

NEW YORK STATE
INSURANCE DEPARTMENT
SECOND AMENDMENT TO REGULATION NO. 171
(11 NYCRR 362)

THE HEALTHY NEW YORK PROGRAM
&
THE DIRECT PAYMENT STOP LOSS RELIEF PROGRAM

I, LOUIS W. PIETROLUONGO, Acting Superintendent of Insurance of the State of New York, pursuant to the authority granted by sections 201, 301, 1109, 3201, 3216, 3217, 3221, 4235, 4303, 4304, 4305, 4318, 4326 and 4327 of the Insurance Law of the State of New York, do hereby promulgate the following Second Amendment to Part 362 of Title 11 of the Official Compilation of Codes, Rules and Regulations (Regulation No. 171), to take effect upon publication in the State Register, to read as follows:

(NEW MATTER IS UNDERSCORED. MATTER IN BRACKETS IS DELETED.)

Section 362-2.5 shall be revised to read as follows:

§ 362-2.5 Annual recertification of eligibility.

(a) Health maintenance organizations and participating insurers shall [annually provide qualifying small employers and qualifying individuals with at least 30 days advance notice of their obligation, pursuant to section 4326(i) of the Insurance Law, to submit a recertification of continued eligibility], at least 90 days prior to the annual renewal date[.]_[In conjunction with such notice, health maintenance organizations and participating insurers shall] provide any forms necessary for recertification.

(b) Health maintenance organizations and participating insurers shall annually collect certifications of continued eligibility for the Healthy New York Program [and necessary supporting documentation] and shall be responsible for examination of such certifications [and supporting documentation] to verify that small employers and individuals participating in the program continue to meet eligibility requirements and continue to comply with the terms of the program. Health maintenance organizations and participating insurers shall determine whether the small employer and individual participants continue to meet the requirements for participation in the Healthy New York Program and shall provide written notice of such determination within two weeks of receipt of the annual recertification.

(c) The failure of an employer or individual to provide written certification demonstrating continued eligibility and continued compliance with the terms of the Healthy New York Program shall be a basis for nonrenewal of a qualifying health insurance contract.

(d) [If a given small employer or individual participant fails to provide a recertification 90 days in advance of the annual renewal date, the health maintenance organization or participating insurer

shall immediately provide such participant with a written reminder of the obligation to recertify. Such reminder notice shall notify the participant that coverage will be non-renewed if the participant fails to provide a recertification at least 60 days in advance of the annual renewal date.

(e)]Health maintenance organizations and participating insurers shall provide no less than 45 days written notice to the contract holder and any covered employees of a nonrenewal[pursuant to subdivision (d) of this section]. Such notice of nonrenewal or termination shall set forth the basis for the nonrenewal and include a description of any applicable conversion rights. Such notice shall also include a description of other coverage options available for purchase from the health maintenance organization or participating insurer.

([f]e) Healthy New York Program enrollees who have transferred into the program from other public programs pursuant to section 4326(p) of the Insurance Law shall not be required to demonstrate satisfaction of the eligibility requirements set forth in section 4326(c) of the Insurance Law at the time of annual recertification.

A new Section 362-2.7 is added to read as follows:

§ 362-2.7 Healthy New York benefit adjustments.

(a) Beginning June 1, 2003, there shall be no copayment applied to preventive and primary health care services for routine well child visits and necessary immunizations.

(b) Beginning June 1, 2003, health plans shall offer an additional Healthy New York benefit package at a reduced premium rate. Such additional benefit package shall contain all of the benefits set forth in section 4326(d)(1) through (13) of the Insurance Law. The prescription drug benefit set forth in Section 4326(d)(14) shall not be included in the additional benefit package. Qualifying small employers and qualifying individuals shall have the option of choosing among the benefit packages. Qualifying small employers must elect to provide the same benefit package to all of their employees participating in Healthy New York. Once enrolled in the program, any change in the selection of benefit package may occur at the time of annual recertification [only] or at anytime the premium rate changes. Notice of this option shall be included with any notice of rate change.

(c) Individuals who are eligible for a federal tax credit under the federal Trade Adjustment Act of 2002, who have 3 months or more of creditable coverage shall be deemed to have sufficient creditable coverage to satisfy the 12-month pre-existing condition waiting period in full.

