

June 23, 1982

SUBJECT: INSURANCE

Circular Letter No. 20

TO: ALL INSURERS, OTHER THAN ARTICLE IX-C CORPORATIONS, LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE

SUBJECT: ACCIDENT AND HEALTH INSURANCE CONVERSION POLICIES

Chapter 438, Laws of 1981, which amended Section 162, New York Insurance Law, takes effect July 1, 1982, and mandates new benefit levels for basic hospital and surgical and major medical conversion policies.

To assist insurers in their compliance with the amended law, this Circular Letter sets forth guidelines to be followed by insurers for conversion policies. These guidelines relate to (1) Policy Form Approval and Benefit Design, (2) Overinsurance Standards, and (3) Premium Rates for the new benefit levels. Guidelines for premium rates applicable to policies under the 1975 benefit levels are also set forth.

1. Policy Form Approval and Benefit Design

- a) The minimum standards for a major medical conversion policy are set forth in subsections 5 and 8 of Section 162, and Sections 52.7, 52.54(a) and all other applicable requirements of Department Regulation 62.
- b) Insurers may design their major medical policy to follow the major medical expense benefit, exclusion, restriction and limitation provisions set forth in Appendices A and B of Circular Letter No. 18 (1975), as modified by Circular Letter No. 10 (1976), so long as such provisions are not less favorable than, and are consistent with, the Insurance Law, Regulation 62, and other Department requirements. For insurers choosing to follow Appendix A of Circular Letter No. 18 (1975), please note: 1) The policy should not include a deductible provision which would permit charges to be included in the deductible which were incurred in a period prior to a 90-day period in the preceding year; 2) The Benefit Period provision cannot be followed verbatim. In particular, the sentence in the Benefit Period provision indicating that the benefit period will terminate at the end of the calendar year in which was incurred the first covered expense in excess of the deductible is inappropriate for an "all cause" policy that permits a "90-day roll-over" from the preceding calendar year.
- c) At the insurer's option, it may elect to offer either or both of the major medical plans described in Section 162.8.
- d) Previously-approved hospital and surgical and major medical conversion policies can continue to be used on or after July 1, 1982, if they comply with subsections 5, 7 and 8 of Section 162, and Sections 52.7, 52.54(a) and all other applicable requirements of Department Regulation 62.
- e) Where an applicant for a conversion policy is entitled to basic coverage and major medical coverage,

the insurer may elect to issue separate policies or a single policy, at its option. If, however, the insurer elects to issue separate conversion policies, and if its major medical policy contains a surgical schedule, the surgical schedules of the two policies must be the same and may vary only as to the applicable statutory maximums.

f) If a person insured under a New York group major medical policy applies for conversion when a resident of another state, the insurer must offer conversion to a major medical coverage if the applicant's state of residence has a major medical conversion law. Otherwise, the insurer must offer conversion to its most liberal hospital and surgical plan then being offered for conversions in that state.

g) The conversion privilege required by Chapter 438, Laws of 1981, should be made available under group policies issued to all policyholders recognized under Section 221.2 of the Insurance Law, except a policy-holder defined in paragraph 2(e).

h) Insurers must offer to group major medical converttees one of the statutory major medical plans and, in addition, may voluntarily offer other conversion plans approved by the Superintendent.

i) The surgical schedule to be included in conversion policies may be either the Society of Actuaries schedule published in TSA Volume X, at the maximum stated in the law, or the Regulation 62 schedule, at 1.9 times the statutory maximum.

j) If the policy includes an optional provision for reducing benefits during the first two years of the policy, it must also provide for an appropriate adjustment of premium.

k) Except for increased benefits and premiums, the basic hospital and surgical coverage in Section 162.7, does not differ from that required by previous law.

l) The major medical coverage described in Section 162.8, differs substantially in both benefits and application, from previously required coverage. A sample major medical claim illustration is attached as Appendix A to this Circular Letter. The claim administration procedures outlined in that illustration represent the Department's interpretation of the benefit description contained in the law. It should be noted that:

1) The room and board benefit is to be the lesser of 80% of the hospital's most common semi-private room and board charge or \$ 115, in addition to the amount provided under any basic coverage. For example, if the room and board charge was \$ 250, the maximum payment for Plan III basic and major medical coverage combined would be \$ 230;

