business Rules Template

These templates can be found on the SERFF website:
http://www.serff.com/plan_management_data_templates.htm
These templates must be submitted in the QHP filing in SERFF. DFS is in the process of finalizing instructions on how to complete the templates, and the instructions will be posted to this DFS website: http://www.dfs.ny.gov/insurance/ihealth.htm.

Posted 4/1/2013

Q: Will the new regulations regarding guarantee issue have an impact on the Minimum Participation requirement set forth in Section II.D.4.c of the Invitation?

A: Yes. By way of this answer we are amending the Invitation to remove Section 11.D.4.c. Minimum Participation is no longer required.

Posted 4/1/2013

Q. NYS has stated that Applicants will submit their Network through the HPN process. Does that mean that Applicants do not need to fill out the Federal Network template? The Plan Data template has a dependency on the Network template (per import) so it will need to be filled out from that perspective. Additionally there is a required field for a network URL. What is that URL? Where do Applicants get it?

A. Applicants will be required to submit their network through the HPN process. However, the Plan Benefits Template submitted through SERFF is dependent on the Network and Service Area templates being completed, and therefore Applicants must submit all the required templates including the Network Template submitted through SERFF. The URL in the Network Template only requires a link to the Applicant's provider directory that the Exchange may use on the Exchange web site.

Posted 4/1/2013

Q. Section III.C.6.a of the Invitation indicates that the factor for Single + Child(ren) is 1.70 and the factor for Single + Spouse + Child(ren) is 2.85. Is there the potential for viewing this as charging more for children if they are attached to a couple versus a single parent?

A. The single + children rate is for coverage of one parent with one or more children. This factor includes an assumed number of children per family where only one parent is covered. The single +spouse + children rate is for coverage of two parents with one or more children. This factor includes an assumed number of children per family. Based upon a review of premium rate filings, it is appropriate to assume a higher number of children will be covered when spousal coverage is issued. For a family with husband and wife and 3 children, where the husband covers the 3 children and the wife is covered by her own group plan, the rate for the husband would be single + child(ren).

Posted 4/1/2013

Q. Do Attachment E and addendums 1 and 3 need to include details on the 3 CSR plans and the Native American Plans?

A. No. The cost-share reduction plans and the Native American plans are variations of products that will be filed, and Health Insurer Applicants do not need to include this information on Attachment E and Addendums 1 and 3.

Posted 4/1/2013

Q. Does an Exchange Broker compensation schedule have to be filed with the rates and forms?

A. Yes. A broker compensation schedule must be filed with premium rates consistent with all policies.

Posted 4/1/2013

Q. Can Applicants offer products with rates that differentiate whether a broker is involved in the sale of the product or not? For example, for each unique metal level plan sold, can an Applicant file two sets of premium rates; one with the broker compensation built in to the rates for groups that use brokers and a lower rate that doesn't include a broker load for groups that don't use a broker? Can the Applicant create unique products that are marketed through brokers vs. those that aren't with the broker compensation only included in those products available to be sold through a broker?

A. At this time, state laws and regulations do not permit differentiation of premium based upon whether a broker is used or not.

Posted 4/1/2013

Q. With reference to Section III.C.6.b of the Invitation, the language for child-only policies says, “Separate policy forms must be created and provided to enrollees of child-only products.” What is the separate policy form being cited? Wouldn’t the policy form be the same form as the Standard Product policy form for the Individual Exchange on each metal level? Is this referring to the separate rate filing form?

A. Model contract language and filing instructions are currently being drafted which will address this question. These types of policies will have a distinct filing number and form number. The benefits of the Child Only policies will be the same as the standard products for the Individual Exchange. However, the eligibility and termination sections of the policy forms will differ.

Posted 4/1/2013

Q. In the list of requested URLs in the Participation Proposal, please describe what DOH is referring to for both “Product Descriptions (if applicable)” and for “Summary(ies) of Benefits.” We are interpreting these as marketing descriptions/materials and SBCs respectively. Is this correct?

A. The URL linking to a product description would be a link to a webpage with information about the product that might include information such as an overview of covered services and cost sharing, premium information, provider network information, and more. It could also be a link to an online marketing brochure. The URL for the Summary of Benefits would be a link to the Summary of Benefits and Coverage required by the ACA.

Posted 4/1/2013

Q. Given the lengthy timeline for trademark review required for product naming (which will not be complete for many plans by the 4/15 filing deadline), will Applicants be allowed to submit "placeholder" names for Exchange products, and then update those names prior to the Exchange going live for enrollment?

A. Final product names may be provided to the DOH after the April filing deadlines and prior to September when testing of information on the Exchange portal will commence.

Posted 4/1/2013

Q. Is a wholly owned subsidiary company, such as a pharmacy benefits administrator, considered a separate service entity for purposes of Section 2 of Attachment E?

A. Yes, a subsidiary company should be considered a separate entity.

Posted 4/1/2013

Q. Should the actuarial value ("AV") associated with a particular plan always be based on a single policy and not a family policy?

A. The AV Calculator standard population and claims data were developed using claims data that did not include any family cost-sharing information. Applicants offering plans with deductibles and/or out of pocket maximum costs that accumulate at the family rather than the individual level have several options depending on the specifics of the family plan. In the case of a plan with a deductible and/or out-of-pocket maximum that accumulates first at the individual level and in addition at the family level, the plan enters the individual deductible and out-of-pocket maximum into the AV Calculator to determine AV. If deductible and out-of-pocket maximum accrues only at the family level and not at the individual level, the issuer may either include the family deductible and out-of-pocket maximum into that actuarial value calculator or, if the issuer believes that the family plan cost-sharing features of the plan's cost-sharing features will make a material difference in the AV produced by the calculator, the issuer may use one of the §156.135(b) exceptions described above to calculate AV and include plan-specific data on how the family-specific cost sharing is adjusted.

Posted 4/1/2013

Q. Regarding plan designs for QHPs offered in the Exchange, can Applicants include waiting periods for major services?

A. No. Waiting periods are not permissible.

Posted 4/1/2013

Q. Are there any restrictions on the product names (e.g. character limitations, etc)?

A. No, as of today, there are no character limitations for product names.

Posted 4/1/2013

Q. Can you clarify what "Network Name" and "Network ID" refer to on Addendum 1? Do these need to match the Network Name and Network ID fields on the Plan Maintenance Network template managed by CMS/CCIIO?

A. Network name refers to the name of the provider network used by the Applicant to identify the network. Network ID is an ID given to the Applicant for each network upon entering the Network information into the SERFF Network Template. The Network ID on Addendum 1 needs to match the Network ID entered on the SERFF Network Template for that particular QHP.

Posted 4/1/2013

Q. If a Health Insurer Applicant would like to offer adult dental as an additional non-standard benefit, does Addendum 4 need to be completed or can the Applicant complete Addendum 1 to indicate this non-standard product?

A. Addendum 4 is to be used by Applicants offering only stand-alone plans. If adult dental is being added as a benefit to a nonstandard product, Applicant should use Addenda 1, 3, 4, or 5 to identify the product they are submitting and for which counties they are being submitted. Applicant should then also use Addendum 2 to indicate changes/additions to the Essential Health Benefits for this particular product.

Posted 4/1/2013

Q. If a health plan currently offers only Medicare plans, is the health plan subject to the out-of-network requirements in the 2014 state Exchange?

A. The requirement refers to only the commercial markets inside and outside of the Individual and SHOP Exchange, and does not pertain to out-of-network business sold through the Medicare program.

Posted 3/18/2013

Q: Based upon the most recent final regulations, CCIIO permits the states to expand upon the number of rating regions. Will NYS be expanding the number of rating regions from the ones shown on Attachment C to the Invitation?

A: Yes. This response amends the Plan Invitation issued on January 31 to make Long Island (Nassau and Suffolk counties) a separate rating region. Attachment C to the Invitation will be revised to reflect this change and posted on this website very soon.

