SECTION IV: PROGRAM REQUIREMENTS

A. NYSHIP Eligibility Requirements

Selected HMOs must accept all individuals determined by the Department to be eligible for services under the Agreement that results from these Specifications and may not enroll any individuals who have not been determined to be eligible by the Department. The Department will send the HMO eligible Dependents on the weekly enrollment file. An HMO may not independently add a Dependent who has not been determined by the Department to be eligible. The only time an HMO may disenroll an individual is when CMS tells an HMO to disenroll the individual due to other coverage. In this situation, the HMO must notify the Department within five (5) Business Days of notification by CMS.

Individuals who may enroll in an HMO through NYSHIP include Employees and Retirees of the State of New York and Participating Employers (PEs) who live or work in the HMO's NYSHIP approved Service Area, as well as their Dependents. Persons who have primary coverage with Medicare, who **reside** in the HMO's Medicare Advantage Plan NYSHIP approved Service Area are also eligible Enrollees under the NYSHIP. Dependent eligibility is subject to the collective bargaining process and may change as a result of labor/management negotiations or changes to State/Federal law.

The HMO must agree to accept all determinations of eligibility as made by the Department and must provide an insurance rider that includes all NYSHIP Dependent eligibility provisions. A draft 2016 NYSHIP Eligibility Rider is included as **Exhibit II.C "2016 NYSHIP Dependent Eligibility Rider"** of these Specifications and provides the NYSHIP Dependent eligibility requirements. The HMO must include this Rider, approved by the New York State Department of Financial Services (DFS), as part of its proposed benefit package.

1. The following summarizes NYSHIP's Dependent eligibility provisions:

    a. An Enrollee's Spouse, including a legally separated spouse. If an Enrollee is divorced or the marriage has been annulled, the former spouse is not eligible, even if a court orders the Enrollee to maintain coverage.

    b. An Enrollee's Domestic Partner. The Enrollee may cover a same or opposite sex Domestic Partner as a Dependent under NYSHIP. A domestic partnership, for eligibility under NYSHIP, is one in which the Enrollee and a partner are 18 years of age or older, unmarried and not related in a way that would bar marriage, living

together, involved in an exclusive mutually committed relationship and financially interdependent. To enroll a Domestic Partner, the Enrollee must have been in the partnership for six months and be able to provide proof of 6 months of cohabitation and 6 months of financial interdependence. There is a one year waiting period from the termination date of the Enrollee's previous partner's coverage before the Enrollee may again enroll a domestic partner.

c. An Enrollee's Children under 26 years of age. This includes the Enrollee's natural children, legally adopted children, children in a waiting period prior to finalization of adoption, stepchildren and children of the Enrollee's domestic partner who are covered without regard to financial dependence, residency with the Enrollee, student status or employment. Other children who reside permanently in the Enrollee's household, who are chiefly dependent on the enrollee and for whom the Enrollee has assumed legal responsibility, in place of the parent, also are eligible; the Enrollee must verify eligibility and provide documentation to the Enrollee's Employer upon enrollment and every two years thereafter. For "other children," legal responsibility by the Enrollee must have commenced before the child reached age 19.

d. An Enrollee's Child with Military Service. For purposes of eligibility for health insurance coverage as a child, up to four years for service in a branch of the U.S. Military between the age of 19 and 25 may be deducted from the Dependent child's age provided that the Dependent child returns to school on a full time basis, is unmarried and is otherwise not eligible for employer group coverage. The Enrollee must be able to provide written documentation from the U.S. Military. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required by the HMO for verification.

e. An Enrollee's unmarried Dependent child 26 or over who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap, who became so incapable prior to attainment of the age at which Dependent coverage would otherwise be terminated, are eligible.

The HMO will be responsible for making clinical Disabled Dependent Determinations for Dependent children with a disability who are enrolled in the HMO. Disabled Dependents of NYSHIP Enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those Dependents are incapable of self-sustaining employment. As part of the Disabled Dependent Determination, an Application for Coverage for your Disabled Dependent Child for Medical, Dental and/or Vision Coverage (Form PS-451), Exhibits II.J and II.J.1.is completed by the Enrollee, the Dependent's physician and the Enrollee's Employer, and then evaluated by the HMO to determine if the Dependent is disabled. All determinations are subject to re-review by the HMO on a periodic basis. The following guidelines must be used for all Disabled Dependent Determinations:

If improvement of the Dependent's condition is:

- "Expected," the case will be normally reviewed within six to eight months, unless the HMO determines a need for a more frequent review.
- Possible," the case will be normally reviewed no sooner than three years, unless the HMO determines a need for a more frequent review.
- "Not expected," the case will normally be reviewed no sooner than seven years, unless the HMO determines a need for a more frequent review.

Once the HMO makes the disability determination, the PS-451 must be sent to the Department to confirm eligibility. If the disabled Dependent is eligible, the HMO will receive confirmation of eligibility through the weekly enrollment transaction file.

The HMO must accept determinations of total disability under the above standards that were made by other NYSHIP plans provided that there has not been a break in coverage between plans.

2. The following summarizes NYSHIP's "Young Adult" eligibility provisions:

The Enrollee's unmarried children, including adopted children and step children through age twenty-nine ("Young Adult"), who live, work, or reside in New York State or the Service Area of the HMO's network-based NYSHIP policy and who:

a. Are not insured by or eligible for coverage through the Young Adult's own employer-sponsored health plan, whether insured or self-funded, provided that the health plan includes both hospital and medical benefits, and
b. Are not covered under Medicare;

are eligible to enroll for coverage under the Young Adult Option.