2) For surgical coverage under major medical, assuming that the Regulation 62 schedule is used, the maximum covered medical expense is \$ 4,750, reflecting a payment of \$ 3,800 at 80%, in turn reflecting the use of the 1.9 factor referred to in paragraph (i) above;

3) The \$ 2,000 "cap", including deductible and other out of pocket covered medical expenses, must be met by applying the individual room and board and surgical limitations described above. In other words, a maximum of (20% x \$ 143.75) per day for Room and Board could be applied toward the \$ 2,000 limit. For surgical expenses, the amount applied toward the \$ 2,000 limit would be the 20% complement of the actual claim payment as described in Appendix A.

m) As stated under previous circular letters, both all cause and each cause major medical plans may be used, with suitable premium adjustments if the all cause plan is used.

n) For the first time, specific recognition in the premium structure for major medical is required for an underlying service type hospital coverage (e.g. Blue Cross) with benefits of 21 days or more. Because of the significantly lower premium, and the importance of maintaining such underlying coverage, insurers may develop an optional policy form, which excludes hospital benefits during the first 21 days of any hospitalization if such underlying coverage is not kept in force. Prominent notice of the nature of the policy and the hospital benefit exclusion must be given on the face of the policy and on each premium notice.

2. Overinsurance Standards

The amended Section 162 contemplates that each insurer may file with the Superintendent its standards for determining overinsurance or duplication of benefits. Standards no less favorable to insureds than the standards in Appendix C are acceptable and any insurer electing to use them should so state in their submission letter. Attention is called to the restrictions set forth in Section 162.5(e), which limits the insurer's right to request information concerning other insurance coverage to the period of the first two years of the policy. An insurer may non-renew the conversion policy for overinsurance only during this two year period and can do so only on the basis of standards of overinsurance on file with the Superintendent.

3. Premium Rates

Rates deemed reasonable for statutory plans are listed in Appendix B. Non-maternity rates in the Appendix were derived as percentages of previously promulgated rates, rather than from first principles. Graduations and other rate structures not listed will be considered for approval by the Department, provided the bases for such variations are consistent with the promulgated rates. Carriers should note that, depending on the level of underlying coverage, there are now three premium levels for major medical benefits. Attained age premiums are provided as an alternative to level premiums, rather than the previously required preliminary term rates.

Rates for ages 60 and over represent 120% of the net premium referred to in Section 162.6. These rates are fixed until July 1, 1987. The rates for under age 60 are likewise intended to be sufficient until July 1, 1987, however, such rates may be changed earlier if industry-wide experience deviates substantially from the experience projected by the Department.

Carriers will be expected to maintain their group conversion experience separately for each Plan of coverage. For major medical coverage, the experience should be maintained separately for each of the three major medical premium levels. It should be noted, that the premium rates for conversion policies are not intended to be self-supporting.

Premiums set forth in this Circular Letter contemplate coverage of normal out-patient services as covered expenses.

[SIGNATURE]

ALBERT B. LEWIS

Superintendent of Insurance

Appendix A

Sample Major Medical Claim

The sample claim chosen for illustration contains the following charges:

	Amount
1. Room and Board \$ 280 per day for 10 days	\$ 2,800.00
2. Miscellaneous	2,500.00
3. Surgical Procedure	5,000.00

I. Major Medical Without Basic Coverage

Since the statute allows limits to the amount payable under Surgical and Room and Board, rather than limits on Covered Expenses, an equivalent amount of covered charges must be deducted. In both cases, "equivalent covered charges" equals the payment divided by 0.8. The calculations resulting from this interpretation are:

	Charges	Covered Expense
R & B	\$ 2,800.00	\$ 1,437.50 n1
Misc	2,500.00	2,500.00
Surg	5,000.00	4,687.00 n2
		\$ 8,625.00

n1 \$ 1,437.50 = (\$ 115/day) x (10 days)/.8, assuming the hospital's semi-private rate is at least \$ 115.

n2 \$ 4,687.50 - Minimum of:

- a. \$ 5,000.00 (charges)
- b. \$ 4,750.00 - (\$ 2,000 Society of Actuaries scheduled amount, assuming a "maximum" procedure) x (1.9, to convert to Reg. 62 schedule)/.8
- c. \$ 4 587.50 - (75% of \$ 5,000 assumed as Reasonable and Customary)/.8