Posted 3/18/2013

Q. What would DFS/DOH expect to see in policy language or benefits for child only plans? The Invitation to Participate indicates that "separate policy forms must be created and provided". In addition, the federal regs indicate that child only plans are those plans with "only child only enrollees". What if anything makes these unique other than the rates?

A. Other than the rates, the only unique characteristic of these plans is that the enrollment is limited to children under the age of 21. DFS is developing model language to address child only plans.

Posted 3/6/2013

Q: In Section 5 of Attachment E - Participation Proposal, at what level of detail do the Summaries of Benefits need to be? Will templates be provided and/or required?

A: 45 CFR Part 147.200 describes the requirements for Summary of Benefits and Coverage and Uniform Glossary of Terms. The template mandated for use by the ACA can be found on the CCIIO website here: http://cciio.cms.gov/resources/other/index.html#sbcug. The DOH requires applicants to submit their summary of benefits URLs during the certification process.

Posted 3/6/2013

Q: Are the submission deadlines the dates that QHP Forms should be received by the Exchange, or may submissions be postmarked by that date? For example, the Participation Proposal must be sent via physical mail, should it be mailed a few days earlier to guarantee receipt by April 5th?

A: Submissions sent via physical mail should be received by DOH by April 5th. For items sent electronically, a date on or before the submission due date is acceptable.

Posted 3/6/2013

Q: What type of signature is required for submission of Proposals? Are electronic signatures acceptable?

A. The proposal can be scanned and sent electronically, however applicants must submit two (2) original, signed copies of the Participation Proposal by mail or hand delivery to the address listed in Section V.C of the Invitation.

Posted 3/6/2013

Q: Section II.G.1.d of the Invitation indicates information must be provided to prospective enrollees and enrollees in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites. Does this include providing subscriber contracts for prospective Individual & SHOP enrollees? Is it acceptable to provide only a URL for access to the contracts, if required?

A: Several provisions of New York State law govern the disclosure of information to prospective and current enrollees. (See, e.g., NY Public Health Law § 4408, NY Insurance Law §§ 3217-a, 4324) These provisions require that written disclosure of information be provided under certain circumstances, including upon the request of a prospective subscriber.

Posted 3/6/2013

Q: Do the URL links for product descriptions, summary of benefits, provider directory, prescription drug formulary, and treatment cost calculator need to be available and active by the April 5th submission of the Participation Proposal or can these links be submitted at a later date?

A: The DOH will begin evaluating Applicant Proposals for certification as soon as they are received and anticipates that the certification process will complete in mid-July of 2013. If the URLs will not be functional by April 5th, Applicants must identify the URLs that are not functional and the reason they are not functional. In this circumstance, Applicants must submit at minimum test link URLs or screen shots of the URLs to the DOH upon request prior to the conclusion of the certification process.

Posted 3/6/2013

Q: Will there be guidance on the creation or use of the Treatment Cost Calculators?

A: The DOH does not anticipate HHS releasing additional guidance on the Treatment Cost Calculators. Health insurer accreditation agencies such as the NCQA may be a source of additional guidance on the cost calculators.

Posted 3/6/2013

Q: Regarding the Vendor Responsibility requirement in the Invitation, does "vendor" refer to Insurers applying for participation in the Exchange or third party vendors that insurers may use to administer benefits, such as a Pharmacy Benefit Manager?

A: The Vendor Responsibility Requirement applies to Applicants applying for certification to participate in the Exchange as a QHP or Dental Plan.

Posted 2/8/2013

Q: If an Applicant and/or its affiliate(s) have different “DBAs” and each DBA covers a distinct service area, is a separate Letter of Interest and Participation Proposal required for each DBA?

A: Yes. Given the explanation in the Answer to the last question in the Number of Products section, separate Letters of Interest and Participation Proposals are required.

<u>Dental Plan Submissions:</u>

Posted 4/1/2013

Q. Given the recent regulations that CCIIO released, will the Department of Health be modifying the Stand-Alone Dental requirements?

A. Yes. The answers in this section amend Section II.D.2.b of the Invitation requirements for Stand-Alone Dental Applicants as identified in bold below:

b. Standard Product. The Stand-alone Dental Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the Stand-alone Dental Applicant must include the same pediatric benefits as outlined in Attachment A. The Standard product can be offered at either a high level (85% AV) or a low level (70% AV), but not both. This requirement applies to both the Individual Exchange and the SHOP Exchange.

Posted 4/1/2013

Q. Section II,D.2.a and Addenda 4-5: Does pediatric dental Essential Health Benefits in the SHOP mean a Child Only plan?

A. Per Section II.D.1.h of the Invitation, Federal law requires coverage for pediatric dental services and permits such services to be covered by health insurers or stand-alone dental carriers. Stand-alone Dental Applicants must agree to provide the pediatric dental benefits outlined in Attachment A. The pediatric dental benefits are minimum benefits and the Stand-alone Dental carrier may add benefits. Stand-alone dental plans can also offer family coverage which must also include the pediatric dental benefits included in the Essential Health Benefits (Attachment A).

Posted 4/1/2013

Q. Will stand-alone dental carriers be required to submit encounter data as described in MEDS3 Data Element Dictionary version 3.2 May 2012? Would reporting of submitted claims and related information satisfy this requirement?

A. Per Section II G.3.c of the Invitation, stand-alone dental carriers will be required to submit encounter data in a format and manner to be prescribed by the Department of Health. The MEDS3 Data Element Dictionary was added to the Invitation as an informational tool the Applicant can use to assess the level of information that is required to submit encounter data.
http://www.health.ny.gov/health_care/managed_care/docs/dictionary_meds3.pdf

Posted 4/1/2013

Q. Will stand-alone dental carriers be required to report on claims from members who visited an out-of-network provider?

A. Yes, stand-alone dental carriers will be required to report on claims from members who visit out-of-network providers. The Data Element Dictionary gives examples of how to report this data when provider ID information is unknown.

Posted 4/1/2013

Q. Please confirm that the NY HBEX will work with dental stand-alone carriers in the development of dental relevant quality strategy as outlined in Section 1 (E) 1.

A. The Department of Health anticipates working with dental carriers in the development of quality parameters for dental services.

Posted 4/1/2013

Q. Please confirm if the 3 plan offering limit for stand-alone dental plans applies to both the SHOP and Individual markets together or if dental stand-alone plans can offer 3 plans in the SHOP Exchange and 3 plans in the Individual Exchange.

A. A total of 3 plans may be offered in each Exchange - 3 plans in the SHOP Exchange and 3 plans in Individual Exchange.

Posted 4/1/2013

Q. Are dental plans authorized to determine plan exclusions and/or frequency limitations that are not already defined in this Attachment A: Essential Health Benefits?

A. Dental Plan Applicants may further refine exclusions and frequency limitations, to the extent they are not addressed in Attachment A, the Essential Health Benefits.

Posted 4/1/2013

Q. Pediatric Dental Services indicate a cost share only for a dental office visit. A dental office visit is equivalent to a dental examination and does not usually include operative procedures. Does the cost share apply to all dental services? Is the cost share 1 copay per date of service per provider?

A. Oral surgery in the dentist's office would be treated the same as surgery in a doctor's office with the dentist being considered a specialist. If on the same day there was a dental examination and oral surgery, then one copay can be charged for the dental examination and in addition a specialist copay for the oral surgery. For a dental examination that does not include oral surgery, one copay per date of service per provider would apply.

Posted 4/1/2013

Q. For the pediatric Essential Health Benefits, the Invitation indicates Orthognathic surgery, TMD, and maxillofacial prosthodontics must be provided in network or through referral. These services are typically covered as medical services. Is it the expectation that these services would now need to be covered by a stand-alone dental plan? Attachment A – Essential Health Benefits references non-dental oral surgery for TMD and Orthognathic surgery under a medical plan. Will you provide clarification as to which procedures are expected to be covered under stand-alone dental policies, as many of the procedures mentioned are not typically covered in a stand-alone dental plan? Also, can the Exchange provide clarification regarding the procedure codes and circumstances in which oral surgery would be covered? How will the exchange define routine dental surgery vs. oral surgery.