In addition:

c. the Young Adult need not live with the parent, be financially dependent upon the parent, or be a student;
d. the Young Adult's eligibility for health insurance coverage through a former employer under federal COBRA or State continuation coverage does not disqualify the Young Adult from electing the young adult option under NYSHIP;
e. the Young Adult's children are not eligible for coverage under the Young Adult Option, but may be eligible for health insurance coverage under other programs, such as the Child Health Plus program;
f. the parent need not have family coverage for the young adult to enroll in the Young Adult Option; and
g. the Young Adult need not have been previously covered under the parent's NYSHIP coverage.

There is no Employer contribution toward the cost of the Young Adult Option. The Young Adult or his/her parent is required to pay the full cost of premium for individual coverage for the NYSHIP option selected by the Young Adult.

The HMO must accept all NYSHIP determinations of eligibility for enrollment in Young Adult coverage. Coverage of a Young Adult as described in this paragraph shall consist of coverage which is identical to the coverage provided to a NYSHIP Enrollee. If the parent is enrolled in the HMO, NYSHIP coverage is available for the Young Adult who lives, works or resides outside of the parent's HMO Service Area but within New York State. However, the parent of the Young Adult need not be enrolled in the HMO in order for the Young Adult to have NYSHIP coverage through the plan in which he/she is enrolling as long as the Young Adult lives, works or resides in that HMO's Service Area. The parent must only be a NYSHIP Enrollee (including under COBRA).

Coverage for Young Adult shall terminate on the first of the following to occur:

a. the Young Adult voluntarily terminates coverage;
b. the Young Adult's parent is no longer enrolled in NYSHIP;
c. the Young Adult no longer meets the eligibility requirements for the Young Adult Option as outlined above;
d. the NYSHIP premium for the Young Adult is not paid in full within the 30-day grace period; or
e. the group or group remittance policy or contract is terminated and not replaced.

The Dependent child does not have a separate federal COBRA or New York State continuation right at the time coverage through this Young Adult option terminates.

A Young Adult and his/her parent have the following opportunities to enroll in the Young Adult Option:

a. "When the Young Adult Would Otherwise Lose Coverage Due to Age Coverage" may be elected within 60 days of the date that the Young Adult otherwise would lose eligibility for coverage as his/her parent's Dependent due to age. Coverage is retroactive to the date that the Young Adult otherwise would have lost coverage due to age. This is the only circumstance in which the Young Adult Option will be effective on a retroactive basis;

b. "When the Young Adult is Newly Qualified Due to a Change in Circumstances Coverage" may be elected within 60 days of the date that the Young Adult newly meets the eligibility requirements for the Young Adult Option, such as due to loss of coverage through his/her employer; moving his/her residence into New York State; or getting divorced. It is possible for a Young Adult to elect coverage under this option on multiple occasions due to changes in the Young Adult's eligibility over time. Coverage will be effective prospectively, no later than 30 days after NYSHIP receives written notice of the election and payment of the first premium; and

c. "During the Young Adult Option Annual 30-Day Open Enrollment Period Coverage" may be elected during the Young Adult Option's annual 30-day open enrollment period which is expected to coincide with NYSHIP's Annual Option Transfer Period. Coverage under this option will be effective prospectively.

B. Required Benefit Package

HMOs must provide at least the minimum benefits as described in the sections below.

1. Commercial Plan Benefit Requirements

a. General Requirements

(1) Must be fully ACA-compliant.

(2) HMOs may specify copayments or coinsurance, as part of their benefit package; however, copayments or coinsurance for inpatient hospital care and **annual deductibles will not be permitted.**

(3) Coverage must comply with all services required by Federal and NYS laws and/or regulations in addition to the following enhanced coverage:

Prosthetic Devices: Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and ostomy supplies. Replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

Durable Medical Equipment: Medically necessary Durable Medical Equipment (DME) that can withstand repeated use and is primarily used to serve a medical purpose must be covered. Examples of DME include but are not limited to: wheelchairs, walkers, respiratory equipment, and oxygen supplies. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

Orthotic Devices: Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance not provided

for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

Prescription Drugs: Medically necessary federal legend and state restricted drugs, compounded medications and injectable and self-injectable medications, contraceptive drugs and devices, fertility drugs and enteral formulas must be covered. (The copayment for self-injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs, except drugs limited to 30-day supply at dispensing.) No annual or lifetime maximum permitted; and

Gender Identity Disorder Services: Diagnosis and treatment of Gender Dysphoria must be covered.

(4) Benefits for services not listed as minimum benefit requirements pursuant to Section IV.B.1. above, such as routine/preventive dental services and/or the provision of eyeglasses for routine vision correction may be included in the HMO's standard package. However, riders that include an additional charge for such benefits will not be accepted. Exclusions and other limiting language are subject to modification by the Department in consultation with the JLMC.

b. Use of Standard Contracts and Riders

HMOs may propose to meet the minimum benefit requirements set forth in these Specifications through the use of a standard contract, or through a combination of a standard contract and riders. **Proposals that do not meet the minimum benefits will be rejected by the Department in consultation with the JLMC.**

All HMOs must submit benefit offerings no later than the Proposal Due Date shown in Section II.A.1 of these Specifications. No change in benefits will be accepted after the Proposal Due Date unless the change is a mandate from a regulatory authority or requested by the Department in consultation with the JLMC.

HMOs are free to propose to the Department the standard contract that the HMO believes best meets the needs of NYSHIP Enrollees. The proposed standard contract must meet the minimum benefit requirements; however, the HMO may provide benefits in excess of the minimum benefits required by these Specifications. The standard contract must be approved for offering by the appropriate regulatory

authority as of the Proposal Due Date shown in Section II. A.1 and **Exhibit II.A** - Timeline of Key Events - of these Specifications.