Payment before considering cut-of-pocket limit (o.o.p.) is

$$(\$ 8,625.00 - \$ 500.00) \times .8 = \$ 6,500.00$$

Amount o.o.p. = (covered expenses) - (payment)

$$\begin{aligned} & \$ 8,625.00 - \$ 6,500.00 \\ & = \$ 2,125.00 \end{aligned}$$

Therefore, an additional \$ 125 is payable, for a total claim payment of \$ 6,625.00

II. Major Medical With Basic Plan III Coverage:

A. Plan III pays:	Payment
1. R & B of \$ 115 x 10	\$ 1,150.00

A. Plan III pays:	Payment
2. Misc	\$ 1,100.00
3. Surgical	\$ 2,850.00 n3
Total	\$ 5,100.00

n

3 (\$ 1,500 SOA schedule) x 1.9 - \$ 2,850

B. Major Medical:

Since the basic payment is \$ 5,100, more than \$ 500, the basic payment becomes the deductible.

Covered Charges	Payment
1. Room and Board: The lesser of:	
a. (\$ 280-\$ 115) x 10 = \$ 1,650.00	
b. \$ 115 x 10/.8 = \$ 1,437.50	\$ 1,150.00 n4
c. (hospital's semi-private rate)x 10/.8	
2. Misc. (\$ 2,500-1,100) = \$ 1,400.00	1,120.00
3. Surg: The lesser of:	
a. (\$ 5,000-\$ 2,850) - \$ 2,150.00	1,720.00
b. \$ 2,000 x 1.9/.8 - \$ 4,750.00	
c. (75% of R & C)/.8 = \$ 4,687.50	
	\$ 3,990.00

n4 Assuming the hospital's most common semi-private rate is at least \$ 115.00

Amount o.o.p.:

$(\$ 1,437.50 + 1,400.00 + 2,150.00) - \$ 3,990.00 = \$ 997.50$

Therefore, total payment is still \$ 3,990.00 under the major medical coverage.

APPENDIX B

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Revised Gross Annual Premiums for Forms

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APPENDIX B
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GROSS ANNUAL PREMIUMS FOR FORMS
UNDER THE LAW PRIOR TO JULY 1, 1982

PLAN: I
AT-
TAINED

AGE	MALE RATE	FEMALE RATE					
		Non- Maternity		Maternity			
				Married		Unmarried	
				Inception Basis	Immediate Basis	Inception Basis	Immediate Basis
					(as increment in 1st year)		(as increment in 1st year)
< 25	61	90	60	15	15	4	
25-29	61	97	57	14	14	3	
30-34	64	114	33	8	10	2	

GROSS ANNUAL PREMIUMS FOR FORMS
UNDER THE LAW PRIOR TO JULY 1, 1982

PLAN: I

AT-
TAINED

AGE

MALE
RATE

FEMALE RATE

Non-
Maternity

Maternity

Married

Unmarried

Inception
BasisImmediate
BasisInception
BasisImmediate
Basis(as increment
in 1st year)(as increment
in 1st year)

35-39	74	127	11	3	4	1
40-44	91	150	1	0	1	0
45-49	109	155	0	0	0	0
50-54	131	154	0	0	0	0
55-59	143	139	0	0	0	0
60-64	166	140	0	0	0	0

ISSUE AGE

MALE
RATE

FEMALE RATE

Non-
Maternity

Maternity

Married

Inception
BasisImmediate Basis
(as increment)1st yr.
Only

OR

Level
Annual

< 25	66	101	48	27	7
25-29	67	112	36	36	6
30-34	78	127	17	24	4
35-39	91	140	5	8	1
40-44	109	152	1	1	0
45-49	127	155	0	0	0
50-54	149	155	0	0	0
55-59	157	144	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE			
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)
				1st yr. Only	OR Level Annual
60-64	166	140	0	0	0

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	Level Annual
		1st yr. Only	OR Annual
< 25	12	7	2
25-29	9	8	1
30-34	5	7	1
35-39	2	3	0
40-44	0	1	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0

CHILDREN (one or more)	Non-Maternity	Maternity		
		Inception Basis	Immediate Basis (as increment)	
			1st yr. Only	OR Level Annual
	82	2	1	1

Increase maternity premiums 13% for Regulation 62 surgical schedule.

