QUESTIONS AND ANSWERS ON THE 2016 INVITATION

(May 15, 2015)

NOTE: The Invitation in Section 3.1(D) on page 26 has been revised to include a category of individuals eligible for the BHP, which was unintentionally omitted, and to update the name of the BHP products to Essential Plan. Attachment F has also been modified to show the different groups of individuals eligible for the BHP and their respective cost-sharing and reflect the new name for the products. Hereinafter, the "Basic Health Program" shall be known as the "Essential Plan Program" and "Basic Health Plans" shall be known as "Essential Plans."

NOTE: Attachment A to the Invitation has been updated to reflect a modification to coverage for external prosthetic devices.

I. QHP AND SADP QUESTIONS AND ANSWERS

(A) STANDARD PRODUCTS

Posted 4/27/2015

Question: Are NYSOH-participating insurers required to offer both bronze plans (the HSA-compliant one and the non-HSA compliant one) in 2016, or only one or the other?

Answer: Only those insurers that offered a HSA eligible Standard Bronze QHP in 2015 will be permitted to offer an additional Bronze QHP, as set forth in Attachment B (labeled HSA Compliant Bronze), and not have it count towards the limit of 3 non-standard products. If an Applicant did not offer an HSA eligible Standard Bronze product in 2015, it can only offer an HSA Eligible Bronze as a non-standard and the non-standard product will count towards the limitation of 3 non-standard products.

Posted 5/6/2015

Question: How will the renewal process work for members currently enrolled in a standard, HSA eligible Bronze plan? Should the new HSA Compliant Bronze plan be assigned a new HIOS ID?

Answer: No, the new HSA compliant Bronze plan must use the same HIOS ID as the current plan. If a new HIOS ID is assigned current members will not be able to automatically renew their enrollment into the plan.

Posted 5/6/2015

Question: I am writing to follow up on one of the questions included in the Q&A document (dated 4/27). Can you please clarify whether plans that offered a HSA eligible Bronze standard plan in 2015 can choose to only offer a HSA compliant standard Bronze plan for 2016, per highlighted section below? If so, will the plans be required to discontinue the 2015 standard Bronze plan and allowed to migrate those individuals to another non-standard Bronze plan that is different from the additional standard Bronze QHP from the attachment B of the invitation ($3,500 deductible with $6850 OOPM)?

Answer: Applicants that currently have an HSA Standard Bronze Plan can choose to offer only the Alternative HSA Compliant Bronze Plan. Applicants will not be required to discontinue the 2015 standard Bronze plan, but instead can use the current HIOS ID for the HSA Standard Bronze plan. At renewal, eligible members will be automatically renewed into the new HSA Compliant Bronze Plan for 2016.

Current enrollees in a standard plan cannot be mapped to a non-standard plan.

Question: Can you clarify the answer posted on 5/6/2015, and whether an insurer brand new to the Marketplace can offer the alternative HSA Compliant Bronze Plan in 2016?

Answer: The purpose of offering the alternative HSA Compliant Bronze Plan was to allow individuals who had this product to carrier over their HSA from the prior year and still maintain a standard product. Insurers new to the Marketplace in 2016 must offer the Standard Bronze plan that is not HSA compliant, and may choose to also offer an HSA compliant bronze product as a non-standard plan.

Question: If an Applicant does not choose to offer the standard HSA compliant bronze plan, it can still offer up to 3 non-standard HSA compliant bronze plans, correct?

Answer: Yes, the Applicant is not obligated to offer the Standard HSA Compliant Bronze Plan and may offer up to 3 non-standard HSA compliant bronze plans, provided the number of non-standard bronze plans does not exceed the number of non-standard products at any other metal tier.

NEW Post 5/15/2015

Question: Currently for our QHP plans, we have a Limited Cost Share and a Zero Cost Share plan for American Indians and Alaskan Natives (AI/AN) offered on all Standard and Non Standard plans. Since the Silver Cost Share variations at 87% AV and 94% AV are being eliminated, is it also eliminating the need for the Limited Cost-Share plans and Zero Cost-Share Plans?