Riders shall be accepted by the Department in consultation with the JLMC only if such rider is necessary to bring the standard contract proposed by the HMO into conformity with the minimum benefit requirements. It is **not** the intent of the Department to purchase from HMOs riders that increase the benefit package to a level above the minimum requirements set forth in the Specifications. **Riders that provide benefits not required by the minimum benefit requirements, or which provide benefits in excess of the minimum benefit requirements, may be rejected by the Department in consultation with the JLMC.**

The following example illustrate acceptable and unacceptable Proposals:

Example:
The Specifications do not require vision care benefits for adults. A standard contract that includes vision care benefits for adults is acceptable. A rider that provides vision care benefits for adults is not acceptable unless the rider is included at no additional cost to NYSHIP.

2. **Medicare Advantage Plan Benefit Requirements**

HMOs must comply with CMS guidelines and in addition the benefit levels provided must meet or exceed the minimum benefits as set forth in Section IV.B.1.a and IV.B.1.b above. Other benefits above the minimum benefits must be comparable to those provided to non-Medicare primary Enrollees. **Instances where Federal Law and/or regulation preclude an HMO from complying with this requirement must be clearly identified in the HMO's Proposal.**

If an HMO is submitting a Medicare Advantage (MA) Plan with Prescription Drug coverage, the MA Plan must be CMS approved for all counties in the proposed Service Area.

An HMO may submit only one product for Medicare primary Enrollees, either the Commercial Plan which coordinates with Medicare and includes prescription drug coverage equal to, or better than, Medicare Part D or a Medicare Advantage with Prescription Drug Plan.

An HMO may not submit a Medicare Advantage product without submitting a non-Medicare Advantage (Commercial) product as well. The Department will **not** accept a Submission that provides coverage only to Medicare eligible Enrollees.

An HMO must provide Part D coverage at an equal level to the Commercial Plan in the coverage gap.

An HMO whose ranking falls below 3 stars and whose enrollment is frozen by CMS would be permitted to keep an Enrollee that otherwise would have aged-into the Medicare Advantage Plan in the Commercial Plan until CMS lifts the enrollment freeze.

C. Service Accessibility

1. General

The Department and the JLMC consider access to services to be one of the most critical aspects of an HMO's overall quality of care and satisfaction to members. Accordingly, HMOs shall be expected by the Department and the JLMC to ensure compliance with the access standards set forth below.

Although not a requirement of the Specifications, in recognition of the unique services offered by various State-run facilities located throughout New York State, the Joint Labor Management Committees on Health Benefits continue to encourage HMOs to include these hospitals (e.g., Roswell Park Cancer Institute, Helen Hayes Hospital) in their network if such hospitals are within the HMO's proposed Service Area. This request recognizes the need for State facilities to satisfy the same stringent credentialing criteria as any other network provider.

2. Twenty-four (24) Hour Coverage

Consistent with New York State Laws and/or regulations, HMOs must provide coverage to members, either directly or through their Primary Care Physician (PCP), twenty-four (24) hours a day, seven days a week. HMOs also must instruct their members on what to do to obtain services after regular business hours.

3. Days to Appointment

HMOs must abide by the following appointment standards:

a. Emergency medical or mental health and substance abuse problems, immediately;

b. Urgent medical or mental health and substance abuse problems, within 24 hours of request;

c. Non-urgent "sick visits," within 48 to 72 hours, as clinically indicated;

d. In-Plan, non-urgent mental health and substance abuse visits, within two (2) weeks;

e. Adult baseline and routine physicals and non-urgent or preventive care visits, within twelve (12) weeks;

f. Initial prenatal visits, within three (3) weeks during the first trimester and two (2) weeks thereafter; and

g. Initial visit for newborns to their PCP, within two (2) weeks of hospital discharge.

D. Communications Material Requirements

The Department and the JLMC place a high priority on ensuring that NYSHIP Enrollees are able to make informed choices when selecting a health plan during the annual Option Transfer Period. Accordingly, all HMOs must abide by the following communications guidelines.

1. General Requirements

All Enrollee material as well as all communications material must be sent to all members of the JLMC prior to distribution to State Enrollees. This includes both annual benefit plan communications and updated communications distributed by the HMO throughout the year.

a. All communication material must present a clear, factually correct, complete and easily understood description of the benefits available through the HMO. Any incorrect or incomplete communications sent by the HMO to NYSHIP Enrollees related to required communication materials (Section IV.D.2 of the Specifications) must be corrected and re-sent at the HMO's expense. Benefits offered and/or received prior to this correction must be covered until Enrollees receive the correction notification or, at the discretion of the Department in consultation with the JLMC, for the balance of the Plan Year.

b. Communication materials may promote the HMO but must not make general or specific comparisons to any other NYSHIP option. HMOs will not be permitted to make reference to the Empire Plan or plan specific comparisons to other HMOs. For example, an HMO may not state that they "serve more NYSHIP members than any other HMO that participates in NYSHIP."

c. Communication activities may not discriminate on the basis of a potential member's health status, prior use of health service, or need for future health services.

d. HMOs may not engage in communication practices or distribute communication materials that mislead or confuse NYSHIP enrollees by promoting benefits for which the NYSHIP Enrollee is not covered.

e. The premium cost of all NYSHIP health plan options will be communicated to Enrollees by the Employee Benefits Division, Department of Civil Service, and shall not be included in any communication materials distributed by any HMO, with the exception of rate filing notifications required by the NYS Department of Financial Services.

f. Visual presentations of Enrollees in the HMO communication material must be representative of the diversity within the New York State enrollment.