PLAN: II
AT-
TAINED

AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Married Maternity		Unmarried Maternity	
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)
< 25	98	142	104	26	26	7
25-29	98	156	99	25	24	6
50-54	104	186	58	14	17	4
35-39	124	206	18	5	7	2
40-44	151	245	2	1	2	0
45-49	184	258	0	0	0	0
50-54	222	254	0	0	0	0
55-59	242	233	0	0	0	0
60-64	284	235	0	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE			
		Non-Maternity	Married Maternity		
		Inception Basis	Immediate Basis (as increment)		Level
			1st yr. Only	OR	Annual
< 25	107	162	84	47	11
25-29	110	182	62	62	11
30-34	127	208	30	42	6
35-39	152	230	9	14	2
40-44	181	253	1	2	0
45-49	214	257	0	0	0
50-54	251	258	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)	
				1st yr. Only	OR	Level Annual
55-59	265	240	0	0		0
60-64	294	235	0	0		0

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	Level Annual
		1st yr. Only	OR
< 25	22	12	3
25-29	16	14	3
30-34	9	12	2
35-39	3	5	1
40-44	1	1	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0

CHILDREN (one or more)	Non-Maternity	Maternity			
		Inception Basis	Immediate Basis (as increment)		
			1st yr. Only	OR	Level Annual
	122	4	1		1

Increase maternity premiums 12% for Regulation 62 surgical schedule.

PLAN: III
ATTAINED

AGE	MALE RATE	FEMALE RATE					
		Non- Maternity		Maternity			
			Married		Unmarried		
			Inception Basis	Immediate Basis	Inception Basis	Immediate Basis	
				(as increment in 1st year)		(as increment in 1st year)	
< 25	134	191	150	38	38	10	
25-29	134	211	143	36	34	9	
30-34	144	257	83	21	24	6	
35-39	170	284	27	7	10	3	
40-44	211	340	3	1	3	1	
45-49	256	356	0	0	0	0	
50-54	313	355	0	0	0	0	
55-59	346	326	0	0	0	0	
60-64	413	329	1	0	0	0	

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non- Maternity		Maternity		
			Married			
			Inception Basis	Immediate Basis		
				(as increment)		
				1st yr. Only	OR	Level Annual
< 25	146	218	121	67		16
25-29	152	250	89	90		16
30-34	176	284	44	60		9
35-39	212	318	13	21		3
40-44	254	350	1	3		0
45-49	304	358	0	0		0
50-54	359	361	0	0		0
55-59	382	336	0	0		0
60-64	413	329	0	0		0

ISSUE AGE	FEMALE RATE			
	Maternity Unmarried			
	Inception Basis	Immediate Basis (as increment		
		1st yr. Only	OR	Level Annual
< 25	31	17		4
25-29	23	20		4
30-34	14	17		3
35-39	5	8		1
40-44	1	2		0
45-49	0	0		0
50-54	0	0		0
55-59	0	0		0
60-64	0	0		0
	Non-Maternity	Maternity		
		Inception Basis	Immediate Basis (as increment)	
			1st yr. Only	Level Annual
CHILDREN (one or more)	160	6	1	1

Increase maternity premiums 13% for Regulation 62 surgical schedule.

PLAN: Major Medical Supplementing
No Basic Plan or Basic Plans I or II

AT-TAINED AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Married		Unmarried	
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)
< 25	195	170	171	26	43	7
25-29	198	262	163	24	39	6
30-34	245	356	95	14	28	4
35-39	321	457	30	5	12	2
40-44	371	568	4	1	3	0
45-49	472	650	0	0	0	0
50-54	711	771	0	0	0	0
55-59	1008	625	0	0	0	0
60-64	1203	894	0	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE			
		Non-Maternity	Married		
		Inception Basis	Immediate Basis (as increment)		Level
			1st yr. Only	OR	Annual
< 25	225	267	137	59	11
25-29	264	361	101	86	11
30-34	336	457	50	59	6
35-39	422	558	14	21	2
40-44	521	655	2	3	0
45-49	689	746	0	0	0
50-54	944	857	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)	
				1st yr. Only	OR	Level Annual
55-59	1114	877	0	0		0
60-64	1203	894	0	0		0

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	Level Annual
		1st yr. Only	OR
< 25	35	15	3
25-29	27	18	3
30-34	16	16	2
35-39	6	8	
40-44	1	2	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0

CHILDREN (one or more)	Non-Maternity	Maternity			
		Inception Basis	Immediate Basis (as increment)		
			1st yr. Only	OR	Level Annual
	203	7	1		1

Increase non-maternity premiums 8% for all cause plan. Reduce non-maternity premiums 10% if coverage for private duty nursing, in-hospital psychiatric care, and out-of-hospital drugs are not provided; and there is an inside limit

on in-hospital physicians fees.