A. All the benefits contained in Child Health Plus for dental coverage are considered part of the Essential Health Benefit package. Coverage for TMJ that is medical in nature or oral surgery to treat an accidental injury to a sound natural tooth or a congenital anomaly is currently covered under the medical contract. It is not expected that coverage required under medical contracts will be duplicated in a stand-alone dental product. There is no change in usual practice, and existing guidelines to determine the definitions of routine dental surgery and oral surgery should be used.

Posted 4/1/2013

Q. The Invitation indicates that the AV calculator must be used when submitting. This is not applicable to stand-alone dental as it is not built into the AV calculator, but the Invitation does not indicate not applicable. Please advise.

A. Federal regulations provide that the HHS AV Calculator cannot be used for stand-alone dental. The stand-alone dental carrier's actuary must develop his/her own model to develop the actuarial value and submit to the Department of Financial Services for review.

Posted 4/1/2013

Q. The rating tiers and risk pool information in Sections III.C.6-7 do not expressly include Dental Applicants. Do these requirements apply only to Health Insurers?

A. These requirements apply only to Health Insurer Applicants. The 4 tier rating structure and standard rating regions apply to a medical QHP and to pediatric dental if included in the medical QHP. The following ACA requirements do not apply to stand-alone dental plans: medical loss ratio; rating standards related to age, family size, rating region, tobacco use; guaranteed availability; guaranteed renewability.

Posted 4/1/2013

Q. Please clarify New York's Essential Community Provider requirement for dental stand-alone carriers.

A. While Essential Community Providers are not specifically required in the description of the network standards related to dental benefits and stand-alone dental carriers, the Health Benefit Exchange encourages the stand-alone dental carriers applying for participation in the Exchange to establish a diverse network of health care providers in order to meet the widest variety of consumers' health care needs.

Posted 4/1/2013

Q. When children "age-out" of benefits, such as Pediatric Dental and Vision, Insurers would normally terminate benefits at the end of the month in which the birthday falls. Will this be the same policy in the Exchange?

A. Yes, the same rule will apply to enrollees in the Child-Only QHPs and Pediatric Dental products offered on the Exchange.

<u>Health and Dental Product Offerings:</u>

Posted 5/7/2013

Q. Would you provide a definition of 'per case' as stated in the standard benefit design description?

A. The following describes what "per case" means in certain circumstances:

Inpatient Hospital Services:

Observation stay/observation care unit - ER copay per case: Case here would be per stay. If someone was moved from the ER to an observation care unit, then back to the ER and then back to the observation care unit, during the same visit to the hospital, that would be considered as one stay, and as one ER visit.

Emergency Medical Services:

Facility charge-Emergency Room - ER copay per case: Case here would be per visit to the emergency room.

Pre-hospital emergency services/transportation Ambulance copay per case: Case here would be per ambulance trip.

Outpatient Hospital/Facility Services

Outpatient facility surgery-hospital facility charge - Outpatient facility-surgery per case: Case here is per surgery, more like per use of the operating room/recovery room. Only one copay would apply for use of the operating room followed by use of the recovery room.

Physician/Professional Services

Inpatient hospital surgery-surgeon - Surgeon copay per case: Case here is per surgery. If the surgeon performs more than one procedure during this surgery, there is only one copay for that surgery.

Outpatient hospital-surgeon - Surgeon copay per case: Case here is per surgery. If the surgeon performs more than one procedure during this surgery, there is only one copay for that surgery.

Posted 3/18/2013

Q: Is it correct to assume that child-only plans will be sold per child?

A: Health Insurers can offer child-only policies that cover multiple children in a family. The pricing for child only policies covering multiple children should mirror separate child-only policies sold for an individual child. A child-only policy covering two (2) children would be priced at the rate of two separate child only policies. A child-only policy covering three (3) or more children would be priced at the rate of three (3) separate child-only policies.

Posted 3/18/2013

Q. Regarding dental plans, can a health insurer establish a product with a separate dental policy, meaning whomever chooses X health insurance product would get X dental product, yet the dental would retain the standalone dental OOP max, and other cost sharing. Or does the separate dental policy have to be free standing?

A. If dental is embedded within the contract/policy, then the dental benefit would fall within the overall OOP maximum. However, the recent federal regulation has clarified that if the dental coverage is provided under a separate contract/policy (stand-alone), then it is subject to its own cost sharing limitations, which must be reasonable and defined by the Exchange.

Posted 3/18/2013

Q. Per the ACA, health plans can be certified without pediatric dental inside the Exchange as long as a sufficient number of stand-alone dental plans are available in each county. Outside the Exchange, the medical plans must offer the full Essential Health Benefits package. The ACA also says that if a carrier offers the same plan outside of the Exchange that it offers inside the Exchange the pricing must be the same. Based on this information, will NYS allow medical carriers outside of the Exchange to offer plans with pediatric dental?

A. The federal regulations addressing Essential Health Benefits would allow QHPs to be certified for sale in the Exchange without pediatric dental benefits if there are sufficient stand-alone dental products covering those pediatric dental benefits available in that area/region. Outside the Exchange, the rule is different.. According to the recently released final federal EHB rule, individuals must be offered the full EHB benefits, including pediatric dental outside the Exchange.

Posted 3/18/2013

Q. Which products in the Individual Exchange need to have an AI/AN plan variation for the >300% of federal poverty level (FPL), covering 100% of the charges from Indian health providers? Only the standard products? Only the standard products and silver CSR variations for the standard products? All standard products and respective CSR variations and non-standard products?

A. American Indians and Alaska Natives (AI/AN) with household incomes below 300 percent of the FPL who are enrolled in any Qualified Health Plan (QHP) at the silver level or at any metal tier offered through the Individual Exchange will not have to pay any cost-sharing. This rule applies to all products offered on the Individual Exchange including standard products, non-standard products, silver products with CSR variation and silver products without CSR variation. Similarly, AI/ANs with income above 300 percent of the FPL do not have any cost sharing when they receive services from Indian health providers or contract service providers regardless of the QHP metal level or product type they enroll in.

Out-of-network Benefits

Posted 3/6/2013

Q: Do we have to make Out-of-Network benefits available on all Silver and Platinum products, or can we make them available on just the standard products within those tiers?

A: Per Section II.D.1.i of the Invitation, to ensure that the consumers purchasing coverage have the same array of choices in the Exchange that they will have outside the Exchange, for 2014, a Health Insurer Applicant that offers an out-of-network product outside the Exchange in the small group or individual market in a county, must also offer an out-of-network product in the same market through the Exchange in that same county. Health Insurer Applicants that are required to offer an out-of-network product must offer the out-of-network product on the Exchange at the silver and platinum levels. Offering an out-of-network benefit on the standard product at the silver and platinum levels would satisfy the minimum requirement.

Posted 3/6/2013

Q. If an insurer offers out-of-network benefits outside the Exchange on a small group policy but not on an individual policy, can it offer the out-of-network benefit only on the SHOP Exchange?

A. Yes. In this circumstance, the Plan Invitation would require the insurer to offer out-of-network benefits at the silver and platinum level on the SHOP.

Posted 2/15/13

Q: If an insurer offers out-of-network benefits outside of the Exchange on a small group policy but not on an individual policy, can it offer the out-of-network benefit only on the SHOP Exchange at the silver and platinum levels? Or is the insurer also required to offer a silver and platinum out-of-network product on the Individual Exchange?

A: Per section II.D.i of the Invitation, if a plan only offers an out-of-network product outside of the SHOP exchange it will only be required to offer an out-of-network product at the silver and platinum levels inside the SHOP exchange in the same counties where the out-of-network product is offered outside of the SHOP Exchange. The plan would not have to offer the out-of-network product on the Individual exchange.

Number of Products:

Posted 3/18/2013

Q: Is the limit of three (3) non-standard products per Applicant calculated by county, or by total service area? For example, if an Applicant wanted to offer a limited network non-standard product in three counties within its service area, and another limited network non-standard product in three different counties within the same service area, do they count as two of the three non-standard variations?