2. <u>Required Communications Materials</u>

The Department in consultation with the JLMC requires that the benefits offered by an HMO be fully described to the HMO's Enrollees. Accordingly, those HMOs that participated in the NYSHIP in 2015 and new HMOs that are selected by the Department in consultation with the JLMC to participate in 2016 must provide the following documentation:

All HMOs are required to submit drafts of the Cover Letter, federally mandated Summary of Benefits and Coverage (SBC), Schedule of Benefits, and Side-by-Side Comparison of Benefit Changes in both hard copies and PDF with their Proposals, as set forth in Exhibit II.A - Timeline of Key Events - of these Specifications. In addition, those HMOs that participated in NYSHIP in 2015 are required to submit drafts of the Side By Side Comparison of Benefits in both hard copies and PDF with their Proposals, as set forth in Exhibit II.A - Timeline of Key Events - of these

Specifications. HMOs that did not participate in NYSHIP in 2015 will not be required to furnish the Side By Side Comparison with their Proposals. A PDF copy of the final Schedule of Benefits and applicable Side By Side Comparisons will be required to be provided to the Department and all members of the JLMC.

The Department may amend the mailing date(s) of communication materials for Retiree groups should it be necessary to coordinate these mailing(s) with Department communications.

The required communication material, after approval by the Department and JLMC, will require that the Cover Letter, Schedule of Benefits, and the applicable Side-by-Side Comparison of Benefit Changes be transmitted to Enrollees in one mailing. **Final versions of these mailings must be sent to all JLMC Contact Members listed in Exhibit II.B one (1) week prior to distribution to Enrollees.**

No premium or rate information, of any kind, shall be included in the required communications materials sent to NYSHIP Enrollees. HMOs may, however, direct NYSHIP Enrollees to rate information provided by the Department. Rate information is provided on the Department's web site at www.cs.ny.gov.

a. Cover Letter

Cover letters for the Communications Materials mailing to HMO members must be submitted as part of the HMO's Proposal. **All HMOs must include the following statement in the Cover Letter, "Your Eligibility Guidelines may be different from those guidelines listed in the contract. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's web site at** www.cs.ny.gov."

b. Summary of Benefits and Coverage

The HMO must comply with ACA to produce, revise, distribute and translate, upon request, a Summary of Benefits and Coverage (SBC) that accurately describes the NYSHIP group benefits and coverage. The SBC must be provided to the Department in an electronic format as a PDF document no later than 30 days before the beginning of each Plan Year for posting to the Department website. The HMO must distribute a SBC to any eligible Employee or Retiree contacting the HMO or the Department to request a copy in accordance with

ACA requirements for timely distribution. Annually at plan renewal or upon material modification of the SBC, the HMO must provide notice to all current Enrollees via a postcard, plan materials, or other Federally-compliant means of notification of how to view or obtain a copy of the SBC from the HMO.

c. Schedule of Benefits

The Schedule of Benefits must include, but not be limited to, applicable copayments and/or coinsurance levels. The Schedule of Benefits must also include a comprehensive description of limitations and exclusions. A separate Schedule of Benefits is required for the Commercial HMO Plan and the Medicare Advantage Plan, if offered in the HMO's Submission. A sample document is included as Exhibit II.E.

d. Side by Side Comparison of 2015 to 2016 Benefits

HMOs that participate in NYSHIP in 2015 are required to submit a Side by Side Comparison of Benefits that lists changes in the benefits offered to Enrollees from 2015 to 2016. Such changes include, but are not limited to: copayments; new benefits; number of days of a prescription supply; delivery of services; and provider networks. **In the event there are no changes in the benefits offered, the HMO will be required to mail to members an affirmative statement that states that there are no changes in either the benefits offered or delivery of services from the previous year**. The Side by Side Comparison of Benefits must be provided to the Department in an electronic format as a PDF document no later than 30 days before the beginning of each plan year for posting to the Department website. A sample document is included as Exhibit II.F.

Note: Any changes made to these documents require resubmission to the Department for review and approval. These documents must be approved by the Department in consultation with the JLMC, before they are printed and mailed to HMO members.

3. CHOICES Guide

To assist NYSHIP Enrollees in choosing a health insurance plan during the annual Option Transfer Period, the Department will develop a Health Insurance Choices guide. This guide will contain uniformly formatted pages for each plan offering

(Commercial and Medicare Advantage, if offered) so that Enrollees may easily compare the benefits offered. The information to be included in these Choices pages is outlined in detail in **Exhibit III.A "Choices Guide."**

All HMOs submitting Proposals will be required to access an online data interface (HMO ePage) through which plan benefit details will be electronically submitted to the Department. HMOs will have unlimited electronic access to their own database information for one week (likely in late-May) after which time, access will be denied. In advance of this access period, you will receive an email from the Employee Benefits Division Communications Unit containing detailed instructions. Additionally, HMOs are required to print a hard copy of their Choices page information from the database and submit it with their Proposal. This process will enable the Department to implement their online health benefit plan comparison tool.

HMOs that participate in NYSHIP during 2015 will be able to edit selected fields of their 2015 Choices page content in the electronic templates to accurately describe plan benefits for the 2016 Plan Year. HMOs that did not participate in NYSHIP during 2015 will access blank templates to electronically submit their Choices page information.

The Department's Employee Benefits Division Communications Unit will use the electronic information submitted by each HMO to format a version of their pages for the Choices guide. HMOs will receive copies of their final Choices pages for sign off via e-mail from the Communications Unit.

4. <u>Optional Marketing Materials and Activities</u>

a. While HMOs may develop and distribute generic marketing materials to NYSHIP Enrollees who live or work in the HMO's approved NYSHIP Service Area, the materials must present the NYSHIP benefits. The Department will not provide any information to HMOs regarding the identification of eligible NYSHIP Enrollees or their mailing addresses. **Any optional marketing materials mailed by the HMO, including provider directories and newsletters, must be submitted to all JLMC Contact Members listed in Exhibit II.B**

b. HMOs may not provide potential NYSHIP members with giveaways as an inducement to enroll in the HMO.

c. HMOs are not permitted to conduct marketing activities at State work sites without prior approval of the Department. Requests for such activities must be submitted to the Department, Attention: Employee Benefits Division, Communications Unit, in writing with a copy to the Governor's Office of Employee Relations, Attention: Employee Benefits Management Unit. Marketing activities include, but are not limited to, participation in health fairs and information booths. HMOs may only distribute materials that provide specific information regarding the HMO or relate to general health care issues at such approved work site presentations. Items that do not meet these criteria and have no more than a nominal value may be distributed to NYSHIP Enrollees attending conferences and/or meetings that are not held at the work site.

d. If an HMO's benefit changes are expected to reduce premium costs, a notation may be included in the HMOs Optional Marketing Materials that certain benefit changes are expected to result in decreased premiums or to help limit premium increases; however, the language may not state how much premiums will decrease or how much savings may be realized.