Increase maternity premiums 12% for Regulation 62 surgical schedule.

PLAN: Major Medical Supplementing

Basic Plan III or Better

AT-TAINED

AGE	MALE RATE	FEMALE RATE					
		Non-Maternity		Maternity			
		Married		Unmarried			
		Inception Basis	Immediate Basis	Inception Basis	Immediate Basis		
			(as increment in 1st year)		(as increment in 1st year)		
< 25	161	148	120	18	30		5
25-29	172	228	115	17	27		4
30-34	213	310	67	10	19		3
35-39	280	398	21	3	8		1
40-44	323	495	3	0	2		0
45-49	411	565	0	0	0		0
50-54	628	671	0	0	0		0
55-59	877	718	0	0	0		0
60-64	1047	778	0	0	0		0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity		Maternity		
		Married		Unmarried		
		Inception Basis	Immediate Basis	Inception Basis	Immediate Basis	
			(as increment in 1st yr.)		(as increment in 1st yr.)	
				1st yr. Only	OR Level Annual	
< 25		196	232	96	42	8
25-29		230	314	71	60	7
30-34		292	398	35	42	4
35-39		368	486	10	14	1
40-44		454	570	1	2	0
45-49		600	649	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)	
				1st yr. Only	OR	Level Annual
50-54	821	746	0	0		0
55-59	970	763	0	0		0
50-64	1[ILLEGIBLE WORD]7	778	0	0		0

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	
		1st yr. Only	Level Annual
< 25	25	10	2
25-29	19	13	2
30-34	11	11	1
35-39	4	5	1
40-44	1	1	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
50-64	0	0	0

CHILDREN	Non-Maternity	Maternity		
		Inception Basis	Immediate Basis (as increment)	
			1st yr. Only	Level Annual
(one or more)	176	5	1	1

Increase non-maternity premiums 8% for all cause plan. Reduce non-maternity premiums if coverage for private

duty nursing, in-hospital psychiatric care, and out-of-hospital drugs are not provided; and there is an inside limit on in-hospital physicians fees.

Increase maternity premiums 4% for Regulation 62 surgical schedules.

PLAN: I

ATTAINED

AGE	MALE RATE	FEMALE RATE					
		Non-Maternity			Maternity		
		Inception Basis	Immediate Basis	Unmarried Inception Basis	Married		Unmarried Immediate Basis
					Inception Basis	Immediate Basis	
			(as increment in 1st year)		(as increment in 1st year)		
< 25	116	171	132	33	34	3	
25-29	116	185	126	31	30	5	
30-34	121	217	73	18	21	5	
35-39	141	242	23	6	9	2	
40-44	173	285	3	1	2	1	
45-49	207	294	0	0	0	0	
50-54	249	292	0	0	0	0	
55-59	271	264	0	0	0	0	
60-64	315	267	0	0	0	0	

ISSUE AGE	MALE RATE	FEMALE RATE					
		Non-Maternity			Maternity		
		Inception Basis	Immediate Basis	Unmarried Inception Basis	Married		Unmarried Immediate Basis
					Inception Basis	Immediate Basis	
			(as increment)		(as increment)		
			1st yr. Only	OR	Level	Level	
					Annua[ILLEGIBLE WORD]		
< 25	125	192	106	59		14	
25-29	128	212	78	79		14	
30-34	148	242	38	53		8	
35-39	173	267	11	18		3	
40-44	207	290	1	3		0	
45-49	242	294	0	0		0	

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity			Maternity	
					Married	
		Inception Basis			Immediate Basis (as increment)	
					1st yr. Only	OR
50-54	283	294	0	0	0	
55-59	299	274	0	0	0	
60-64	315	267	0	0	0	

ISSUE AGE	FEMALE RATE				
	Maternity Unmarried				
	Inception Basis	Immediate Basis (as increment)			
		Level			
		1st yr. Only	OR	Annual	
< 25	27	15		1	
25-29	21	17		3	
30-34	12	15		2	
35-39	4	7		1	
40-44	1	2		0	
45-49	0	0		0	
50-54	0	0		0	
55-59	0	0		0	
60-64	0	0		0	

CHILDREN one or more)	MALE RATE	FEMALE RATE				
		Non-Maternity		Maternity		
				Immediate Basis (as increment)		
		Inception Basis		1st yr. Only	OR	Level Annual
	155	5	1		1	

Increase maternity premiums 10% for Regulation 62 surgical schedule.