A: DOH has reviewed the fact that a limited network product may only be available to consumers within a portion of an Applicant's service area, as opposed to the Applicant's entire service area. As a result, to support ample choice for consumers across the state, the DOH is clarifying its approach to the review of such products as set forth in Section II (D)(1)(f) of the Invitation, as follows:

The limit of three (3) non-standard products per Applicant will be calculated by county at the affiliate level. For example, in the scenario described above, if an Applicant serves 20 counties and the Applicant wanted to offer a limited network product (Product A) in three counties within this service area, and a separate limited network product (Product B) in three different counties within the same service area, the Applicant would be permitted to offer two (2) additional non-standard products in each of the counties in which Products A & B are offered. If an Affiliate of an Applicant then seeks to offer a non-standard product in the same counties where Product A is offered, the Applicant/Affiliate has one (1) additional product that it could offer in those counties.

Posted 2/8/2013

Q: Under Section E of the Letter of Interest, should a Health Insurer Applicant include all the variations of the silver metal product (i.e., cost-sharing variations based on federal poverty level and Native American variations) as separate products, or should they be considered one product?

A: Health Insurer Applicants should list the silver metal level product variations as one product.

Posted 2/8/2013

Q: If a Health Insurer Applicant has multiple affiliates and/or doing business as (DBAs), and the service areas of the respective affiliates/DBAs do not overlap, how many standard and non-standard products is the Applicant permitted to submit?

A: Each Applicant must offer a Standard Product in each county of its respective service area. Each Applicant may also elect to offer up to three (3) non-standard products within that service area. As set forth on page 9 of the Invitation, if affiliated entities of the Health Insurer Applicant apply to participate in the Exchange, the limitation of three (3) non-standard products per metal level in each Exchange (Individual and SHOP) will apply to the Health Insurer Applicant and its affiliates collectively. However, if a Health Insurer Applicant and/or its affiliated entities (including different DBAs) operate in entirely separate and distinct geographic areas, the standard and non-standard products offered in the separate, non-overlapping services areas will not be counted collectively.

<u>Essential Health Benefits:</u>

Posted 4/1/2013

Q. Please confirm that Health Insurer Applicants can carve out Mail Order Rx in both Standard and Non-standard Plans, and in both Individual and SHOP Exchanges, per Attachment A "*Mail Order up to a 90 day supply optional benefit."

A. Health Insurer Applicants may elect to offer a 90 day mail order pharmacy benefit for both Standard and Non-standard products, but are not required to do so.

Posted 4/1/2013

Q. Can drugs be added to and/or deleted from the state benchmark formulary?

A. Nothing in the federal rules prohibit an insurer from making updates to its formulary, so long as it continues to meet the minimum requirements.

Posted 4/1/2013

Q. Can Applicants offer prescription drug coverage with cost-sharing tiers that are labeled appropriately to support coverage of preferred and non-preferred drugs? If so, can Applicants make tier level determinations around the placement of drugs?

A. Prescription drug coverage may be divided in to a maximum of three tiers. Both standard and non-standard plans must cover at least the greater of one drug in each category or class, or the number in each class that the Oxford benchmark plan covers. Plans may designate which drugs are in which tier, as long as the cost sharing meets actuarial value requirements.

Posted 4/1/2013

Q. Will there be a period of time when Applicants can re-submit the formulary drug list for additional updates?

A. Formularies will be reviewed during the initial review of a QHP filing and upon recertification each year. We expect that issuers may update formularies more frequently than once a year. Any updates must be in compliance with the prescription drug rules established in 45 CFR 156.122.

Posted 4/1/2013

Q. Please confirm that quantity limit coverage rules are acceptable for prescription drugs.

A. Model language has been released by DFS that addresses this question and can be found on the DFS website at: http://www.dfs.ny.gov/insurance/health/model_lang_indx.htm

Posted 4/1/2013

Q. Is emergency care transportation included for both domestic and international scenarios?

A. Yes, emergency care transportation included in the Essential Health Benefits applies to situation where that service is needed both domestically and abroad.

Posted 4/1/2013

Q. Per the Essential Health Benefits: Attachment A, do Health Insurer Applicants have to cover DME? Is the copay for home health care services capped at $50 deductible?

A. DME is a category of EHB. Coverage of DME is subject to medical necessity. If a plan is imposing a deductible on home health care, the plan must comply with the $50 copay cap.

Posted 4/1/2013

Q. Please clarify if power wheelchairs are covered under the standard product.

A. Coverage of power wheelchairs is subject to medical necessity standards.

Posted 4/1/2013

Q. Per Attachment B: Standard Plan Designs, Women's Preventive Health Services indicates that the PCP/Specialist copay is applied based on the type of provider performing the service when services are not required due to Section 2713 of ACA. Cost share is not indicated when the service is not rendered by a physician. If services are provided by an outpatient facility or independent lab, are the services not covered or subject to the cost share of the same or similar service in the outpatient facility section?

A. If a state mandate covers more services than is required under Federal Law for preventive services, then cost sharing may be applied for those additional services. Cost-sharing is based on where services are received. For further information, please see the model Schedule of Benefits found on the DFS website at: http://dfs.ny.gov/insurance/health/model_lang_indx.htm

Posted 4/1/2013

Q. Regarding PCP/specialist copay in the Diagnostic Lab & Path section of the Physician/Professional Services section of Attachment B - Standard Benefit Design and the specialist copay in the Outpatient Hospital/Services section:

- In the professional section; when would a provider providing a lab service be defined as a PCP?
- If a provider is performing labs in their office along with an office visit will the rule of 1 copay per day per provider apply or will a separate copay apply for the each lab service billed?
- If the service is split between technical component & a professional component will 2 copays apply or just 1 for the total service?
- What benefit section does the Independent Lab apply to (outpatient facility or professional provider)?

A. Please see a response to each bullet below:

- If the health care professional who performs the service is a primary care doctor or a technician who works for the primary care doctor, the PCP copay would apply. If the person who performs the service is a specialist doctor or a technician who works for the specialist doctor, the specialist copay would apply.
- If a provider is performing lab tests in their office along with an office visit, one copay per day per provider will apply.
- If the service is split between a technical component & a professional component, one copay would apply for the total service which can be the highest single copay applicable to the various services.
- An independent lab should be treated in the same manner as a doctor’s office and the applicable physician/professional copay would apply.

Posted 4/1/2013

Q. If a provider is performing x-rays in their office along with an office visit will 2 copays apply or just 1 for the total service?

A. If a provider is performing x-rays in their office along with an office visit and the person who performs the service is a primary care doctor or a technician who works for the primary care doctor, the PCP copay would apply. If the person who performs the service is a specialist doctor or a technician who works for the specialist doctor the specialist copay would apply. The rule of one copay per day per provider would apply for an office visit that also included x-rays and/or laboratory work done during that office visit. If during the office visit two CAT scans (or PET or MRI) were performed in the doctor's office, then the copay would be one office visit copay and one additional specialist copay for the CAT scans. We understand that it is rare for a CAT scan, PET scan or MRI to actually occur in a doctor's office during an office visit as opposed to another facility. If the service is split between technical component and a professional component, one copay would apply for the total service which can be the highest single copay applicable to the various services.

Posted 4/1/2013

Q. If a provider is performing x-rays in their office along with an office visit will 2 copays apply or just 1 for the total service?

A. If a provider is performing x-rays in their office along with an office visit and the person who performs the service is a primary care doctor or a technician who works for the primary care doctor, the PCP copay would apply. If the person who performs the service is a specialist doctor or a technician who works for the specialist doctor the specialist copay would apply. The rule of one copay per day per provider would apply for an office visit that also included x-rays and/or laboratory work done during that office visit. If during the office visit two CAT scans (or PET or MRI) were performed in the doctor's office, then the copay would be one office visit copay and one additional specialist copay for the CAT scans. We understand that it is rare for a CAT scan, PET scan or MRI to actually occur in a doctor's office during an office visit as opposed to another facility. If the service is split between technical component and a professional component, one copay would apply for the total service which can be the highest single copay applicable to the various services.

