

Filing Guidance

Priority of Review and Filing Types

What is the Priority of Review?*

A filing can achieve expedited review if it is submitted under one of the following filing types:

1. [Certification by Checklist](#)
2. [Certification by Previously Approved Form](#)
3. [Certification by Template](#)
4. [Rate Adjustment Pursuant to Section 3231\(e\)\(1\)](#)
5. [Rate Adjustment Pursuant to Section 4308\(c\)](#)
6. [Section 3201\(b\)\(6\) Deemer](#)

Filing types available for submission to the Health Bureau that receive the standard priority of review are:

7. [Advertising \(for Medicare Supplement filings\)](#)
8. [Filed for Reference](#)
9. [Group Prefiling Notification](#) *updated*
10. [Normal Pre-Approval](#)
11. [Out-of-State \(applicable to domestic insurers only\)](#)
12. [Prior Approval Prefiling](#)

Filing types available for various reports that must be filed with the Health Bureau are:

13. [Experience Monitoring / Reporting](#)
14. [HHS MLR Annual Rebate Report](#)
15. [Long Term Care Annual Report](#)
16. [Loss Ratio Report – Other](#)
17. [Med Supp Refund Calculation Report](#)
18. [Multiple Med Supp Report](#)

SERFF filings receive a higher priority of review than paper filings, regardless of the filing type chosen above.

What is each Filing Type and When can I use it?

Below is a description of each of these methods and when each is available for use. Special Filing Types to be used for individual and small group comprehensive medical products, both On and Off Exchange, will be announced each year. Please note that pursuant to Section 3201 (a) of the Insurance Law, “policy form” includes a policy, contract, certificate, amendment, endorsement, rider, application or enrollment form.

1. Certification by Checklist

Description: This filing type may only be used when an appropriate product checklist is available on the Department’s web site. Use of this filing type is beneficial to companies that are making a policy form submission where the company has diligently completed the product checklist and followed all applicable regulations and statutes in its preparation of the filing.

Availability: The Certification by Checklist process may be used for:

- all form and rate submissions,¹ and
- all form only submissions², but

- not applicable to rate only submissions.³

2. Certification by Previously Approved Form

Description: This process may be used by insurers that are making a policy form submission where the major portion of the policy form was previously approved but the new submission reflects some proposed changes to the same policy form. The policy form upon which the new submission is based must have been approved within three years of the date of the new submission. Under this method, the insurer knows in advance that the major portion of the policy form is acceptable and that review will be primarily based on the proposed changes.

Availability: The Certification by Previously Approved Form process may be used for:

- all form only submissions², or
- all form and rate submissions¹, but
- not applicable to rate only submissions.³

if previous form was approved within three years of the date of submission.

3. Certification by Template

Description: This process may be beneficial to companies that frequently file policy form submissions. A template consists of language commonly included by an insurer in its various form filings without variation. The template upon which the new submission is based must have been approved within three years of the date of the new submission. Under this method, the insurer knows in advance that the major portion of the policy form is acceptable and that review will be primarily based on the proposed changes.

Availability: The Certification by Previously Approved Form process may be used for:

- all form only submissions,² or
- all form and rate submissions,¹ but
- not applicable to rate only submissions.³

4. Rate Adjustment Pursuant to Section 3231(e)(1)

Description: This filing type may be used for insurers to file rate adjustments pursuant to the new prior approval law. File and use rate adjustment filings under Section 3231(e)(2)(A) are no longer available.

Availability: This filing type may only be used for the following rate only submission:

- Rate adjustment filings by commercial insurers (Article 42), not by non-profit corporations (Article 43) or an HMO.

5. Rate Adjustment Pursuant to Section 4308(c)

Description: This filing type may be used for corporations to file rate adjustment pursuant the new prior approval law. File and use rate adjustment filings under Section 4308(g) are no longer available.

Availability: This filing type may only be used for the following rate only submission:

- Rate adjustment filings by a non-profit corporation (Article 43) or an HMO, not by commercial insurers (Article 42).

6. Section 3201(b)(6) Deemer

Description: This filing type is available for submissions that contain policy forms. Section 3201(b)(6) provides specific timeframes for action on the filing or it may be deemed approved or denied. For example, within 90 days of receipt, the Department must approve, deny or detail additional information to make a determination. However, if the filing is incomplete or noncompliant, the Department may close the file within 60 days of receipt.

Availability: The Section 3201(b)(6) Deemer process may be used for:

- all form only submissions,² or
- all form and rate submissions,¹ but
- not applicable to rate only submissions.³

7. Advertising (for Medicare Supplement filings)

Description: This filing type should be used to file only Medicare Supplement advertising. Advertising is not filed for any other products such as long term care insurance, however, insurers are required to keep advertising for all products in compliance with Regulation 34 (11 NYCRR Part 215).

Availability: This filing type is a form only submission and may be used for Medicare Supplement insurance advertising only.