PLAN: II

AT-TAINED

AGE	MALE RATE	FEMALE RATE					
		Non-Maternity	Maternity				
			Married		Unmarried		
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)	
< 25	187	269	223	56	57	14	
25-29	187	296	213	53	51	13	
30-34	193	353	124	31	36	9	
35-39	235	392	40	10	15	4	
40-44	287	465	5	1	4	1	
45-49	349	490	0	0	0	0	
50-54	422	483	0	0	0	0	
55-59	461	442	0	0	0	0	
60-64	540	447	0	0	0	0	

ISSUE AGE	MALE RATE	FEMALE RATE			
		Non-Maternity	Maternity		
			Married		
			Inception Basis	Immediate Basis (as increment)	
			1st yr. Only	OR	Level Annual
< 25	203	308	179	100	24
25-29	210	347	132	134	23
30-34	242	394	65	90	14
35-39	290	438	19	31	4
40-44	344	481	2	4	1
45-49	406	488	0	0	0
50-54	477	490	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)	
				1st yr. Only	OR	Level Annual
55-59	504	456	0	0		0
60-64	540	447	0	0		0

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	Level Annual
		1st yr. Only	OR
< 25	46	25	6
25-29	35	29	6
30-34	20	25	4
35-39	7	11	2
40-44	2	3	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0

CHILDREN (one or more)	Non-Maternity	Maternity			
		Inception Basis	Immediate Basis (as increment)		
			1st yr. Only	OR	Level Annual
	233	9	2		2

Increase maternity premiums 10% for Regulation 62 surgical schedule.

PLAN: III
ATTAINED

AGE	MALE RATE	FEMALE RATE					
		Non-Maternity		Married Maternity		Unmarried Maternity	
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)	
< 25	255	363	267	67	68	17	
25-29	255	401	254	64	61	15	
30-34	274	488	148	37	43	11	
35-39	324	540	47	12	18	5	
40-44	401	645	6	2	4	1	
45-49	486	677	0	0	0	0	
50-54	595	675	0	0	0	0	
55-59	657	620	0	0	0	0	
60-64	784	625	0	0	0	0	

ISSUE AGE	MALE RATE	FEMALE RATE			
		Non-Maternity		Married Maternity	
		Inception Basis	Immediate Basis (as increment)		
			1st yr. Only	OR	Level Annual
< 25	278	415	214	119	29
25-29	290	474	158	160	28
30-34	335	540	78	107	16
35-39	404	604	22	37	5
40-44	483	666	3	5	1
45-49	577	679	0	0	0
50-54	682	686	0	0	0
55-59	725	638	0	0	0
60-64	784	625	0	0	0

ISSUE AGE	FEMALE RATE			
	Inception Basis	Maternity Unmarried Immediate Basis (as increment 1st yr. Level Only OR Annual		
< 25		55	30	
25-29	41	35		7
30-34	24	30		5
35-39	9	14		2
40-44	2	4		0
45-49	0	0		0
50-54	0	0		0
55-59	0	0		0
60-64	0	0		0
		Non-Maternity		Maternity
		Inception Basis	Immediate Basis (as increment) 1st yr. Level Only OR Annual	
CHILDREN (one or more)	303	10	3	3

Increase maternity premiums 13% for Regulation 62 surgical schedule.

PLAN: Major Medical Supplementing

No Basic Plan or Basic Plans I or II

AT-
TAINED

AGE	MALE RATE	FEMALE RATE				
		Non- Maternity	Married		Unmarried	
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)
< 25	272	250	262	39	67	10
25-29	290	385	250	38	60	9
30-34	359	523	145	22	42	6
35-39	472	672	46	7	18	3
40-44	545	835	6	1	4	1
45-49	693	955	0	0	0	0
50-54	1060	1133	0	0	0	0
55-59	1481	1212	0	0	0	0
60-64	1768	1314	0	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non- Maternity	Maternity			
			Inception Basis	Immediate Basis (as increment)		
				1st yr. Only	OR	Level Annual
< 25	330	392	211	91		17
25-29	388	530	156	132		16
30-34	494	672	76	91		10
35-39	621	820	22	32		3
40-44	766	962	3	4		0
45-49	1013	1096	0	0		0
50-54	1387	1260	0	0		0