Posted 4/1/2013

Q. What are the copays for outpatient cardiac and pulmonary rehab?

A. The PCP copay applies to cardiac and pulmonary rehab visits, so it would be one PCP copay for a single cardiac visit and one PCP copay for a single pulmonary rehab visit.

Posted 4/1/2013

Q. What are the copays for external and internal prosthetics?

A. The cost sharing for external and internal prosthetics are the same as the DME/medical supplies coinsurance.

Posted 3/18/2013

Q. Can insurers choose to administer a richer "hospice/end of life" benefit in both standard and non-standard plans if it is substantially equal from an actuarial standpoint?

A. An insurer can choose to offer a rich "hospice/end of life" benefit in a non-standard plan. Substitutions or additions to standard plans are not allowed. Substitutions may only be made to preventative and wellness benefits and to rehabilitation and habilitation benefits in non-standard plans. Because hospice benefits fall outside of these categories, no substitutions of actuarially equivalent hospice benefits may be made in a standard or non-standard plan. Additional hospice benefits may be made to create non-standard plans.

Posted 3/18/2013

Q. Hospice currently indicates "210 days/year". Could this be either days or visits depending on whether the care is rendered in-patient or in an out-patient setting?

A. Yes, however, the benefit cannot be reduced from that of the benchmark plan. So if a member requires more than one visit per day, all the visits taking place during that day count as one for the purpose of the 210 limit.

Posted 3/18/2013

Q. Can health plans "not cover" non-emergent use of the emergency room?

A. Plans are required to cover the benefits in the essential health benefit benchmark plan. Plans may review covered services in order to determine whether a service is Medically

Necessary. For treatment of an emergency condition, Article 49 of the Insurance Law requires that a prudent layperson standard be applied.

Posted 3/18/2013

Q. Can health plans "not cover" non-urgent use of an urgent care facility?

A. Plans are required to cover the benefits in the essential health benefit benchmark plan. Urgent care centers are covered as part of the essential health benefit package. Plans may review covered services in order to determine whether a service is Medically Necessary.

Posted 3/18/2013

Q. Are health plans required to offer a 90 day "mail order" RX benefit for non-standard plans?

A. No. A mail order prescription drug benefit is optional at the issuer's choice.

Posted 3/18/2013

Q. Are the Outpatient Rehab 60 visits per condition per lifetime and the Habilitation 60 visit limits per condition per lifetime separate, or would they be combined to allow 120 visits total per condition per lifetime?

A. Outpatient Rehab and Habilitation are two separate benefits.

Posted 3/18/2013

Q. The hearing aid benefit currently indicates "single purchase" is this intended to be per ear? How will the "per 36 months" come into play with members changing carriers/plans year after year within the exchange?

A. A single purchase once every three years may be for one ear or both, depending if the member needs hearing aids for both ears. If the member is getting two hearing aids, then they would have to be purchased at the same time. As for tracking the once every three year requirement, an issuer can only track it when the member is covered under them.

Posted 3/18/2013

Q. Is the exercise facility reimbursement intended to be an Essential Health Benefit for non-standard plans?

A. Yes, the exercise facility reimbursement is a benefit provided in the benchmark plan so it is an Essential Health Benefit. It would be considered a benefit in the Wellness category and an insurer could substitute this benefit for one that is actuarially equivalent (see 45 CFR 156.115(b) for actuarially equivalent). The substitution parameters can be found on page 9 of the Plan Invitation.

Posted 3/18/2013

Q. Does TMJ include appliances?

A. Yes. DFS has always stated that if the coverage includes coverage for durable medical equipment, then the issuer would have to provide coverage for appliances for TMJ that are medical in nature. The essential health benefit package includes coverage for durable medical equipment.

Posted 3/18/2013

Q. Can health plans have limits on contraceptive counseling visits?

A. No. The HRSA guidelines include frequency recommendations. The recommendation for contraceptive counseling is "as prescribed."

Posted 3/18/2013

Q. Does anything about the prescription drug benefit benchmark information prohibit us from having a closed formulary assuming it includes the required number of drugs per category?

A. A closed formulary is permitted as long as it meets the formulary requirements found in 45 CFR 156.122. That includes having a procedure in place that a Member may request and gain access to clinically appropriate drugs not covered by the plan (an exception process).

Posted 3/18/2013

Q. All Non-Governmental Products are subject to the risk adjustment fee. Is Child Health Plus considered a governmental program?

A. Yes, Child Health Plus is considered a governmental program and will not be subject to the risk adjustment fee.

<u>Plan Service Area</u>:

Posted 3/18/2013

Q. Although Article 43 commercial insurers are licensed to sell products in every county of the state, many of them do not sell their products in each county of the state due to the inability to obtain an adequate network. Is the DOH requiring these insurers to sell QHP products in every county of the state or just the counties in which they currently sell products?

A. Applicants must apply in their entire service area as approved by the Department of Financial Services or the Department of Health at the time of application. See Section II.C. on page 7 of the Plan Invitation for additional information.

Posted 3/6/2013

Q: Does the insurer's current service area have to match the Exchange service area if they are applying under the license used to sell Medicaid products?

A: The Health Insurer Applicant must sell QHP products in each county of its service area. This requirement applies to a licensed insurer that submits an Application to Participate in the Exchange under the license it uses to sell Medicaid products. Per Section II.C of the Invitation, an Applicant can apply for an exception to this requirement by requesting such exception in writing and explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Exchange.

Posted 3/6/2013

Q: What are the service area demarcations for the non-standard plans? For example, can you offer certain additional plans in only certain cities or counties within rating region?

A: Per Section II.D.1.f of the Invitation, Health Insurer Applicants may opt to offer up to three (3) non-standard products at any metal level, and in all or any part of its service area. The plan service area consists of the counties in which the Applicant provides coverage as approved by DOH and DFS. As a result, an Applicant could offer a non-standard plan in a subset of counties of its service area.

Posted 2/11/2013

Q: Our service area only includes a few counties within the rating region. Do we have to request an exception not to provide plans in all of the counties within the rating region, or do we just need to state the counties that we currently operate within the region.

A: Section II.C of the Invitation states that Applicants must apply to participate in their entire service area as approved by the Department of Financial Services (DFS) or DOH at the time of application. Plan service areas and standardized rating regions are two separate concepts. The plan service area consists of the counties in which the Applicant provides coverage as approved by DOH and DFS. The standardized rating regions provide geographic parameters for the purpose of rate (premium) development. Applicants' service areas may not necessarily include all the counties within the rating region.

Posted 2/11/2013

Q: If a Health Insurer Applicant utilizes its Medicaid service area to sell QHP standard products on the Exchange, can the QHP standard products be sold in a subset of counties within the Medicaid service area?

A: No, the Health Insurer Applicant must sell the QHP standard products in each county of the Medicaid service area. Per Section II.C of the Invitation, an Applicant can apply for an exception to this requirement by requesting such exception in writing and explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Exchange.

<u>Provider Network Submissions</u>:

Posted 5/7/2013

Q. Regarding section F (Network Adequacy) of the Invitation to participate in the NY Health Benefit Exchange, we are requesting the following clarification: Does the 30 minute or 30 mile adequacy standard also apply to retail pharmacies or is there a separate and unique standard?

A. The 30 minute/30 mile adequacy standard should be applied to all providers including retail pharmacies unless specifically stated otherwise.

Posted 5/7/2013

Q. What are the requirements under federal law and/or regulation for reimbursing Federally Qualified Health Centers? Will DOH be providing any funds towards the reimbursement of these centers for services rendered to qualified health plan (QHPs) enrollees?

A. Pursuant to 45 CFR § 156.235(e), "an item or service covered by a QHP [that] is provided by a federally-qualified health center...to an enrollee of a QHP, [requires] the QHP issuer [to] pay the FQHC for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and FQHC from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer." The DOH will not be providing any additional funds towards the reimbursement of providers for services rendered to QHP enrollees.

