

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

Questions and Answers (as of February 15, 2013)

Prescription Drug Formulary Submission:

New – 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.

Out-of-network Benefits

New – 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 2/15/13

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 Gold product in three counties within its service area, and another limited network Gold 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 Gold product (Gold Product A) in three counties within this service area, and a separate limited network Gold product (Gold Product B) in three different counties within the same service area, the Applicant would be permitted to offer two (2) additional Gold products in each of the counties in which Gold Products A & B are offered. If an Affiliate of an Applicant then seeks to offer a Gold product in the same counties where Gold Product A is offered, the Applicant/Affiliate has one (1) additional Gold 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.

Application Submissions:

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.

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.

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.

Plan 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:

New – 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.

New – 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:

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:

New – 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.

New – 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.