Section 362-3.2 shall be revised to read as follows:

§ 362-3.2 Small employer participation (other than individual proprietors).

(a) Qualifying small employers must have fifty or fewer eligible employees.

(b) Qualifying small employers must offer coverage to all employees, as defined in this part, who are earning annual wages of \$30,000 or less (adjusted annually as per section 4326(c)(1)(F) of the Insurance Law).

(c) Qualifying small employers must offer coverage to all persons who are considered to be eligible employees for the purpose of determining the employer's eligibility to purchase a qualifying group health insurance contract.

(d) Qualifying small employers may, but shall not be required to, offer coverage to part-time workers who work less than the required number of work hours to qualify as employees. However, if part-time workers are included as eligible employees for the purpose of meeting the eligibility requirements set forth in section 4326(c)(1)(B)(iii) of the Insurance Law, then the coverage must be offered to part-time workers.

(e) At least thirty percent of eligible employees must earn annual wages of \$30,000 or less (adjusted annually as per section 4326(c)(1)(F) of the Insurance Law).

(f) At least fifty percent of eligible employees must participate in group health insurance coverage through the Healthy New York Program.

(g) At least one eligible employee earning annual wages of \$30,000 or less (adjusted annually as per section 4326(c)(1)(F) of the Insurance Law) must participate in group health insurance coverage through the Healthy New York Program.

(h) On behalf of participating employees, qualifying small employers must contribute at least fifty percent of the premium for the qualifying group health insurance contract. Qualifying small employers choosing to offer coverage to part-time workers may choose the level of premium contribution on behalf of part-time workers.

(i) An employer's place of business must be located within New York State in order to be eligible to purchase a qualifying group health insurance contract.

(j) Qualifying small employers shall in no case include employers who have provided group health insurance covering their employees during the 12-month period preceding the date of application. Small employer applicants shall be considered to have provided group health insurance if they have arranged for group health insurance coverage (insured or self-insured) on behalf of their employees and contributed more than a de-minimus amount towards the cost of coverage on behalf of their employees. Through January 31, 2005, de-minimus contributions are those that do not exceed an average of \$50 per employee per month. Beginning February 1, 2005, de-minimus contributions are those that do not exceed an average of \$75 per employee per month for employers in the counties of Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester or an average of \$50 per employee per month for employers in all other counties. De-minimus contributions shall not prevent small employers from qualifying to purchase health insurance coverage through the Healthy NY program.

(k) Mid-year fluctuations in group size, wage levels and employee participation shall not serve as a basis for termination of a qualifying group health insurance contract.

(l) Qualifying group health insurance contracts shall be subject to all applicable continuation and conversion rights including those described in sections 3216(c)(5), 3221(m), 4304(e), 4304(h), 4305(d) and 4305(e) of the Insurance Law. A member covered under a qualifying group health insurance contract who elects to exercise a statutory conversion right shall be provided with the option of converting directly to a qualifying individual health insurance contract if such member satisfies the eligibility criteria set forth in section 4326(c)(3)(A)(ii)-(iv) of the Insurance Law.

(m) Upon initial application [and at the time of annual re-certification], health maintenance organizations and participating insurers shall collect and examine certifications of eligibility and any supporting documentation to determine eligibility for a qualifying group health insurance contract and compliance with the terms of the Healthy New York Program.

(n) Qualifying group health insurance contracts shall include a provision providing for a 30 day grace period for payment of premiums.

(o) Qualifying small employers may, in their discretion, impose waiting periods which newly hired workers must satisfy in advance of obtaining coverage under the small employer's qualifying group health insurance contract. However, the waiting period shall not exceed 45 days from the date of hire and it must be the same for all newly hired workers.

Section 362-4.1 shall be revised to read as follows:

§ 362-4.1 Definitions applicable to working uninsured individuals and individual proprietors.

(a) *Employed person* shall mean, for purposes of determining eligibility for qualifying individual health insurance contracts, any person [currently]employed [(]on a full-time or part-time basis[)] either currently or within the past 12 months for which monetary compensation was received[and currently receiving monetary compensation and any person engaged in episodic employment].

(b) [*Episodic employment* shall mean employment for some portion of at least 20 of the 52 weeks immediately preceding the date of application or recertification.