Revised 4/16/2013

Q: Per the Invitation Schedule of Events, submission of provider networks is required on **April 30, 2013**. Is it permissible to submit providers that we intend to contract with as part of the first submission, then follow up with providers we have actually contracted in July?

A: Given the short time frame for establishing and submitting a provider network, it is permissible for an insurer to submit a network of providers that have entered into Letter Agreements or Letters of Intent to participate in newly created networks for QHPs offered on the Exchange, or that have entered into all-products contracts with the insurer; provided, however, the Applicant follows it up with information about the providers with whom it has actual contracts during the subsequent submissions.

Posted 3/6/2013

Q: Will the PNDS data dictionary be updated to include the QHPs and stand-alone dental plans?

A: The Department of Health is in the process of updating the PNDS data dictionary to include the QHP and Dental products. The DOH will issue more instruction and information regarding the submission as soon as possible. Please note, however, that submission of the provider network will be linked to the HIOS Plan ID (i.e., formerly called the Standard Component ID) provided on the Addendums to the Invitation. Applicants will need to obtain the HIOS Plan IDs prior to submitting the provider networks through PNDS.

Posted 3/6/2013

Q: Should insurers be submitting any provider network information through SERFF?

A: No provider network information will need to be submitted through SERFF other than the URL for the provider directory. The DOH will utilize the PNDS system for submission of provider network information.

Posted 2/15/13

Q: Will dental providers be submitted through a separate network submission? If yes, is this only if the Insurer is offering stand-alone dental plans or would all dental providers be submitted through a separate submission?

A: If a QHP is offering a product that has dental services embedded in a benefit package together with health care services, the dental provider network data should be included with the submission of health care provider data to the Health Commerce System (HCS) as one single submission. Instructions for submitting provider network data are included in Attachment F of the Invitation.

Stand -alone dental plans will submit their provider network data to the Health Commerce System as indicated in Attachment F of the invitation.

Posted 2/15/13

Q: Should pharmacies be combined with the provider network submission or should the pharmacy networks be submitted through a separate submission?

A: Pharmacy network data should be submitted with the provider network data submission as one provider network submission.

Posted 2/11/2013

Q: Is it possible to submit a provider network and allow for an amendment after the submission date or is the network submitted on April 12, 2013 the only and final network plans can submit?

A: The initial submission of provider network data is due April 12, 2013. Following this initial submission, Applicants will submit provider network data quarterly including a submission in July, 2013.   The April and July 2013 submissions will form the primary basis under which the DOH will review network adequacy.

<u>Quality and Enrollee Satisfaction</u>:

Posted 5/7/2013

Q. For the HEDIS, CAHPS and QUARR requirements, will Applicants need to have separate reporting for Exchange vs. off-Exchange data?

A. Yes, Applicants will need to have separate quality reporting for products offered on the Exchange and products offered off the Exchange.

Posted 3/18/2013

Q. Regarding Section II.E.3. of the Invitation, please clarify the timeframe regarding the CAHPS surveys.

A. The CAHPS survey data will be submitted to the DOH as part of the QHP QARR reporting requirements. QHPs will perform CAHPs surveys in the beginning of the reporting year, or January 2015 for the 2014 plan year.

Posted 3/18/2013

Q. With regard to QHP quality reporting (e.g., CAHPS, HEDIS, and other measures), will QHPs be required to report these measures on a product-specific basis, or in aggregate for all QHPs offered in the NY Health Benefit Exchange in each market (one report for the Individual Exchange products, one for the SHOP Exchange Products)?

A. QHPs will not need to submit separate quality reports per product or per Exchange (i.e., one for Individual Exchange products and one for SHOP Exchange products). QHPs will need to submit separate quality reports for their products with no out-of-network coverage and their products with out-of-network coverage.

Posted 3/6/2013

Q. For purposes of responding to the Plan Invitation, how much detail should the Applicant provider on the plan's quality program.

A. Applicants should use their judgment to provide sufficient information for the DOH to evaluate the plan's quality program.

Posted 2/8/2013

Q. Can you advise whether the minimum participation and "Quality and Enrollee Satisfaction" requirements will apply to Stand Alone Dental Plans?

A. The Minimum Participation Standards set forth in Section II. 4.c. and the "Quality and Enrollee Satisfaction" requirements in Section II.E. do not apply to Stand Alone Dental Plans. However, Stand Alone Dental Plans will be required to submit encounter data per Section II. G.3.

Administrative:

Posted 4/1/2013

Q. In Family plans, where not all covered family members are eligible for American Indian/Alaska Native cost sharing reductions, what are the rules?

A. American Indian/Alaska Native cost-sharing reductions are only applied to members of federally recognized tribes. For mixed status families where not all household members are members of federally recognized tribes, cost-sharing reductions will have to be determined for each household member. If the household income is below 300% of the federal poverty level, the household members that are federally recognized American Indians or Alaska Natives will have zero cost sharing. Household members that are not federally recognized American Indians or Alaska Natives will only be eligible for cost share reductions if their income is below 250% of the federal poverty level and they enroll in a silver level QHP.

Exchange Enrollment and Eligibility:

Posted 4/1/2013

Q: With respect to special enrollment periods, 45 CFR 155.420 (b)(3) provides the Exchange discretion to allow for the effectuation of coverage effective dates in a timeframe shorter than specified in paragraphs (b)(1) and (b)(2)(ii) of the same section. Will the NYS Health Benefit Exchange be pursuing these shorter timeframes?

A: The Department of Health will not be pursuing shorter timeframes for special enrollment periods at this time. The DOH will adhere to those timeframes specified in the paragraphs referenced above.

Posted 3/18/2013

Q. Is the DOH standardizing waiting periods for employees to enroll in employer coverage offered through the SHOP Exchange?

A. The Public Health Service Act specifies that a waiting period cannot be longer than 90 days, but the DOH will not be providing further guidance as to the length of waiting periods.

Posted 3/18/2013

Q. When children "age-out" of benefits – such as Pediatric Dental and Vision, when would benefits terminate?

A. When someone ages out of child only benefits or products, the benefits would terminate at the end of the month in which the birthday occurs.

Posted 3/6/2013

Q: If members do not join during an open enrollment period, do they have to wait for the next open enrollment period? May members switch to another plan during the year, outside of the open enrollment period?

A: Enrollment into QHPs offered on the individual Exchange is only open during the annual open enrollment period unless a qualifying event triggers a special enrollment period. The circumstances comprising a special enrollment period can be found in 45 CFR § 155.420. Members cannot otherwise switch to a new plan outside of the open enrollment period.

Posted 3/6/2013

Q: Regarding the Child-only coverage tier, for a single parent will there be a mechanism in place to prevent purchase of a "single person" policy for the parent plus a "child only" policy?

A: If the family is above the federal poverty level (FPL) for Medicaid eligibility and below 400% of the FPL, the child(ren) would be required to be enrolled in Child Health Plus and therefore the only option for a single parent would be an individual policy. If the family is above 400% of poverty, to provide the maximum number of choices for consumers, a single parent will be able to choose family plans with child coverage included, individual coverage plus a child-only product, or they can enroll their children in unsubsidized Child Health Plus products and enroll themselves in an individual policy.

Posted 3/6/2013

Q: Will Navigators and In Person Assistors always complete applications online via the Exchange Portal, or is there also a paper application form that they can use?

A: Navigators and In-Person Assisters will be required to complete the application online and submit it via the Exchange web portal.

Posted 3/6/2013

Q: When can we expect further guidance on 834 submissions and the DOH's draft companion guide?

A: The DOH will continue to host monthly technical meetings, including meetings about 834 transactions. DOH expects to release the draft companion guide within the next couple of weeks. The DOH will provide a copy of the companion guide to those that provided their contact information when they submitted their Letters of Interest, as well as through the health plan associations.

<u>Advanced Premium Tax Credits:</u>

Posted 3/6/2013

Q: With regard to premium billing, is it the expectation of NYS that plans bill the IRS directly for the Advanced Premium Tax Credit?

A: The Exchange is required to transmit all enrollment transactions to HHS. These enrollment transactions, which will be frequently transmitted to HHS and will form the basis of the federal payment of premium tax credits to health insurers. These transactions will form the basis of payment to the insurer and so it should not be necessary for insurers to bill the IRS.