Answer: Implementation of the BHP means that you will no longer offer your Zero Cost Share and Limited Cost Share AI/AN variations for the Silver Cost Share 87% AV and 94% AV levels. No other AI/AN variations should be eliminated. Insurers must offer these variations at all metal levels.

(B) STAND ALONE DENTAL PLANS

Posted 4/27/2015

Question: Do stand-alone dental plans filing outside the Marketplace need to submit a letter of interest by April 24, 2015? Or, is the letter of interest required only for plans on the Marketplace?

Answer: The letter of interest is required for those plans that participate on the Marketplace only. Questions related to outside the Marketplace, should be directed to the NYS Department of Financial Services (DFS).

(C) HEALTH INSURER APPLICANT PRODUCT OFFERINGS

Posted 4/27/2015
Question: Will the formulary for the Individual Marketplace and the Small Business Marketplace be based upon Oxford benchmark as previous years?

Answer: Yes, the benchmark plan for the Essential Health Benefits has not changed for 2016.

II. BASIC HEALTH PROGRAM (BHP)

(A) INVITATION SUBMISSION

Posted 5/6/2015

Question: As a BHP ONLY Plan, are we required to submit a product benefit template by May 29th?

Answer: No, the BHP templates have not been released. We expect them to be available by mid-May with submissions due back to DOH no later than August 31, 2015.

Posted 5/6/2015

Question: Please confirm that the Stand-Alone Dental Plan (SADP) due dates are different than the due date for the BHPs Plus Vision/Dental. For example, if a health plan proposes to have an available dental/vision program for the non-Aliessa population, the Stand-alone Dental Applicant Forms and Rates due to DFS on April 30 would not apply. If correct, any and all dental related information would be supplied based on BHP scheduled dates only.

Answer: That is correct. The BHP Plus Vision/Dental products are not related to the SADPs that are sold on the Marketplace. DFS Form and Rate submissions do not apply. The DOH will set the capitation rates paid to the insurers offering the BHPs Plus Vision/Dental.

Posted 5/6/2015

Question: Some responders to the BHP invitation will be new to the Marketplace and therefore will not have had the necessary time to develop the requested URLs (Attachment I – Question 5) prior to the response deadline of May 22nd. In this instance, please confirm plans can provide confirmation of our understanding of the requirements for each and assurance that these would be available prior to acceptance of final rates (August).

Answer: BHP participation proposals are due by May 22nd. The required templates which include URLs are not required at this time. We expect the templates to be submitted to DOH by August 31st. Prior to the submission date, as we are testing the system, DOH may request testing URLs and/or screen shots of web sites until final URLs are developed**.**

Posted 5/6/2015

Question: Can you please clarify what the Invitation means when referencing Basic Health Plan (BHP) "templates" that are to be submitted to DOH (see, for example, pages 2, 29, and 48)?

Answer: Applicants that decide to participate in the BHP will be required to complete templates developed by DOH that are similar to the SERFF Binder templates. The DOH will be posting the templates and instructions to the NY State of Health website in mid-May.

Posted 4/27/2015

Question: If stand-alone dentals are interested in participating in the BHP, are they required to submit a separate Letter of Interest?

Answer: No, they are not required to submit a separate Letter of Interest. Individuals enrolled in a BHP will be permitted to purchase the same stand-alone dental products that QHP

enrollees can purchase. There is no requirement to submit separate BHP Stand-alone dental products.

(B) BHP BENEFITS

Posted 5/6/2015

Question: On Attachment F, the Emergency Copay section states that –the copay is waived if patient is admitted as an inpatient (including as an observation care unit) directly from the emergency room. Is the omission of "…observation stay" on the BHP Benefit Summary intentional?

