

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

Questions and Answers (as of March 18, 2013)

## QHP and Dental Plan Invitation:

**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 11<sup>th</sup>.

**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.

## QHP and Dental Plan Proposal Submission:

**New – 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.

**New – 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: Sections 5.A.c and 5.B.c of Attachment E- Participation Proposal instruct applicants to submit to the DOH a copy of all final documents submitted through SERFF and approved by DFS as part of the Rate and Form Filings. Rate and Form filings are due to DFS on April 15, 2013, but will not be approved until later. How will applicants meet that requirement?

A: Applicants will submit their Participation Proposal to DOH on or before April 5, 2013. Applicants will also submit their completed Administrative Data Template, Plan Benefit Template, Prescription Drug Template, Network Template, Service Area Template, Rate Templates, Business Rules Template, and Rate Review Template to DFS via SERFF on April 15, 2013. The DOH expects to access the templates via SERFF as part of the certification process. However, in the event that the DOH is unable to access this information from the SERFF system directly, the DOH will request that Applicants submit to the DOH a copy of all final documents submitted through SERFF.

**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 5<sup>th</sup>?

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 5<sup>th</sup> 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 5<sup>th</sup>, 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.

## **Health and Dental Product Offerings:**

**Revised 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.

**New – 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.

**New – 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.

**New – 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:**

**New – Posted 3/18/2013**

Q: Per section II.D.1.f of the Invitation ("Nonstandard Products"), the Health Insurer Applicant is permitted to offer up to 3 non-standard products "at any metal level". Did the Department of Health intend for Insurers to be able to offer the nonstandard products at certain metal levels or every metal level?

A: The Invitation erroneously stated "any" metal level. **In the event a Health Insurer Applicant decides to offer nonstandard products**, the Health Insurer Applicants **must offer** up to 3 non-standard products at every metal level, for a maximum of 4 products at every metal level (one standard at each metal level, plus up to 3 non-standard products at every metal level).

**Revised – 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.

**Essential Health Benefits:**

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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."

**New – 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).

**New – 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.

**Plan Service Area:**

**Revised – 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.

## **Provider Network Submissions:**

**Posted 3/6/2013**

Q: Per the Invitation Schedule of Events, submission of provider networks is required on April 12, 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, 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.

**Quality and Enrollee Satisfaction:**

**New – 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.

**New – 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.

**Exchange Enrollment and Eligibility:**

**New – 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.

**New – 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 Assisters 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.

### **Advanced Premium Tax Credits:**

**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.

### **Miscellaneous Questions:**

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.

**New – 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.*

**New – 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.

**New – 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.

**New – 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](http://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 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.

**Prescription Drug Formulary Submission:**

**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](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 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.