E. Reporting

1. Complaint/Grievance/External Appeals

HMOs must maintain records of all complaints that have been unresolved for more than forty-five days (45) days. Such records shall include the actual complaint, all correspondence related to the complaint, and an explanation of the disposition of the complaint. The HMO must make these records available to the JLMC Contact Members listed in Exhibit II.B in searchable format upon request. All Enrollee identifying information must be redacted.

The Department requires HMOs to maintain a report summarizing the number of grievances filed for the most recent Plan Year, sorted by procedure type. The report must include the total number of grievances, the number of grievances upheld, overturned, modified or withdrawn. The HMO must make these records available to the JLMC Contract Members in **Exhibit II.B** upon request.

The Department requires HMOs to maintain a report summarizing the number of external appeals filed for the most recent Plan Year, sorted by procedure type. The

report must include the total number of external appeals, the number of appeals upheld, overturned, modified or withdrawn. The HMO must make these records available to the JLMC Contract Members in **Exhibit II.B** upon request.

The Department reserves the right to seek information immediately from an HMO pursuant to investigation of a particular member or provider complaint.

2. Member Satisfaction Surveys

Whenever an HMO conducts a member satisfaction survey that includes NYSHIP Enrollees, the HMO must provide a copy of the survey and survey results electronically in searchable format within 30 days upon request from any JLMC Contact Member listed in **Exhibit II.B**

3. Medicare Advantage Plan Enrollments/Disenrollments

The HMO must notify the Department on a monthly basis of any members no longer eligible to be enrolled in the Medicare Advantage Plan for reasons identified by the HMO or CMS; including but not limited to, missing HICN, no Medicare Parts A and/or B. The Department must also be notified if an Enrollee moved out of the HMOs Service Area, or is deceased.

4. Federal Medical Loss Ratio (MLR)

The HMO must file its Medical Loss Ratio (MLR) with the federal government by June 1 each year. In those instances where the HMO fails to meet the required MLR threshold for community rated large group contracts during the preceding calendar year, rebates must be paid to NYSHIP by August 1 of that calendar year. In addition, notification must be provided to both Enrollees and the employer group in instances where the MLR threshold has not been met.

5. Low Income Subsidy (LIS)

The HMO must submit an LIS report to the Department no later than fifteen (15) Business Days from the date the HMO receives the subsidy payment from CMS. The report must include the following information regarding payments made by the HMO to LIS Enrollees: Payment Date, Carrier ID, Benefit Plan, Benefit Program, Last Name. First Name, DOB, HICN, Member ID, SSN, # of Payments, Payment Start

Date, Payment End Date, ADJ Reason Code, ADJ Reason Code Description, and LIS Premium Subsidy Amount.

6. Healthcare Effectiveness Data and Information Set (HEDIS) Reports

Consistent with State and Federal regulations, HEDIS reports need to be completed on a timely basis.

F. Submission of Premium Rates

Those HMOs selected by the Department and the JLMC for participation in the NYSHIP in 2016 shall be required to submit premium rates to the Department by the date specified in Exhibit II.A and in accordance with Exhibits II.M, II.M.1 and II.M.2. In order to prepare for the annual health insurance Option Transfer Period, NYSHIP premium rate submissions are due by September 1 of each Calendar Year. The premium rates shall be accompanied by the HMO's most recent available year-to-date loss ratio for the community pool in which NYSHIP Enrollees are included. The premiums submitted to the Department shall be guaranteed rates under the NYS Department of Financial Services (DFS) regulation 11 NYCRR 52.42(b). The premium rates guaranteed shall be the presently prevailing approved or filed premiums or the HMO's best estimate of the expected average filed or approved premium rates for the following year adjusted by any prospective or retrospective adjustments required for guaranteed premium rates under 11 NYCRR 52.42(b). The premium rates for those Enrollees who reside out of state must be the same as NYS premium rates filed with the NYS DFS. Upon request, the HMO shall provide detailed information to support the quoted premium rates.

Premium Rate Billing

NYSHIP rates are comprised of (1) the HMO's Community Rates associated with the JLMC approved benefits for the following Plan Year, as submitted to and approved by the NYS Department of Financial Services (DFS), (2) Medicare Rate Adjustments (if applicable); and (3) Prior Period Adjustments:

(a) Community Rates: The basis for NYSHIP rates are the HMO's Community Rates (basic contract rates and required benefit rider rates) for Plan Year for the specific Commercial Plan approved by the Department in consultation with the JLMC which have either been approved or are pending approval by DFS.

(b) Medicare Rate Adjustments: NYSHIP's rate structure and billing system do not differentiate between Medicare and non-Medicare contracts. Regardless of Medicare status, Enrollees/Employers are billed and HMOs are paid the same rates. In accordance with CMS guidelines, the HMO is required to submit Medicare Rates to CMS for each Medicare Plan. The premium rates for the Medicare Plan approved by the JLMC will vary from the Commercial Plan rates; they are typically less than those for the Commercial Plan. The variances between the Commercial Plan rates and the Medicare Rates are recognized in the NYSHIP rate development calculation by means of adjustments to the Community Rates (see Exhibits II.M, II.M.1 and II.M.2 for details concerning Medicare Rate Adjustment calculations).