<u>Miscellaneous Questions:</u>

Posted 5/7/2013

Q. Are there any regulations around the frequency to bill the members? Will it remain as monthly?

A. Health insurers will bill members directly for Individual Exchange products. This is typically done monthly. The SHOP Exchange will bill small businesses on a monthly basis.

Posted 5/7/2013

Q. If an issuer has already completed the New York State “vendor responsibility” process because of its involvement in other state-sponsored health care coverage programs, will the issuer be required to complete the process again?

A. A vendor responsibility determination will be required for participation in the Exchange. The level of the review will depend on the circumstances including, but not limited to, when the last determination was made and whether there is new information.

Posted 5/7/2013

Q. Which Internet browser(s) (e.g., Firefox, Google Chrome, Internet Explorer, etc.) will be compatible with the Exchange web portal?

A. The Exchange online web portal will be compatible with the following web browsers:

- Internet Explorer Versions 7, 8, or 9
- Safari Versions 5 or 6
- Google Chrome Versions 18 or 19
- Mozilla Firefox Versions 12 or 13

Posted 5/7/2013

Q: A recent NYS Health Benefit Exchange presentation to brokers that’s posted on the NYS Health Benefit Exchange website notes that the Exchange’s customer service center will open in September 2013. Will QHP issuers that receive certification in July 2013 be allowed to market products/provide general Exchange education to target customer populations prior to the opening of the Exchange’s customer service center? If so, when can QHP issuers expect to receive the Exchange’s branding materials (logo, telephone number, and website link) for inclusion on QHP issuers’ marketing materials?

A. This information will be shared with health insurers as soon they are available.

Posted 3/18/2013

Q. Will a broker be able to sell a product and be compensated by an insurer that they are not credentialed with outside of the Exchange or will they need to get credentialed with any and every insurer selling products in their region?

A. In order to enroll and receive compensation for enrolling consumers in the Exchange, producers will need to meet any applicable health insurer credentialing requirements. The Exchange does not intend to require a producer to be credentialed with all health insurers participating in the Exchange or with all health insurers operating in a given region. Brokers that wish to sell Exchange products will also need to complete specific training and be certified by the Exchange.

Posted 3/18/2013

Q. How can a broker's website interact with the Exchange web portal? Can a broker directly link to the Exchange portal?

A. Brokers, as described in the question above, will be able to assist clients using the Exchange information technology system.

Posted 3/18/2013

Q. Currently it is possible for a Chamber of Commerce to buy small group policies and allow members of the chamber to buy into those policies via the chamber. These chambers do not collect a commission, they charge an administrative fee. Can these chambers continue this model within the Exchange? Additionally, since these chambers are not being paid by an insurer, can they also qualify at the same time as navigators on the Individual Exchange?

A. Chambers cannot purchase small group coverage through the Exchange. Only small employers and individuals can purchase coverage through the Exchange. Chambers of Commerce must operate in compliance with New York's producer licensure laws. The Request for Applications for In-Person Assistors and Navigators has been released by the Exchange. Chambers of commerce may qualify as navigators. Under federal requirements, navigators may not receive direct or indirect compensation from health plans.

Posted 3/18/2013

Q. Is there regulation around what day the grace period must begin (e.g., invoiced date, due date).

A. Pursuant to state law, grace periods begin once the payment has not been made on the date that premium is due.

Posted 3/18/2013

Q. How long must an insurer wait prior to terminating an individual or employer if only partial payment was received? Should claims be paid for during this time period when only partial payment is received?

A. An insurer must wait the entire grace period prior to terminating for partial payment. Claims should continue to be paid during the grace period.

Posted 3/18/2013

Q. Who will be providing notices regarding discontinuance of products, the health plans or the Exchange?

A. Health insurers will be required to provide notice to each policy/contract holder and to all participants and beneficiaries insured under the policy of a discontinuance at least 90 prior to the date of discontinuance.

Posted 3/18/2013

Q. Will PHSPs need to obtain an NAIC number? NAIC recently indicated that they won't provide PHSPs with a NAIC number until they convert their licensure to an HMO license.

A. Prepaid Health Services Plans (PHSPs) need to get an NAIC Company Code. DFS will need it in order to accept the form and rate filings. DFS has received the following instruction from NAIC on completing the NAIC Company Code form for Prepaid Health Services Plans (PHSPs): *Under Business Sub-Type, please select None and write in "PHSP." Additionally, on the top of the second page, select that choice for Annual Statement Blank as "Not Required to File." This will enable a PHSP to receive an NAIC Company Code without triggering any filing requirements at the NAIC.*

Posted 3/18/2013

Q. When will the Exchange Broker compensation information need to be filed with DFS? Will insurers need to file it with our rates and forms?

A. Consistent with existing requirements, broker compensation schedules for Exchange and non-Exchange products must be submitted with all premium rate filings for review and approval by the Department of Financial Services.

Posted 3/18/2013

Q. Regarding premium billing, will one premium bill be acceptable for members of a family with separate policies or will the premium bills need to be sent separately to the individual policy holders?

A. The DOH is not aware of any guidance on this issue and therefore defers to the Applicants as to how they wish to bill enrollees.

Posted 3/18/2013

Q. Will claims paid be subject to the HCRA tax in the Exchange?

A. Yes. HCRA taxes will apply to Exchange products as they are commercial insurance.

Posted 3/6/2013

Q. When will a demo (or screen shots) of the Exchange shopping experience be available?

A. Demonstrations of the prototypes for the enrollment experience in the Individual and SHOP Exchange are available on the Exchange web site at www.healthbenefitexchange.ny.gov. Demonstrations of the final shopping experience will be made available in the future.

Posted 3/6/2013

Q. What are the different Sales Channels for a customer to purchase insurance via the Exchange?

A. Individuals and small business will be able to purchase Exchange coverage through the webportal, by phone, by mail or in person. Licensed brokers, who have an arrangement with an insurer and who complete certification requirements for the Exchange, will be allowed to distribute both coverage on the Individual and SHOP Exchange. Broker commissions will be paid by health plans. Navigators and In-Person Assisters will also be able to assist individuals and small businesses in purchasing coverage through the Exchange. Consistent with federal requirements, Navigators and In-Person Assisters will be reimbursed for their services through grant contracts with the DOH.

Posted 3/6/2013

Q. Regarding Section F of the Plan Invitation, can you clarify how the carrier invitation information would be made public? We assume that any information we indicate as proprietary would not be made public in a FOIL request.

A. As set forth in Section F of the Invitation, for purposes of Article 6 of the New York State Public Officers Law (the "Freedom of Information Law" or "FOIL"), Applicants may clearly identify information in their submission constituting trade secrets or information that if disclosed would cause substantial injury to the competitive position of the subject enterprise. In the event the carrier's information is requested, the DOH Records Access Office will review the request and the material that has been identified as subject to an exception from disclosure under FOIL, and make a determination with respect to the release of the requested information pursuant to FOIL.

Posted 3/6/2013

Q. Will claims paid for Exchange enrollees be subject to HCRA?

A. Yes. Exchange coverage is considered commercial insurance.

Marketing Guidelines:

Posted 2/11/2013

Q: Are facilitated enrollers allowed to engage with potential exchange enrollees at any point in the process of enrollment? For example, can a health plan FE assist a person through the online process? Are they allowed to see if a potential exchange enrollee is interested in enrolling into the plan the FE is employed by? If so, do FEs have to be licensed as well and go through the Exchange training?

A: On January 22, 2013, HHS released a Notice of Proposed Ruling that includes guidance with respect to Certified Application Counselors. DOH is currently reviewing these regulations to determine whether health plans will be permitted to act as Certified Application Counselors in a manner that is similar to the role they play today as facilitated enrollers in the Medicaid and Child Health Plus programs. Health plans are precluded from being Navigators.

Posted 2/11/2013

Q: Can QHPs display marketing materials, including literature, in emergency rooms? Can they market on digital screens located in emergency rooms?