Answer: The copayment is waived when the patient is admitted for observation regardless of whether it is to an observation care unit or considered an observation stay.

Posted 5/6/2015

Question: In Attachment F, the reference concerning the Maximum Out-of-Pocket (MOOP) mentions Pediatric Dental and Pediatric Vision, although those are not covered services on BHP. Is this intentional?

Answer: The above reference to pediatric dental and vision was an error. A revised Attachment F removing this reference has been posted.

Posted 4/27/2015

Question: The BHP standard benefits grid lists both "eyewear" and "vision care – lenses and frames." Can you please clarify how these benefit categories differ? Would a Standard BHP Plus Vision/Dental enrollee receive both or only one of these benefit categories?

Answer**:** This was an error and a corrected Attachment F has been posted. The "eyewear" line with the corresponding cost-share was removed.

NEW Post 5/15/2015

Question: Is there a set dollar limit for the cost of glass frames? If so, are the consumers able to upgrade their frames and pay the difference out of pocket?

Answer: The DOH has not established a set dollar limit on the cost of the glass frames. Cost-sharing is outlined in Attachment F of the Invitation as 10% coinsurance for those making 151-200% FPL and $0 cost-sharing for all others.

NEW Post 5/15/2015

Question: Does the drug formulary for BHP follow Formulary II (State Exchange), FFS Formulary, Medicaid Managed Care approved formulary or a custom formulary?

Answer: Per Section 42 CFR §600.405, the formulary must follow the Essential Health Benefits requirements, which is currently applicable to the commercial QHP market.

NEW Post 5/15/2015

Question: In Part 3, page 26 of the Invitation, it states that the wellness benefit may be substituted for a different wellness benefit. Please provide additional detail.

Answer: Per federal regulation, 42 CFR §600.405 (which references 45 CFR §156.115), the Essential Health Benefits may be substituted when certain requirements are met. The DOH has limited substitution to the wellness benefits. The benchmark plan, which can be found on Attachment A and in more detail on Attachment B, includes a $250 gym reimbursement benefit. This benefit can be either offered as part of the Basic Health Plan, or it may be substituted with an equivalent benefit or a better benefit. Such substitution will be submitted as part of the BHP Plan Information submission and reviewed by DOH.

(C) SUBMISSION OF BHP INFORMATION

Posted 5/6/2015

Question: Will the BHP Plus Adult Vision/Dental plan necessitate a new HIOS ID, or would insurers be allowed to add a 2-digit variation to the Standard BHP HIOS ID?

Answer: The BHP Plus Adult Vision/Dental will require a new HIOS ID. A 2-digit variation cannot be added to the Standard BHP HIOS ID.

NEW Post 5/15/2015

Question: Can insurers add their own product name to the name of the BHP standard naming conventions outlined in Section 3.D.1.d like they do for QHPs?

Answer: No, insurers cannot add their own product name to the name of the BHP standard naming conventions. After considering various options, the DOH has determined that the BHP will be known as the "Essential Plan". Accordingly, the naming conventions for BHP products shall be as follows and consistent with the populations and benefit design shown in Attachment F to the invitation added on May 12, 2015:

- Essential Plan 1
- Essential Plan 2

- Essential Plan 3
- Essential Plan 4

All insurers must use these names for the BHP products, as well as their company name and/or logos.

(D) ENROLLMENT INTO THE BHP

Posted 4/27/2015

Question: With respect to the Basic Health Program, for those that owe premium, will premium be due prior to the coverage start date?

Answer: Yes, premium will be due prior to the initial start date, and the same initial payment grace period of 10 days that applies to QHP will need to be applied to BHPs.

NEW Post 5/15/2015

Question: Are there any ID Card content requirements that are specific to the BHP?