ISSUE AGE	MALE RATE	FEMALE RATE			
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)
				1st yr. Only	Level Annual
				OR	
55-59	1637	1289	0	0	0
60-64	1758	1314	0	0	0

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	Level Annual
		1st yr. Only	OR
< 25	54	22	4
25-29	41	28	4
30-34	24	25	3
35-39	9	12	1
40-44	2	3	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0

CHILDREN (one or more)	Non-Maternity	Maternity		
		Inception Basis	Immediate Basis (as increment)	
			1st yr. Only	Level Annual
			OR	
	298	10	2	2

Increase non-maternity premiums 8% for all cause plan. Reduce non-maternity premiums 10% if coverage for private duty nursing, in-hospital psychiatric care, and out-of-hospital drugs not provided; and there is an inside limit on

in-hospital physicians fees.

Increase maternity premiums 17% for Regulation 62 surgical schedule.

PLAN: Major Medical Supplementing

Basic Plan III or Better

AT-TAINED

AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Married		Unmarried	
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)
< 25	237	218	215	32	55	8
25-29	253	335	205	31	49	7
30-34	313	455	119	18	35	5
35-39	411	565	38	6	15	2
40-44	474	727	5	1	4	1
45-49	604	831	0	0	0	0
50-54	923	986	0	0	0	0
55-59	1289	1055	0	0	0	0
60-64	1539	1144	0	0	0	0

ISSUE AGE	MALE RATE	FEMALE RATE		
		Non-Maternity	Married	
		Inception Basis	Immediate Basis (as increment)	
			1st yr. Only	Level Annual
< 25	288	341	74	14
25-29	338	461	108	13
30-34	430	585	74	8
35-39	540	714	26	2
40-44	667	837	4	0

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Inception Basis	Maternity Married	Immediate Basis (as increment)	
				1st yr. Only	OR	Level Annual
45-49	882	954	0	0		0
50-54	1207	1097	0	0		0
55-59	1425	1122	0	0		0
60-64	1539	1144	0	0		0

ISSUE AGE	FEMALE RATE			
	Inception Basis	Maternity Unmarried	Immediate Basis (as increment)	
		1st yr. Only	OR	Level Annual
< 25	44	16		4
25-29	33	23		3
30-34	19	20		2
35-39	7	0		1
40-44	2	2		0
45-49	0	0		0
50-54	0	0		0
55-59	0	0		0
60-64	0	0		0

CHILDREN	Non-Maternity	Maternity			
		Inception Basis	Immediate Basis (as increment)	Level Annual	
			1st yr. Only	OR	Annual
one or more)	259	8	1		1

Increase non-maternity premiums 8% for all cause plan. Reduce non-maternity premiums 10% if coverage for private duty nursing, in-hospital psychiatric care, and out-of-hospital drugs are not provided; and there is an inside limit on in-hospital physicians fees.

Decrease maternity premiums by 16% for Regulation 62 surgical schedule.

PLAN: Major Medical Supplementing a

Hospital Service Plan Covering

21 Days or More

(An additional 8% has been included

in the non-maternity premiums

for this all cause;

AT-
TAINED

AGE	MALE RATE	FEMALE RATE					
		Non- Maternity	Maternity				
			Married	Unmarried			
			Inception Basis	Immediate Basis (as increment in 1st year)	Inception Basis	Immediate Basis (as increment in 1st year)	
< 25	176	152	156	23	40	6	
25-29	188	249	149	22	36	5	
30-34	233	338	86	13	25	4	
35-39	306	435	28	4	11	2	
40-44	353	541	4	1	3	0	
45-49	449	618	0	0	0	0	
50-54	686	723	0	0	0	0	
55-59	959	785	0	0	0	0	
60-64	1144	851	0	0	0	0	

ISSUE AGE	MALE RATE	FEMALE RATE				
		Non-Maternity	Maternity	Inception Basis	Married Immediate Basis (as increment)	Level
					1st yr. Only	OR Annual
< 25	214	254	125	54	10	
25-29	251	343	93	79	10	
30-34	320	435	45	54	6	
35-39	402	531	13	19	2	
40-44	496	623	2	3	0	
45-49	656	710	0	0	0	
50-54	898	815	0	0	0	
55-59	1060	834	0	0	0	
60-64	11[ILLEGIBLE WORD]	851	0	0	0	