(c) [*Individual proprietor* shall mean an individual proprietor who is the sole owner and employee of a business and shall include, but not be limited to, independent contractors and other self-employed persons.

Section 362-4.2 shall be revised to read as follows:

§ 362-4.2 Working uninsured individuals and individual proprietor participation.

(a) Qualifying individuals shall in no case include individuals who have health insurance in force or who would be eligible to obtain health insurance under an employer provided group health benefits plan. Qualifying small employers shall in no case include individual proprietors who have health insurance in force or who would be eligible to obtain health insurance under an employer provided group health benefits plan.

(b) An applicant would be considered eligible for an employer provided group health benefits plan if they are eligible to participate in an employer sponsored health benefit plan (insured or self-insured) and the employer contributes toward the cost of the plan or the payment of the premium.

(c) A working uninsured individual or individual proprietor applicant shall not be denied eligibility for the Healthy New York Program on the basis that their employer provides coverage if the applicant is precluded from participation in the employer sponsored health benefits plan due to conditions of eligibility which are based upon conditions pertaining to employment, as defined in section 52.18(f) of this Title.

(d) A working uninsured individual or an individual proprietor shall be eligible for the Healthy New York Program without regard to the existence of health insurance coverage during the 12-month period preceding application if such health insurance coverage terminated due to one of the events listed in section 4326(c)(3)(C) of the Insurance Law, provided that the applicant has not obtained other health insurance coverage subsequent to such termination.

(e) A working uninsured individual or an individual proprietor shall be eligible for the Healthy New York Program without regard to the existence of health insurance coverage during the 12-month period preceding application if such health insurance coverage terminated due to reaching the age of dependency under such prior coverage, provided that the applicant has not obtained other health insurance coverage subsequent to such termination.

(f) Mid-year fluctuations in household income or employment status shall not serve as a basis for termination of a qualifying health insurance contract.

(g) Working uninsured individuals and individual proprietors must be residents of New York State in order to qualify to purchase a qualifying health insurance contract. Documentation of New York State residency must be provided at initial application [and in conjunction with annual recertification].

(h) Qualifying health insurance contracts shall be subject to all applicable conversion rights including those described in sections 3216(c)(5), 3221(m), 4304(e) and 4305(d) of the Insurance Law. A member covered under a qualifying health insurance contract who elects to exercise a statutory conversion right shall be provided with the option of converting directly to a qualifying individual health insurance contract if such member satisfies the eligibility criteria set forth in section 4326(c)(3)(ii)-(iv) of the Insurance Law.

(i) Upon initial application, [and at the time of annual recertification,] health maintenance organizations and participating insurers shall collect and examine documentation sufficient to

demonstrate eligibility for a qualifying health insurance contract and compliance with the terms of the Healthy New York Program. Appropriate forms of documentation shall, at a minimum, include:

- (1) proof of residency;
- (2) proof of employment status; and
- (3) proof of income.

(j) Qualifying health insurance contracts shall include a provision providing for a 30 day grace period for payment of premiums.

(k) In order to purchase a qualifying individual health insurance contract, applicants must be employed persons. Applicants for qualifying individual health insurance contracts may also meet this employment requirement by demonstrating that their spouse (residing in their household) is an employed person.

Section 362-4.3 is hereby amended to read as follows:

§ 362-4.3 Verification of net household income.

(a) To qualify for coverage under the Healthy New York Program, individual proprietors and working uninsured individuals must satisfy the household income criteria set forth in sections 4326(c)(1)(A)(ii) and (3)(A)(iii) of the Insurance Law. For the purpose of determining household income eligibility, household members shall include the applicant, the applicant's legal spouse if residing in the household and any children eligible for coverage under the policy. Income received by the applicant and the applicant's legal spouse residing in the household shall be counted.

(b) Income shall include, but shall not be limited to, the following:

- (1) monetary compensation for services including wages, salary, commissions, overtime compensation, fees or tips;
- (2) net income from farm and nonfarm self-employment;
- (3) social security payments or benefits;
- (4) dividends, interest on savings or bonds, regular income from estates or trusts, or net rental income;
- (5) unemployment compensation;
- (6) government, civilian employee or military retirement or pension or veteran's payments;
- (7) private pension or annuity;
- (8) alimony[or child support payments received];
- (9) regular contributions from persons not living in the household;
- (10) net royalties; and
- (11) such other income as determined by the superintendent.