8. Filed for Reference

Description: Insurers writing group coverage (other than statutory Disability Benefits Law coverage) may provide coverage for a specific policyholder prior to the filing and approval of policy forms. The filing type is used to submit the required notice of the effective date of coverage and the benefits. This procedure may only be used:

- (1) on a single case basis;
- (2) when it is not reasonably possible for the insurer to obtain approval prior to the effective date of coverage; and
- (3) when the insurer has a reasonable expectation of approval of the appropriate forms by the Department.

The insurer must seek formal approval of the policy forms and rates. Insurers are strongly encouraged to submit policy forms and rates within 60 days of the date the insurer agreed to provide coverage, using the appropriate filing type.

For products subject to guaranteed availability requirements, any approval of subsequent form filings submitted for a pre-filing will be subject to the condition that the forms will be offered on a general availability basis and not limited to a particular group or groups.

In order to minimize the need to use the pre-filing process, insurers are strongly encouraged to use variable material for inclusion in the group policy forms. This is especially useful with respect to the cost sharing provisions in the policy form and/or policy schedule of benefits.

The prefilling process should not be used for any innovative or unique products, features or benefits. In general, an innovative or unique product, feature or benefit would include one that has not been previously approved and would be new to the New York accident and health insurance marketplace. For innovative or unique products, features or benefits, insurers should meet with the Department early in the product development process prior to making a submission.

Availability: Group Prefiling Notification filing type is a form only submission and may only be used with group coverage other than statutory Disability Benefits Law coverage. It may not be used with individual or blanket coverage.

9. Group Prefiling Notification (11 NYCRR 52.32)

Description: Insurers writing group coverage (other than statutory Disability Benefits Law coverage) may provide coverage for a specific policyholder prior to the filing and approval of policy forms. The filing type is used to submit the required notice of the effective date of coverage and the benefits. This procedure may only be used:

- (1) on a single case basis;
- (2) when it is not reasonably possible for the insurer to obtain approval prior to the effective date of coverage; and
- (3) when the insurer has a reasonable expectation of approval of the appropriate forms by the Department.

The insurer must seek formal approval of the policy forms and rates. Insurers are strongly encouraged to submit policy forms and rates within 60 days of the date the insurer agreed to provide coverage, using the appropriate filing type.

For products subject to guaranteed availability requirements, any approval of subsequent form filings submitted for a prefilling will be subject to the condition that the forms will be offered on a general availability basis and not limited to a particular group or groups. Any non-grandfathered health plans⁴ that were previously approved on a single case basis and are in effect on or after January 1, 2014, must be made generally available to any other large group that seeks that same coverage.

In order to minimize the need to use the prefilling process, insurers are strongly encouraged to use variable material for inclusion in the group policy forms. This is especially useful with respect to the cost sharing provisions in the policy form and/or policy schedule of benefits.

The prefilling process should not be used for any innovative or unique products, features or benefits. In general, an innovative or unique product, feature or benefit would include one that has not been previously approved and would be new to the New York accident and health insurance marketplace. For innovative or unique products, features or benefits, insurers should meet with the Department early in the product development process prior to making a submission.

Availability: Group Prefiling Notification filing type is a form only submission and may only be used with group coverage other than statutory Disability Benefits Law coverage. It may not be used with individual or blanket coverage.

10. Normal Pre-Approval

Description: This filing type is the standard filing type for a filing containing forms and/or rates that do not qualify for one of the expedited filing types listed above.

Availability: The Normal Pre-Approval filing type may be used for:

- all form only submissions,²
- all form and rate submissions,¹ and
- rate only submissions including commission schedules and experience rating formula filings, but excluding any rate adjustment filing subject to Section 3231(e)(1) or 4308(c).³

11. Out-of-State (applicable to domestic insurers only)

Description: Domestic insurers are required to file all accident and health policy forms intended for use outside New York with the Department before their issuance under Section 3201(b)(2). This filing type may not be used for submissions pursuant to Regulation 123 (11 NYCRR 59) where coverage is issued out-of-state to cover New York residents.

Availability: The Out-of-State filing type is a form only submission.

12. Prior Approval Prefiling

Description: This filing type is used for advance filings by Article 42 insurers, Article 43 Corporations, and Health Maintenance Organizations (HMOs) that plan to submit a rate adjustment filing pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance law. This prefiling must contain a draft of the initial notice to policy/certificate holders of proposed premium rate adjustments and a draft of the narrative summary explaining the reason(s) for the proposed rate. This prefiling is required to be submitted at least 10 calendar days before submitting a premium rate adjustment application. The final forms of the initial notice and the narrative summary must be included with the insurer's rate adjustment application. Please refer to Circular Letter No. 12 (2011).

Availability: The Prior Approval Prefiling filing type is a rate only submission.