A: No. QHPs cannot display marketing materials including literature in emergency rooms and cannot market on digital screens located in emergency rooms. The marketing standards set forth in Section II.G.2.b.5 of the Invitation state e that "Marketing may not take place in patient rooms or treatment areas," which includes hospital emergency rooms including the emergency room waiting areas.

Posted 2/11/2013

Q: Do all of the materials developed to market QHP products offered on the Exchange have to get approval by the Department of Health before circulating or do they only have to be provided upon request for review?

A: QHP marketing materials will be provided to DOH upon request for review as indicated in Section II.G.2.b.6 of the Invitation.

Posted 2/11/2013

Q: Are marketing material disclosures going to be released that must be included on any material created for the exchange?

A: Applicants will be required to use the logo and branding designated by the DOH in referring to Exchange products in marketing and outreach activities, including any printed materials. Such materials must prominently display the Exchange website and toll-free telephone number as indicated in Section II.G.2.b.2 of the Invitation. If additional disclosures are required, DOH will communicate those disclosure requirements to QHPs at a later date.

Posted 2/11/2013

Q: The invitation stipulates that insurers must include the Exchange logo, URL, and toll-free # on advertisements "that mention exchange products." Does that mean that advertising campaigns that do not mention products do not need to reference the exchange or include the below information?

A: Section II.G.2.b.2 of the invitation indicates that marketing and advertising efforts including printed materials that reference products to be offered on the Health Benefit Exchange must prominently display the Exchange logo, website, and toll-free number. This marketing standard pertains only to marketing and advertising efforts relating solely to commercial products sold through the Exchange.

<u>Prescription Drug Formulary Submission:</u>

Posted 2/15/13

Q: How does DFS want Insurers to submit prescription drug formulary information? Will they be required to use the Prescription Drug Template (SERFF)?

A: DFS will be requiring that formularies be submitted using the SERFF template for formulary. You can find the latest versions of the SERFF templates at http://www.serff.com/draft_plan_management_data_templates.htm. Please note that some updated templates were posted to SERFF's Draft Plan Management Data Templates page as of February 7, 2013.

Posted 2/8/2013

Q. Can you advise whether the minimum participation and "Quality and Enrollee Satisfaction" requirements will apply to Stand Alone Dental Plans?

A. The Minimum Participation Standards set forth in Section II. 4.c. and the "Quality and Enrollee Satisfaction" requirements in Section II.E. do not apply to Stand Alone Dental Plans. However, Stand Alone Dental Plans will be required to submit encounter data per Section II. G.3.

SHOP Exchange:

Posted 5/7/2013

Q. On 3/1/13, HHS released a proposed rule indicating that would delay the premium aggregation function for the Federally-facilitated SHOP. Will NYS still be invoicing groups participating on the SHOP exchange beginning October 1, 2013 or is New York delaying this SHOP function as well?

A. NY Health Benefit Exchange will perform the premium aggregation function for the SHOP Exchange beginning October 1, 2013.

Posted 4/1/2013

Q. Do employers participating in the SHOP Exchange have to make a contribution towards their employees' premiums?

A. No, employers offering coverage in the SHOP market can choose to make no contribution towards their employees' coverage.

Posted 2/15/13

Q: Do all plans offering coverage to small business in New York have to cover the Essential Health Benefits?

A: Yes. All non-grandfathered plans offering coverage to small businesses in New York either through the SHOP Exchange or outside of the SHOP Exchange must cover the Essential Health Benefits listed in Attachment A of the Invitation.

Posted 2/15/13

Q: My business' primary location is in New York, but we have satellite offices in other states. Do we have to offer plans from the NY SHOP Exchange to all of our employees or can we offer plans from the various Exchanges where each of the satellite offices are located?

A: Pursuant to the employer eligibility requirements listed in section 45 CFR § 155.710(b-c), eligible employers can purchase coverage through a SHOP if their principal business address in the Exchange service area and they offer coverage to all full–time employees through that SHOP, or if they offer coverage to each eligible employee through the SHOP serving that employee's primary worksite. For example, if an eligible employer has its principal business address in New York, but has work sites in New York and Connecticut, it can choose to offer plans for the New York based employees through the SHOP exchange and the Connecticut based employees through the Connecticut exchange; or it can offer coverage through the New York SHOP exchange to all of the employees.

Posted 2/11/2013

Q: Will a small employer group be able to purchase only a stand-alone dental product through the SHOP Exchange?

A: Small employers, as well as individuals, can purchase stand-alone dental products in conjunction with QHPs, but they will not be able to only purchase a stand-alone dental product.

Posted 2/11/2013

Q: Could you clarify the counting method to determine if a group is 50 or under and therefore eligible for Exchange. Given the recent Federal guidance, will small group continue to be 50 or fewer employees eligible for health insurance (State law), or are you adopting the Federal counting definition?

A: Insurance Law Section 4235(d) defines employees, for the purpose of obtaining group health insurance, as the officers, managers, employees, and retired employees of the employer and of subsidiary or affiliated corporations of a corporate employer and the individual proprietors, partners, employees and retired employees of affiliated individuals and firms controlled by the insured employer through stock ownership, contract or otherwise. employees" may be deemed to include the individual proprietor or partners if the employee is an individual proprietor or a partnership and "employees as used in subparagraph A of paragraph one of subsection c hereof may also include the directors of the employer and of subsidiary or affiliated corporations of a corporate employer. In some circumstances, independent contractors may be considered to be employees according to an opinion by the Office of General Counsel. See OGC Opinion 00-09-06. This Insurance Law definition of employee is very broad.

Section 4235c(1)(A) of the Insurance Law permits employers to offer insurance to employees based on upon their class of employment. Section 52.18(f) of Regulation 62 allows employees to be classified for insurance purposes based upon geographic situs of employment, earnings, method of compensation, hours and occupational duties. See also Section 360.3(a)(1)(i) which states that the employer must seek to restrict coverage to these classes.

State law defines a small group health insurance policy as one covering between 2 to 50 employees or members. Section 360.3(3) of Regulation 62 states that an insurer may restrict employee eligibility for small group policies based upon a required number of work hours, not to exceed 20 hours per week. This means that an insurer may not require that an employee work more than 20 hours per week to be eligible for group insurance.

The term "employee" in the ACA is based on the definition in the Public Health Service Act which in turn incorporates the definition in ERISA. Section 2791 of the Public Health Service Act, 42 USC Section 300gg-91(d) (5) which in turn references ERISA. 29 USC Section 1002. An employee is defined as an individual employed by an employer. This is the common law definition of employee and is much more restrictive than New York Law would allow.

To purchase coverage in the SHOP, an employer must have at least one common law employee. An employee would not include a sole proprietor or an employee's spouse. Section 2791 of the PHSA.

An employer must offer all full time employees the opportunity to enroll in a qualified health plan through the SHOP. A full time employee is one who, with respect to any month, is employed on average 30 hours per week. For hourly employees, employers must count paid work and non work hours, such as vacation, jury duty or illness. For employees who are not paid on an hourly basis, the employer can choose to use either actual hours or an equivalency method, i.e. 8 hours per day or 40 hours per week.

Under the ACA, a small group market will include plans that cover up to 100 employees beginning in 2016. Proposed regulations use the FTE method in the shared responsibility provisions to determine how to count employees for the purpose of determining group size. HHS has proposed making the effective date for the definitions of small employee and full time employee January 1, 2016 and will not take enforcement action for including a group in the small group market using existing state definitions.

Until 2016, New York will maintain its current definition of employee and its current method of allowing employers to classify them for purposes of purchasing small group comprehensive health insurance. The pending budget legislation will conform the state definitions of employee to federal law and add the federal definition of full time employee. This will not take effect until January 2016.

Letter of Interest Submissions:

Posted 2/8/2013

Q: Under the estimated number of products section of the Letter of Interest should the applicant only indicate the number of non-standard products we intend to offer?

A: No. Applicants should include both non-standard and standard product offerings in the estimated number of products in the Letter of Interest.