(c) Income shall not include public assistance; SSI; foster care payments; capital gains; any assets drawn down as withdrawals from a bank; receipts from the sale of property; or payments for

compensation for injury. Also excluded are noncash benefits, such as employee fringe benefits, food or housing received in lieu of wages, and receipts from Federal noncash benefit programs.

(d) Health maintenance organizations and participating insurers shall collect such documentation as is necessary and sufficient to initially[, and annually thereafter,] verify that the household income requirements of the Healthy New York Program have been satisfied. Such documentation may include, but not be limited to one or more of the following:

- (1) [annual] income tax returns and, if not prohibited by Federal law for purposes of income verification, the social security account number;
- (2) paycheck stubs;
- (3) written documentation of income from all employers; or
- (4) other documentation of income (earned or unearned) as determined by the superintendent to be acceptable, provided however, such documentation shall set forth the source of such income.

Section 362-5.1 is hereby amended to read as follows:

§ 362-5.1 Definitions applicable to the Direct Payment Market Stop Loss Relief program and state funded stop loss relief for the Healthy New York Program.

(a) *Capitation payments* means contractually based prepayments made to a health care provider, on a per member per month or a percentage of premium basis, in exchange for health care services to be rendered, referred or otherwise arranged by such provider.

(b) *Claims corridor* means:

(1) for the direct payment stop loss fund and the direct payment out-of-plan stop loss fund, claims paid on behalf of a covered member in a given calendar year in excess of \$20,000 and less than \$100,000;

(2) for calendar years 2001 and 2002, for the small employer stop loss fund and the qualifying individual stop loss fund, claims paid on behalf of a covered member in a given calendar year in excess of \$30,000 and less than \$100,000[.];

(3) beginning in calendar year 2003, for the small employer stop loss fund and the qualifying individual stop loss fund, claims paid on behalf of a covered member in excess of \$5,000 and less than \$75,000.

(c) *Claims paid* means claims paid by a health maintenance organization on behalf of a covered member pursuant to an individual enrollee direct payment contract issued pursuant to section 4321 of the Insurance Law or an individual enrollee out-of-plan direct payment contract issued pursuant to section 4322 of the Insurance Law. *Claims paid* shall also mean those claims paid by a health maintenance organization or participating insurer pursuant to a qualifying health insurance

contract issued pursuant to section 4326 of the Insurance Law. Claims paid shall be determined by the date of payment rather than the date of service or date the claim was incurred.

(d) *Claims threshold* means the aggregate amount that a health maintenance organization or participating insurer must pay out as claims paid before reaching the applicable claims corridor and before becoming eligible for reimbursement on behalf of a covered member in a given calendar year. [For the direct payment stop loss fund and the direct payment out-of-plan stop loss fund, the claims threshold is \$20,000. For the small employer stop loss fund and the qualifying individual stop loss fund, the claims threshold is \$30,000.]

(e) *Direct payment out-of-plan stop loss fund* means the fund established pursuant to section 4322-a(a) of the Insurance Law which is available to reimburse health maintenance organizations for certain claims paid during a calendar year on behalf of members covered under individual enrollee out-of-plan direct payment contracts issued pursuant to section 4322 of the Insurance Law.

(f) *Direct payment stop loss fund* means the fund established pursuant to section 4321-a(a) of the Insurance Law which is available to reimburse health maintenance organizations for certain claims paid during a calendar year on behalf of members covered under individual enrollee direct payment contracts issued pursuant to section 4321 of the Insurance Law.

(g) *Health maintenance organization* shall mean an organization (or line of business of an article 43 corporation) which has received a certificate of authority to operate as a health maintenance organization from the Commissioner of Health pursuant to article 44 of the Public Health Law, or, an article 43 corporation which is qualified within the meaning of section 1310 (c) of title XIII of the Public Health Service Act.

(h) *Individual enrollee direct payment contract* means a contract written pursuant to section 4321 of the Insurance Law.

(i) *Individual enrollee out-of-plan direct payment contract* means a contract written pursuant to section 4322 of the Insurance Law.