(c) Prior Period Adjustments: Typically the HMO's NYSHIP premium rate submission will include Community Rates that are pending approval by DFS. The rates eventually approved by DFS may be greater than or less than the Community Rates submitted to the Department and implemented for the Plan Year, resulting in insufficient or excess premiums paid to the HMO. As such, the NYSHIP premium rate calculations incorporate prior period adjustment calculations to recognize those differences between the submitted rates and the final approved DFS rates. The prior period adjustment calculations represent the differences in the initial and final rates multiplied by actual current year enrollment (as provided by the Department, taken from NYBEAS) and are applied as adjustments to the Community Rates (see Exhibits II.M, II.M.1 and II.M.2 for details concerning Prior Period Adjustment calculations.)

(d) Many HMOs submit for a rate adjustment to DFS with an effective date of January 1. Such rate adjustments are only applicable until another rate request is made and approved by DFS. For administrative purposes, an HMO may guarantee the payment of the implemented rate for one year and incorporate any approved mid-year rate changes into the prior period adjustment of the following year's guaranteed rate.

(e) For an HMO that has withdrawn from NYSHIP, within the first six months following its withdrawal, a prior period calculation will be required for each of administered NYSHIP options. Unlike the active HMO options in which prior period adjustments are applied to a future rate period, an aggregate

overpayment/underpayment is calculated for the withdrawn HMO. An aggregate credit, or negative, dollar amount would represent an overpayment of prior year premium by the Department to the HMO. An aggregate debit, or positive, dollar amount would represent an underpayment or prior year premium by the Department to the HMO. The period adjustment calculation is subject to review and approval by the Department. Upon written approval of the prior period adjustment calculation by the Department, any amount due, whether to the Department or the HMO, shall be paid within thirty days of written approval.

G. Administrative Requirements

1. Account Management Team

The Department expects the HMO's Account Management Team to have a proactive, experienced account leader and team in place who have the authority and expertise to coordinate the appropriate resources to:

(a) Ensure that there is a process in place to gain immediate access to appropriate corporate resources and senior management necessary to meet all HMO Program requirements and to address any issues that may arise during the performance of the Agreement;

(b) Be accessible and sufficiently staffed to provide timely responses (within 1 to 2 Business Days) to concerns and inquiries posed by the Department, or other staff on behalf of the JLMC regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department; and

(c) Immediately notify the Department in writing of actual or anticipated events impacting the HMO Program requirements and/or delivery of services to Enrollees such as but not limited to, change from not-for-profit status to for-profit status, applications by another party to acquire control of the HMO, legislation, class action settlements, and operational issues.

2. Alternate Identification Number

The HMO is required to use an identification number other than Social Security Number on identification cards and other documents, forms or correspondence provided to users external to the HMO for its members enrolled through NYSHIP.

3. Hospital and Provider Group Changes

The HMO is required to advise all JLMC Contact Members (Exhibit II.B) of the potential withdrawal of any hospital or hospital group and of any significant provider group from the HMO's provider network as soon as the potential withdrawal is identified but no later than thirty (30) days prior to the group's potential withdrawal date.

4. NYSHIP Standing within HMO Customer Base

For the initial year of this contract term, the HMO is required to list its current ten largest employer groups, in descending order, by number of contracts for the organization's HMO business (i.e., large group HMO product) in which NYSHIP is included and indicate where NYSHIP enrollment would rank in the standings. On an ongoing basis, an HMO must advise the Department and JLMC Contact Members of any change to NYSHIP's position in the standings.

5. Key Subcontractor Changes

The HMO must provide all JLMC Contact Members (Exhibit II.B) with notification of changes in Key Subcontractors within thirty (30) days of such changes becoming final.

6. Region Configuration Changes

Prior notification of proposed changes in the configuration of Service Area counties, including a shift in counties within rating regions or the establishment of a new rating region(s), must be provided to the Department. This notification must be made to the Department at the time the request is submitted to the regulatory agency and noted as pending. The Department must be notified of the determination by the regulatory agency and upon approval be provided all pertinent information including, but not limited to, the effective date of the change. The HMO must also provide the Department and all JLMC Contact Members (Exhibit II.B) with copies of all notification materials for members impacted by the region switch prior to distribution to the members.

7. Website Access

The HMO must provide the Department and JLMC Contact Members responsible for administrative oversight of NYSHIP HMOs with access to website applications that

are available only to members. The HMO must also provide the URL of the main website and provide a dummy ID and password so that the Department may view the capabilities and user friendliness of the HMO's website.

8. Enrollment Data Transmission Requirement

A participating HMO must use the enrollment data transmission protocol and encryption method as stipulated by the Department. The current data transmission protocol must be Secure FTP, and the current encryption methodology must be PGP or as otherwise specified by the Department. Secure FTP must be compatible with the OpenSSH implementation of Secure FTP. Further, the HMO must agree to execute the Department's Third Party Connection Agreement and Third Party User Agreement and their amendments as required and any other agreement or protocol required by the Department to ensure the security of its data transmissions.

9. Release of Protected Health Information Requirement

The HMO must accept a signed and valid NYSHIP Authorization for Release of Protected Health Information form, or any alternative form developed during the contract term, for the purpose of the release of protected health information to NYSHIP representatives.