Answer: There are no ID Card content requirements that are specific to the Basic Health Plan. Insurers must comply with all applicable federal and state laws and regulations with respect to ID Card requirements. Individuals who are eligible for BHP and not Medicaid eligible due to immigration status will keep or maintain a Certified Identification Number (CIN) in order to access non-emergency transportation services.

III. QUESTIONS AND ANSWERS APPLICABLE TO ALL APPLICANTS

(A) PROVIDER NETWORK SUBMISSION

Posted 4/27/2015

Question: Do existing issuers who are recertifying for plan year 2016, with no changes to their network, need to resubmit their Provider Network via HCS as part of the recertification, when we have regularly submitted and will continue to submit our Provider Network in HCS through the balance of the current plan year?

Answer: Applicants who are recertifying for plan year 2016 will continue to submit their network filings on a quarterly basis and network will be reviewed on a quarterly basis. The submission prior to the open enrollment period will be the network reviewed as part of the certification process, and will be the submission used for display on the Marketplace during open enrollment period, which begins on November 1, 2015. Per the Invitation, as changes in

the network occur, the insurer is required to submit such changes to the NYSOH within 15 business days of the change.

NEW Post 5/15/2014

Question: Is there a BHP network adequacy standard submission requirement? If so, when is its due date?

Answer: The BHP network adequacy standards are the same as the QHP network adequacy standards, and are described in Section 4B of the invitation (pages 31-32). Networks will need to be initially submitted on July 15, and should be a snapshot of your BHP network as of June 30, 2015. This submission, and all submissions beyond this date, will need to include your 2016 product offerings and 2016 service area. After this, submissions of the BHP networks will follow the regular schedule, with the next submission occurring on August 24, 2015.

(B) CONTRACTING

Posted 5/6/2015

Question: According to the 2016 invitation on page 49, it reads as follows: "d. Vendor Responsibility. On or around the same time Applicants submit Forms and Rates, Applicants that are applying for the first time will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System." Since we are not first time applicants, do we still complete this for 2016?

Answer: Plans that currently participate in the Marketplace will need to complete and submit either an updated hard copy Vendor Responsibility Questionnaire (VRQ Form AC 3290-S or AC 3291-S) or, update and recertify their Online VRQ. Contracting rules require that Vendor Responsibility Questionnaires be submitted or recertified at least yearly.

(C) ENROLLMENT

Posted 5/6/2015

Question: Will a member's outstanding premium balance apply to their BHP plan? For example, if a QHP enrolled member moves to a BHP 150-200 FPL plan and has a negative premium balance, can this apply on their BHP Standard plan premium balance?

Answer: No, the negative QHP premium balance cannot be applied to the BHP premium balance. Since enrollment into the BHP is enrollment into a new program, premium payments must be treated separately.

Posted 5/6/2015

Question: If a standard 150-200 FPL BHP member has a life changing event and elects a QHP plan with a premium balance, can the insurer apply it to their new QHP plan?

Answer: No, the negative BHP premium balance cannot be applied to the QHP premium balance. Since enrollment into the QHP is enrollment into a new program, premium payments must be treated separately.

NEW Post 5/15/2015

Question: How will individuals transition from the Silver CSR variations of 87% AV and 94% AV to the Basic Health Program? Will they be auto-enrolled and will they be notified that their plan will not offered in 2016?

Answer: For purposes of responding to this question, we define "auto-enrollment" as the transfer of individuals enrolled in one HIOS ID to another HIOS ID of the same insurer without the enrollee taking an affirmative action. The DOH is contemplating allowing auto-enrollment of individuals enrolled in a QHP in 2015 and determined by the Marketplace to be eligible for the BHP in 2016 provided that (1) the insurer in which the individual was enrolled in 2015 offers a BHP product in 2016 and (2) there is reasonable assurance that the provider networks of these two products are comparable so that disruption to the consumer is minimized. Auto-enrollment will be reviewed on a plan by plan basis. NYSOH will issue notices explaining program and plan changes to all consumers transitioning from QHPs to BHPs.