(j) *Qualifying individual stop loss fund* means the fund established pursuant to section 4327(a) of the Insurance Law which is available to reimburse health maintenance organizations and participating insurers for certain claims paid during a calendar year on behalf of members covered under a qualifying individual health insurance contract issued pursuant to section 4326 of the Insurance Law.

(k) *Small employer stop loss fund* means the fund established pursuant to section 4327(a) of the Insurance Law which is available to reimburse health maintenance organizations for certain claims paid during a calendar year on behalf of members covered under a qualifying group health insurance contract issued pursuant to section 4326 of the Insurance Law.

Section 362-5.2 is hereby amended to read as follows:

§ 362-5.2 Eligibility of claims paid for reimbursement from the stop loss funds.

(a) For each contract eligible for reimbursement from a given stop loss fund, health maintenance organizations and participating insurers shall record and aggregate claims paid on a per member basis. Reimbursement from the applicable stop loss fund shall be calculated based on such per member aggregates.

(b) Health maintenance organizations and participating insurers shall be eligible for reimbursement of 90 percent of claims paid within the applicable claims corridor on behalf of each member covered under an individual enrollee direct payment contract, an individual enrollee out-of-plan direct payment contract, a qualifying group health insurance contract and a qualifying individual health insurance contract.

(c) Health maintenance organizations and participating insurers shall not be entitled to any reimbursement on behalf of a covered member if the claims paid on behalf of that member in a given calendar year do not, in the aggregate, reach the applicable claims threshold. Additionally, claims paid on behalf of a covered member which exceed [\$100,000] the claims corridor in a given calendar year shall not be eligible for reimbursement from the stop loss funds.

(d) Claims paid within a calendar year shall be determined by the date of payment rather than the date of service or date the claim was incurred. No health maintenance organization or participating insurer shall delay or defer payment of a claim solely for the purpose of causing the date of payment to fall into a subsequent calendar year.

(e) Claims paid shall not include interest paid out by a health maintenance organization or participating insurer pursuant to subsection (c) of section 3224-a(c) of the Insurance Law.

(f) Claims paid which are not submitted for reimbursement prior to April first of the calendar year following the year in which they are paid shall not be eligible for reimbursement from the stop loss funds and shall not be credited as paid claims in any year for the purpose of determining whether the claims threshold has been reached. If the superintendent determines that the claims data submitted in conjunction with a reimbursement request is insufficient to make a reimbursement determination, the superintendent or the stop loss fund administrator shall make a request for clarification of the data or for the submission of additional data. Health maintenance organizations and participating insurers shall comply with all such requests within 15 business days. If a health maintenance organization or participating insurer fails to comply with such a request from the superintendent or the stop loss fund administrator within 15 business days, the superintendent may in his discretion deem any affected claims ineligible for reimbursement.

(g) For individual enrollee direct payment contracts and individual enrollee out-of-plan direct payment contracts, claims paid shall not include claims paid prior to January 1, 2000. For qualifying group health insurance contracts and qualifying individual health insurance contracts, claims paid shall not include claims paid prior to January 1, 2001.

(h) Claims paid shall include capitation payments which can be directly attributed to securing the services of a given provider or provider group on behalf of a member covered under an individual enrollee direct payment contract or an individual enrollee out-of-plan direct payment contract.

(i) Claims paid may include regional covered lives assessments paid pursuant to section 2807-t of the Public Health Law or percentage surcharges paid pursuant to section 2807-j or section 2807-s of the Public Health Law, but shall not include amounts paid in satisfaction of 24 percent surcharge requirement set forth in section 2807-j 2(b)(i)(B) of the Public Health Law. Health maintenance organizations and participating insurers which include the covered lives assessments shall convert the family covered lives assessment into a per member assessment component in order to be included with claims expenses attributable to any one member.

(j) If a health maintenance organization writes the out-of-network portion of their individual enrollee out-of-plan direct payment contract through an affiliate insurer, then the claims paid by that insurer may be credited in determining whether the health maintenance organization is eligible for reimbursement from the stop loss fund on behalf of the covered member.

Section 362-5.3 is hereby amended to read as follows:

§ 362-5.3 Rating of products eligible for claims reimbursements.

(a) The premium rates established for individual enrollee direct payment contracts, individual enrollee out-of-plan direct payment contracts, qualifying group health insurance contracts and qualifying individual health insurance contracts must recognize the availability of reimbursement from the applicable stop loss fund.