10. Medicare Secondary Payer Claim Administration (Applies only to Commercial Plan)

The HMO shall agree to follow the procedures set forth below in handling Medicare Secondary Payer (MSP) claims for any NYSHIP Enrollees and Dependents:

(a) Upon receipt of a demand letter directly from the Centers of Medicaid and Medicare Services (CMS) or indirectly from the Department for the payment of a claim that was paid primary by Medicare and for which CMS asserts NYSHIP coverage should have been primary, the HMO shall make its best effort to resolve the claim within the timeframe specified by CMS. This shall include working with the Department to determine the claimant's employment status at the time the claim was incurred, the amount of liability for such claim on the part of the HMO and the payment of any liability owed by the HMO to CMS;

(b) In the event an MSP claim is not settled with CMS within the timeframe specified in the demand letter, the Department reserves the right to have CMS

reimbursed the full amount of the claim by another NYSHIP plan administrator for the purpose of avoiding any interest charges and/or the offset of other Federal funds payable to the State. The HMO agrees that if it is determined that there was liability for payment of all or part of such claim including accrued interest, the HMO shall, upon the direction of the Department, repay to the NYSHIP insurer/third party administrator amounts paid on behalf of the HMO for MSP claims by the NYSHIP insurer/third party administrator;

(c) The HMO agrees to periodically report to the Department the status of any unresolved MSP claims, including both claims received directly from CMS or indirectly received from the Department. The timing and information to be included in such reports shall be specified by the Department. In addition, the HMO shall provide to the Department copies of any correspondence it sends to CMS regarding NYSHIP MSP claims; and

(d) In the event there is an offset of Federal funds payable to a New York State agency by the U.S. Treasury because of an unresolved MSP claim attributable to the HMO, the Department shall reimburse the agency for the offset using monies from the Health Insurance Fund and shall reduce the next premium payment to the HMO by the amount of such offset.

H. Medicare Part D Administration Requirements

Any HMO that does not offer a Medicare Advantage plan for NYSHIP's Medicare primary Enrollees/Dependents must comply with any and all requests from the Department for assistance and support, as the Department may require, to administer the Retiree Drug Subsidy. This includes all services necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) including but not limited to:

1. Disclosing to CMS, on behalf of the Department, any information received from the Department or within the HMO's control, necessary for the Department to comply with the requirements of the Retiree Drug Subsidy Program (RDS). This includes providing and maintaining the accounting and enrollment records, as well as reporting documentation in the format and layout required by the Department, necessary to enable the Department to collect and verify the Retiree Drug Subsidy from CMS. The format will be provided to each NYSHIP participating HMO required

to provide RDS reporting. The format and layout may be revised at the discretion of the Department. If revised, the Department will provide revised layout documentation to the HMO. Required RDS tasks shall include but not be limited to:

(a) Submitting to the Department all records and reports in a manner, form, and timeliness acceptable to the Department as required support of the HMO's semi-annual submission of data to CMS in order to permit the Department's receipt of Retiree Drug subsidy payments on a semi-annually basis. Semi-annually data submission must be received by the Department no later than 45 days following the end of each semi-annual period;

(b) Submitting to the Department all records and reports in a manner, form, and timeliness acceptable to the Department as required support of the Department in its completion of the annual reconciliation process. The HMO must provide such records and reports in a manner, form, and timeliness acceptable to the Department; including but not limited to the tracking of Final Paid Claims and the submission of such information to CMS and the Department, in compliance with the RDS and the Department's requirements. The required data and records must be submitted to the Department as follows:

(1) All components of the annual RDS Reconciliation Reporting (Detail and Summary Payment files, Detail and Summary Payment file Record Counts and Cost Report), meeting the Department's specifications for completeness and accuracy, must be submitted to the Department no later than February 1 of the calendar year in which the Reconciliation is required to be filed with CMS;

(2) Except for those occurrences where a delay is due to a CMS regulation or requirement change impacting file production, should the HMO fail to provide all components of the required Reconciliation reporting by the specified due date, the HMO shall:

(a) remit to the Department $1,000 for each day beyond the due date that the required complete and accurate files are not provided to the Department; and

(b) indemnify the Department, in total, for any loss incurred should the HMO's failure to provide acceptable files and timely cost reporting to CMS result in any loss of Retiree Drug Subsidy reimbursement to the Department; and

(3) Once the Department has approved the annual RDS Reconciliation reporting, the HMO shall report such information to the CMS/Retiree Drug Subsidy website;

(c) Providing any assistance necessary to facilitate the Department's annual attestation of actuarial equivalence for the 2016 Plan Year and subsequent plan years. If applicable, the HMO must also cooperate with the Department to disclose to CMS and to NYSHIP's Part D-eligible Enrollees if the Department is unable to attest to the requisite actuarial equivalence;

2. The Department acknowledges and agrees that it shall be solely responsible for providing creditable coverage notices required with respect to Retiree Subsidy Program; and for determining whether enrolled individuals are qualifying covered retirees. The Department shall timely provide to the HMO, as verified by CMS prior to submission to the HMO, a list of qualifying covered retirees, as such list may be updated from time to time;

3. The HMO shall establish and implement proper safeguards against the unauthorized use and disclosure of the data exchanged pursuant to the administration of the NYSHIP Retiree Drug Subsidy as well as other aspects of the interface between NYSHIP and CMS. Such safeguards shall include the adoption of policies and procedures to ensure that the data obtained as a consequence of the NYSHIP Retiree Drug Subsidy application shall be used solely in accordance with applicable federal and State law. The HMO shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data. The safeguards shall provide a level of security at least comparable to the level of security required of the Department by CMS, as specified by CMS. Any and all HMO Personnel interacting with this data must be advised by the HMO of the confidential nature of the information, the safeguards required to protect the information, and the

administrative, civil and criminal penalties for noncompliance contained in applicable federal laws;

4. The HMO acknowledges that the information furnished in connection with the administration of the NYSHIP Retiree Drug Subsidy is being provided to obtain federal funds. The HMO shall require all sub-contractors, including any plan administrators, if applicable, who submit information required by CMS to obtain the Retiree Drug Subsidy on behalf of NYSHIP to acknowledge that information provided in connection with the subcontract is used for the purpose of obtaining federal funds; and

5. The HMO acknowledges that its provision of services pursuant to these Specifications is subject to audit and evaluation by the Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of the resulting Agreement. The HMO shall comply with any record retention requirements required pursuant to 42 CFR SubPart R in this regard.