13. Experience Monitoring / Reporting

Description: This filing type may be used for the annual filing of the following experience data:

- experience data as required under Sections 52.44(a) and (b) of Regulation 62 (11 NYCRR Part 52) for individual policies
- experience monitoring/reporting as required under Section 59.7(b) of Regulation 123 (11 NYCRR Part 59), or
- experience data for individual and group Medicare Supplement policies as required under Section 52.40(k) of Regulation 62 (11 NYCRR Part 52). **Use this filing type ONLY if the experience data is submitted separately from a rate adjustment request.**

Availability: The Experience Monitoring/Reporting filing type is a rate only submission.

14. HHS MLR Annual Rebate Report

Description: Sections 3231(e)(1) and 4308(c) of the Insurance Law require an annual loss ratio report to be submitted to the Department by June 30 of the following year for non-Medicare Supplement products. For products subject to these sections, other than Medicare Supplement products, and which are subject to the Department of Health and Human Services (HHS) medical loss ratio (MLR) annual reporting form and rebate testing, submitting a copy of the HHS MLR annual reporting form by June 30 will satisfy the reporting requirement of these sections. Insurers completing this form should follow the HHS methodology and instructions using the reporting forms prescribed by HHS. See also Circular Letter No. 15 (2011) and the loss ratio reporting guidance posted on the Department's website. For Medicare Supplement products refer to filing types Experience Monitoring/Reporting and Med Supp Refund Calculation Report.

In addition, this submission would then be amended by August 1st to indicate whether, in accordance with HHS requirements, the insurer has paid any rebates to policyholders. If rebates have been, or will be paid, the amount of such rebates by each market segment (i.e., aggregation pool) is to be reported to DFS using this amendment process.

Availability: The HHS MLR Annual Rebate Report filing type is a rate only submission.

15. Long Term Care Annual Report

Description: This filing type is used for insurers filing the three required reports relating to long term care insurance with the Department. The reports that may be included in this filing type are: (1) the rescission report, due March 1 annually, (2) the claims denial report due June 30 annually, and (3) the lapse and replacement report, due June 30 annually. An insurer may submit one or all reports in a filing, and may bypass any reports that are not contained in the filing.

Availability: The Long Term Care Annual Report filing type is a form only submission.

16. Loss Ratio Report – Other

Description: Sections 3231(e)(1) and 4308(c) of the Insurance Law require an annual loss ratio report to be submitted to the Department by June 30 of the following year for non-Medicare Supplement products. This filing type code is used for products subject to these sections, other than Medicare Supplement products and products subject to the HHS MLR annual reporting form and rebate testing. Instructions and a report template are posted on the Department's website.

Availability: The Loss Ratio Report-Other filing type is a rate only submission.

17. Med Supp Refund Calculation Report

Description: This filing type is used to submit the report required for all individual and group Medicare Supplement policies per Section 52.44(c) of Regulation 62 (11 NYCRR 52.44), entitled Premium Refund or Credit Calculation for Individual and Group Medicare Supplement Policies. The report is due by May 1 of each year. The reporting and refund calculation form is found in Section 52.28 of Regulation 62 for each type in a standard Medicare Supplement benefit plan. See also the loss ratio reporting guidance posted on the Department's website.

Availability: The Med Supp Refund Calculation filing type is a rate only filing type

18. Multiple Med Supp Report

Description: On or before March 1st of each calendar year, each issuer is required to report the information specified in 11 NYCRR 58.1(h) for every NYS resident for which the issuer has in force more than one Medicare supplement insurance policy or certificate. The information shall be reported using the form included in the regulation.

Availability: The Multiple Med Supp Report filing type is a form only submission.

* The Health Bureau has periodically modified its filing process to help expedite the prior approval of policy forms and rates, most recently with the following:

- Circular Letter No. 4 (2003) announced a new procedure for expedited prior approval by Certifications (Certification by Checklist, Previously Approved Form, and Certification by Template).
- Circular Letter No. 9 (2004) announced that the Bureau would begin receiving electronic filings via **SERFF** and how those filings would be prioritized.

The combination of these changes apparently resulted in some confusion to insurers. This guidance is intended to alleviate this confusion.

¹ “*Form and rate*” filings are the predominant filing method because the overwhelming majority of changes in benefit language result in corresponding changes in premium. If changes in language have no rate impact, an actuarial certification to that effect is still required, making that submission a form and rate submission. (see [the Filing Guidance on Submissions with No Rate Impact](#))

² “*Form only*” filings are limited to applications or enrollment forms or documents filed for reference/informational purposes.

³ “*Rate only*” filings are limited to changes in rates to existing products (for example, rate increases or decreases or changes in ratio calculation rules or procedures, or underwriting).

⁴ A grandfathered health plan is hospital, medical, or surgical expense insurance coverage in which an individual was enrolled on March 23, 2010, for as long as the coverage maintains grandfathered status in accordance with Section 1251(e) of the Affordable Care Act, 42 U.S.C.§18011(e).