(b) Reimbursement from the applicable stop loss fund shall reduce claims expenses for the purposes of calculating loss ratios, premium rates and premium rate adjustments and for the purposes of determining compliance with section 4308 of the Insurance Law and sections 52.40 through 52.45 of this Title.

(c) Initial rate submissions and rate adjustment applications submitted for individual enrollee direct payment contracts, individual enrollee out-of-plan direct payment contracts, qualifying group health insurance contracts and qualifying individual health insurance contracts shall contain such information as may be needed in order to assist the superintendent in determining the anticipated premium rate impact of the availability of reimbursement from the stop loss funds.

(d) Estimates of anticipated receipts from the stop loss funds may be calculated based upon available enrollment data and such other data as may be deemed appropriate by the superintendent.

(e) Healthy New York qualifying group health insurance contracts and qualifying individual health insurance contracts shall be treated as [small group] individual products for the purpose of applying loss ratio standards.

(f) Health maintenance organizations and participating insurers may reinsure their Healthy New York business in whole or in part if they determine it would favorably impact premium rates. The impact of any such reinsurance shall be factored into the premium rates for affected qualifying group health insurance premiums and individual health insurance premiums.

(g) No later than 30 days from the effective date of this regulation, health maintenance organizations and participating insurers shall submit the policy form amendments and premium rate adjustments necessitated by these amendments.

Section 362-5.5 is hereby amended to read as follows:

§ 362-5.5 Data filing requirements.

(a) The superintendent shall require the submission of necessary claims data in connection with each health maintenance organization's and participating insurer's annual submission of requests for reimbursement from the stop loss funds. Each health maintenance organization and participating insurer shall also provide the superintendent with such additional data, as he deems necessary, to oversee the operation of the stop loss funds and the Healthy New York program. Reports pertaining to stop loss reimbursement or loss ratio shall be certified by an officer of the company that such report is accurate and complete. Data to be submitted may include, but shall not be limited to, the following:

(1) the total number of contracts issued within the reporting period and the total number of contracts in force which are covered by the stop loss fund;

(2) the number of qualifying individual health insurance contracts issued which do not provide coverage for dependents;

(3) the number of qualifying small employer health insurance contracts where the employer elects not to make dependent coverage available to employees;

(4) the total number of primary insureds, the total number of dependents covered, and the total number of child dependents covered (a breakdown of these totals by geographic region may be required);

(5) total premium earned and per member per month premium earned for all contracts covered by the stop loss fund for the reporting period;

(6) claims payment data, reported individually for each covered member and/or for each covered member for whom the health maintenance organization or participating insurer has paid claims eligible for reimbursement;

(7) total claims eligible for reimbursement year to date; and

(8) paid claims continuance tables containing the number of claimants and the total number of claims paid by claimant dollar intervals. The superintendent shall provide a written and

electronic spreadsheet with specific claimant dollar intervals and any partitions of paid claims other than by stop loss fund.

(b) Data must be reported separately for each stop loss fund. Data reporting periods may be other than a calendar year and reporting frequency for some data could be as often as monthly. Claims payment data shall clearly set forth both the date the claim was incurred and the date the claim was paid. Claims payment data may also be requested on a cumulative basis or in the form of aggregates, categoricals, and averages.

(c) A health maintenance organization or participating insurer shall use a coding system to ensure the privacy of insured individuals. Personally identifying information shall not be submitted with claims data.

I, LOUIS W. PIETROLUONGO, Acting Superintendent of Insurance of the State of New York, do hereby certify that the foregoing is part of Second Amendment to Part 362 of Title 11 of the Official Compilation of Codes, Rules and Regulations (Regulation No. 171), entitled "The Healthy New York Program & The Direct Payment Stop Loss Relief Program", promulgated by me on January 10, 2007, pursuant to the authority granted by Sections 201, 301, 1109, 3201, 3216, 3217, 3221, 4235, 4303, 4304, 4305, 4318, 4326 and 4327 of the Insurance Law of the State of New York, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on November 1, 2006. No other publication or prior notice is required by statute.

Louis W. Pietroluongo
Acting Superintendent of Insurance

January 12 , 2007