I. Medicare Advantage Enrollment Requirement

1. The MA Plan must follow the regulations and requirements set forth in the CMS Medicare Managed Care Manual (MMCM). The DCS is obligated to follow the rules and regulations in the MMCM as applicable to the employer group.

2. The HMO shall agree to follow the procedures set forth in Chapter 2 of the MMCM, Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage , which allows an employer to group enroll its retirees using a group enrollment process that does not require submission of a signed application by the retiree. The HMO must agree to work in cooperation with the DCS to enroll individuals into the HMO's Medicare Advantage Plan as they become Medicare eligible in accordance with this process. The DCS will follow the process required of the employer group for providing information to each eligible Employee/Retiree in the timeframes defined in the MMCM, as follows:

   (a) The Department shall provide advance notice to eligible Enrollees and/or their eligible Dependents that Department intends to enroll them in MAPD Plan;

(b) The Department shall provide eligible Enrollees and/or their eligible Dependents notice that they may affirmatively opt-out of such enrollment; explain the process to opt-out; and any consequences to their benefits opting out would bring;

(c) The Department shall provide eligible Enrollees and/or their eligible Dependents a summary of benefits offered under the MAPD, an explanation of how to get more information about the MAPD, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available; and

(d) The Department shall provide eligible Enrollees and/or their eligible Dependents the information contained in the MMCM Chapter 2 Exhibit 2 Model Employer/Union Group Health Plan Enrollment Request Form under the heading "Please Read & Sign Below."

3. The Department shall include in the enrollment files submitted to the HMO all the information required for the HMO to submit an enrollment request to CMS, as set forth in the MMCM. The HMO must advise the DCS in writing of any changes to the required enrollment data at least 60 days prior to implementation. If the HMO receives notification of change from CMS less than 60 days in advance of implementation, the HMO must advise the DCS within 2 business days from receipt of such notification from CMS.

4. The HMO shall provide health care benefits to MAPD Members who receive covered services under the terms of this Agreement and the EOC. The HMO shall furnish MAPD identification cards and EOCs to each MAPD Member enrolled for MAPD Plan benefits.

5. The HMO shall agree to follow the procedures set forth in Chapter 2 of the MMCM, Optional Employer/Union MA Disenrollment Request Mechanism, which allows MA Plans to accept voluntary disenrollment elections directly from the employer or union without obtaining a MA disenrollment form from each individual and Group Disenrollment for Employer**/**Union Sponsored Plans, which allows an employer to group disenroll its MAPD Members using a group disenrollment process that does not require submission of a signed disenrollment form. The HMO must agree to work in cooperation with the Department to disenroll individuals out of the HMO's

Medicare Advantage Plan. The Department shall agree to follow the process and timelines required for group disenrollment as stated in the MMCM including notification of the group's intention to disenroll the MAPD Members and transmit the information required for the HMO to submit a disenrollment request to CMS. For individual voluntary disenrollment requests, the Department shall agree to submit disenrollment information which accurately reflects the Department's record of the disenrollment made by each MAPD Member according to the processes the Department has in place.

6. An HMO that offers a Medicare Advantage Plan through NYSHIP shall agree to notify the Department when CMS regulations impact the enrollment of a NYSHIP Enrollee or Dependent in the Medicare Advantage Plan. These events include but are not limited to the following:

   (a) CMS generated disenrollments that remove a NYSHIP Enrollee or Dependent from the Medicare Advantage employer group plan;

   (b) Disenrollments prompted by MAPD Member correspondence where CMS regulations require the HMO to act on the MAPD Member's request prior to the Department's notification through the Optional Employer/Union MA Disenrollment Request Mechanism or Group Disenrollment for Employer/Union Sponsored Plans;

   (c) Enrollments received from the Department through the Group Enrollment for Employer/Union Sponsored Plans that cannot be processed with CMS. These situations include but are not limited to cases where the NYSHIP Enrollee or Dependent is not enrolled in Medicare Part A or Part B, already enrolled in another Medicare Advantage Plan, has an invalid or missing HICN or does not reside in service area; and

   (d) Other situations not described above.

7. The HMO shall agree that the commencement of coverage for Enrollees and their eligible Dependents will begin as of the requested effective date, in accordance with CMS regulations, for any eligible NYSHIP who makes a timely application for enrollment.

8. Termination of coverage for a MAPD Member who is determined by the Department to be ineligible for benefits shall be reported to the HMO in the enrollment files transmitted on the scheduled basis. Upon the Department's notification to the HMO, the coverage of such MAPD Member shall terminate after providing notice to such MAPD Member in accordance with the Department's policy and CMS regulations. The Department is responsible for providing NYSHIP required notice; the HMO is responsible for providing CMS required notice. Retroactive disenrollment shall not be permitted except in specific situations approved by CMS.

9. An HMO that offers a Medicare Advantage Plan through NYSHIP must within forty-five (45) business days from the date the HMO receives the Low Income Subsidy (LIS) payment from CMS, send the LIS beneficiary the low-income premium subsidy payment.

10. The Department acknowledges that a Medicare Part D Late Enrollment Penalty (LEP) may be assessed to a MAPD Member when the Member has a break in Creditable Coverage. To determine the existence of Creditable Coverage, the HMO shall review the MAPD coverage history by viewing the MAPD NYSHIP enrollment record in the New York Benefits Eligibility & Accounting System (NYBEAS). For those MAPD Members whose NYBEAS record does not confirm continuous Creditable Coverage, the HMO shall send a Creditable Coverage attestation form to the MAPD Members in accordance with CMS regulations. The HMO shall bill the MAPD Member directly for any LEP assessed by CMS.