

December 19, 1977

SUBJECT: INSURANCE

CIRCULAR LETTER NO. 18 (1977)

December 19, 1977

TO: All Insurers, including Article IX-C Corporations, licensed to write Accident and Health Insurance in New York State

RE: I. Chapter 894 of the Laws of 1977: Coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments

II. Chapter 893 of the Laws of 1977: Coverage for services performed by a certified and registered social worker

III. Chapter 663 of the Laws of 1977: Coverage for newborn infants

I. Chapter 894 of the Laws of 1977, effective January 1, 1978, amends Sections 162 and 250 of the New York Insurance Law and requires that every insurer issuing a group policy for delivery in this State which provides coverage for in-patient hospital care, and every Article IX-C Corporation which provides coverage for in-patient hospital care and/or physician services, make available, and if requested by the group contractholders or all the subscribers in a group remittance group, provide coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.

To expedite the timely filing and approval of insurance forms and premium rates to implement Chapter 894, the following Department guidelines are applicable:

A. Insurers and Article IX-C Corporations are required to make available at least the coverage set forth in the law, at the inception of new group policies and contracts issued on or after January 1, 1978, and with respect to policies and contracts issued before this date, at the first anniversary date thereafter without evidence of insurability and at subsequent anniversary dates with evidence of insurability.

B. The contractholder or all the subscribers in a group remittance group must be notified of the availability of the coverage at the time of application for a group policy or contract to be issued on or after January 1, 1978, and for a policy or contract issued before this date, at the first anniversary date thereafter.

C. Commercial insurers providing benefits for in-patient hospital care due to physical illness should provide the same level of benefits, subject to the same deductibles and coinsurance, for in-patient services in a hospital as defined in subdivision 11 of Section 1.05 of the Mental Hygiene Law.

D. In the case of Article IX-C Corporations, the statutory benefits for inpatient services in a hospital, as defined by subdivision eleven of section 1.05 of the mental hygiene law, should be payable at the fee or rate set by the Department of Mental Hygiene pursuant to the provisions of Section 43.01 of the Mental Hygiene Law, and in effect when the services were rendered. If no such fee or rate has been established by the Department of Mental Hygiene for a hospital

defined in subdivision 11 of Section 1.05 of the Mental Hygiene Law, the benefit payable shall be:

1) in member hospitals, an amount agreed to between the corporation and the hospital, subject to approval of the Superintendent as provided for in Section 254.2(b), New York Insurance Law.

2) in non-member hospitals, no less than 80% of the hospital's average regular charge for semi-private accommodations.

E. "Active treatment" should be defined in the contract or rider as treatment provided in connection with in-patient hospital care for mental or nervous disorders which meets such standards as shall be prescribed pursuant to regulations promulgated by the Commissioner of Mental Hygiene.

F. Chapter 894 establishes a maximum dollar amount per calendar year for out-patient care without specifying the benefit structure. Recognizing that there are many possible benefit provisions utilizing deductibles, internal limits and coinsurance factors which could be used and considered reasonable, the Department is not at this time adopting a standard benefit for the out-patient care required to be provided by Chapter 894. The Department will, however, review contracts and riders submitted to comply with Chapter 894 to determine that the benefit structure is reasonable and in conformance with the intent of the law. Another factor which will be considered in evaluating the benefit structure is its cost to the policyholder. The Chapter 894 coverage is required on an available basis only and should not be structured and priced in a manner which would make its purchase unrealistic or impossible.

G. Chapter 894 is not applicable to blanket, franchise or individual policies, and in the case of Article IX-C Corporations, direct payment contracts.

H. Hospital indemnity policies and riders do not provide coverage for in-patient hospital care and are, therefore, exempt from the requirements of Chapter 894.

I. Any additional premium charge for the coverage to be made available under the provisions of Chapter 894 should be based on credible statistics and reasonable assumptions acceptable to the Department. Each insurer and Article IX-C Corporation should maintain separate experience data for this coverage.

J. Forms providing the statutory coverage in accordance with Chapter 894 of the Laws of 1977, together with appropriate rating material, should be submitted to the Department for review and approval as soon as possible.

II. Chapter 893 of the Laws of 1977, effective January 1, 1978, amends Sections 162 and 253 of the New York Insurance Law and provides that every insurer issuing a group policy for delivery in this State, and every health service or medical expense indemnity corporation issuing a group contract or group remittance contract for delivery in this State, which provides reimbursement for psychiatric or psychological services by a physician, psychiatrist, or psychologist, must make available, and if requested by the group contractholder or a specified proportion of subscribers in a group remittance group, provide the same coverage when such services are performed by a certified and registered social worker.

The law requires the coverage to be made available at the inception of new policies and contracts issued on or after January 1, 1978, and with respect to policies and contracts issued before this date, at the first anniversary date thereafter, without evidence of insurability, and at any subsequent anniversary date subject to evidence of insurability.

To expedite the timely filing and approval of forms and premium rates to implement Chapter 893, the following guidelines are applicable:

A. The contractholder or all the subscribers in a group remittance group must be notified of the availability of the coverage at the time of application for a group policy or contract to be issued on or after January 1, 1978, and for a policy or contract issued before this date, at the first anniversary date thereafter.

B. Chapter 893 is not applicable to blanket, franchise or individual policies, and in the case of Article IX-C Corporations, direct payment contracts.

C. Any additional premium charge for the inclusion of this optional coverage should be based on credible statistics and reasonable assumptions acceptable to the Department. Each insurer and Article IX-C Corporation should maintain separate experience data for this coverage.

D. A list of all certified and registered social workers qualified for reimbursement under Chapter 893 will be maintained by the State Board of Social Work, but the Insurance Department has been advised that such list shall not be available until sometime after April 1, 1978. To obtain the listing write:

Philip R. Johnston
Executive Secretary
State Board for Social Work
State Education Department
99 Washington Avenue
Albany, New York 12230

E. Forms and rates to provide this coverage should be submitted to the Department for review and formal approval as soon as possible.

III. Chapter 663 of the Laws of 1977 takes effect on January 1, 1978 and amends Sections 164(2) (b) (3), 221(5) (a) and 253(2) of the New York Insurance Law and applies to policies and contracts issued, renewed, modified, altered or amended after the effective date. The law requires that any family coverage include coverage for newborn infants from the moment of birth for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth.

To expedite the timely filing and approval of insurance forms and premium rates to implement Chapter 663, the following Department guidelines are applicable:

A. It is not anticipated that existing premium rates for dependent children coverage will require change to provide the coverage required by Chapter 663. If it is the intention of an insurer to charge an additional premium for the coverage, adequate justification in the form of credible supporting data must be submitted to the Department.

B. Chapter 663 is not applicable to family blanket policies issued pursuant to Section 222 of the Insurance Law.

C. Insurance policies or contracts designed and issued to an insured and spouse with no provision for the addition of any other persons is not considered "family coverage" subject to this Law, since there is no intention to cover any children, newborn or existing.

D. Regulation 62, Section 52.16(c)(1) now requires coverage for congenital anomalies; however, the coverage does not commence until the child becomes a "covered dependent". We do not view the Regulation as inconsistent with the Law, and read together would require a child to become covered from the moment of birth providing benefits for congenital anomalies.

[SIGNATURE]

JOHN F. LENNON

Acting Superintendent of Insurance