ISSUE AGE	FEMALE RATE		
	Inception Basis	Maternity Unmarried Immediate Basis (as increment)	Level
		1st yr. Only	OR Annual
< 25	32	13	3
25-29	24	17	2
30-34	14	15	2
35-39	5	7	1
40-44	1	2	0
45-49	0	0	0
50-54	0	0	0
55-59	0	0	0
60-64	0	0	0

	Non-Maternity	Maternity		
		Inception Basis	Immediate	
			Basis (as increment)	
			1st yr. Only	Level OR Annual
CHILDREN (one or more)	193	6	1	1

Reduce non-maternity premiums 10% if coverage for private duty nursing, in-hospital psychiatric care, and out-of-hospital drugs are not provided; and there is an inside limit on hospital physicians fees.

Increase maternity premiums 29% for Regulation 62 surgical schedule.

Assumptions for

Maternity, Premiums for Group Conversion Policies

1. Birth frequencies: 1980 live birth rate per female in New York State excluding New York City.
2. Unmarried frequencies were increased 10% to cover situations where actual marital status is unknown or where it changes from unmarried to married.
3. No anti-selection was assumed except in the first year for immediate maternity coverage. A 25% increase was assumed in the first year maternity claim costs for the base plans and a 15% increase was assumed in the first year maternity claim costs for the major medical plan.
4. Average hospital stay for normal delivery: 3.6 days.
5. Average hospital miscellaneous charge as of 1/1/83 for normal delivery: \$ 750.
6. Average cost for normal delivery (excluding fees for pre-natal and postnatal care) as of 1/1/83: \$ 800. Average cost for physician's services for prenatal and postnatal care as of 1/1/83: \$ 500.
7. 75% loss ratio.

Appendix C

Standards for Overinsurance Involving Converted Policies Issued Under Section 162, N.Y. Ins. Law

Definitions. As used in these standards:

1. "health care coverage" means coverage for charges made or services provided for hospital, surgical or medical care, treatment, services or supplies.
2. "converted policy" means any policy or contract issued on exercise of any conversion privilege which has been approved by the applicable governmental agency which regulates insurance as complying with a statute mandating such a privilege to convert terminating health care coverage.

3. "duplicating plan" means any one or more of the following plans which pays benefits or provides services for health care coverage: any other hospital, surgical or medical expense insurance policy, any hospital or medical service subscriber contract, any medical practice or other prepayment plan any other voluntary plan or program whether insured or uninsured, or any other plan or program established to comply with any federal or state law (except Medicaid).

4. "overinsured" means, with respect to any person, that his or her health care coverage under the converted policy and all duplicating plans would be more than the applicable maximum set forth below:

(a) As to hospital room and board expense coverage, \$ 10 a day in excess of the average cost of semiprivate accommodations in the area where that person lives;

(b) As to surgical expense coverage, the usual and customary charges made for surgical procedures in the area where that person lives; and

(c) As to major medical expense coverage, another major medical policy other than one providing high deductible catastrophic coverage.

Overinsurance will be determined separately for hospital expense, surgical expense and major medical expense coverage.

Issue Standard. An Insurer may refuse to cover under a converted policy any person or persons who, [ILLEGIBLE WORD]if so covered at the date of conversion, would be overinsured.

Renewal Standard. An Insurer may refuse to renew an in-force converted policy if . any person or persons covered by it is overinsured, would be overinsured, subject to the following conditions:

1. The Insurer must give the Insured written notice at least 31 days in advance of a renewal date that the Insured may elect, prior to that renewal date, (a) to have such person or persons eliminated from the converted policy's coverage or (b) to have the converted policy terminated or (c) to have the total coverage reduced below the overinsurance standards. If the Insured elects elimination or reduction of benefits, this election or reduction must be evidenced by a rider signed by the Insured and by an appropriate adjustment in premium for the converted policy.

2. The elimination, termination or reduction of coverage will take effect after notice to the Insured and on the first renewal date after such notice in accordance with the provisions of the policy.

3. After the converted policy has been in force for two years, the Insurer can refuse to renew coverage only if: (a) each person whose coverage is to be non-renewed is eligible for Medicare coverage or (b) the governmental agency which regulates insurance in the jurisdiction where the Insured resided on the date of issuance of the converted policy has given advance approval to the non-renewal.