

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

(11 NYCRR 361)

THIRD AMENDMENT TO REGULATION NO. 146

ESTABLISHMENT AND OPERATION OF MARKET STABILIZATION

MECHANISMS FOR INDIVIDUAL AND SMALL GROUP HEALTH

INSURANCE AND MEDICARE SUPPLEMENT INSURANCE

I, NEIL D. LEVIN, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, 1109, 3201, 3216, 3217, 3221, 3231, 3232, 3233, 4235, 4304, 4305, 4317, 4318, 4321, 4322, Article 45 of the Insurance Law, Chapter 501 of the Laws of 1992 and Chapter 504 of the Laws of 1995, do hereby promulgate the following Third Amendment to Part 361 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 146), to take effect upon publication in the State Register.

(NEW MATTER UNDERLINED; DELETED MATTER IN BRACKETS)

Section 361.1(d)(1) is hereby amended to read as follows:

(1) to share among insurers and HMOs those substantive cost variations attributable to significant differences in demographic characteristics or specified medical conditions of the persons covered. The protection afforded by this sharing process will facilitate the introduction of mandated open enrollment and community rating by providing some assurance to insurers and HMOs that their business and competitive interests will be secure because they are protected from sudden or significant changes in the proportion of high cost persons they cover, and because other insurers and HMOs will not obtain a competitive advantage by avoiding or failing to insure a proportionate share of high cost persons;

Section 361.1(e) is hereby amended to read as follows:

(e) The market stabilization process intended to be implemented by the sections below includes two components.

(1) The first component for use prior to the year 2000 uses an age/sex relative morbidity table to measure the relative risk for each insurer and HMO, with respect to the demographic characteristics of the persons

covered by that insurer or HMO. The average risk for all insurers and HMOs is then determined. Insurers and HMOs with relative risk factors less than the average contribute money to regional pools; insurers and HMOs with relative risk factors greater than the average receive money from the pools. Insurers and HMOs which are expected to make contributions are permitted to include their projected contributions in their premium rates as if the contributions were claim expenses, while insurers and HMOs which are expected to receive money shall treat the projected receipts as if they were offsets to claims and thus reduce premium rates below what those premium rates would otherwise need to be.

(2) The second component uses a list of specified, high-cost medical conditions. This component protects insurers and HMOs from part of the adverse financial effects of covering a disproportionate number of people with such conditions. [Each] Prior to January 1, 1999 each insurer and each HMO contributes to the pool a pre-set amount per person covered, and prior to January 1, 1998 each insurer and each HMO receives a pre-set amount from the pool for each covered occurrence of a listed medical condition. From January 1, 1998 through December 31, 1998 each insurer and each HMO may collect from the pool if the carrier's specified medical condition index is greater than the regional specified medical condition index.

Section 361.2(j) is hereby amended to read as follows:

(j) *Individual health insurance policy* means an insurance policy written by a carrier under the provisions of section 3216, 4304, 4321, 4322 and 4501(o) of the Insurance Law, issued directly to an individual (not on a group or group remittance basis), except for policies covering only: long-term care benefits, nursing home benefits, home care benefits, dental or vision care services, hospital or surgical indemnity benefits with specific dollar amounts unless the dollar amounts exceed the amounts required to meet the definitions of basic hospital and basic medical insurance in sections 52.5 and 52.6 of this Title, accident only indemnity benefits, accidental death and dismemberment benefits, prescription drug benefits, disability income benefits or specified disease benefits.

Section 361.2(k) is hereby amended to read as follows:

(k) *Medicare supplement insurance policy* means an insurance policy or contract defined in section 52.11 of this Title, and similar policies or contracts issued prior to May 1, 1992 which supplement Medicare benefits as well as Medicare select policies and certificates as defined in section 52.14 of this Title.

Section 361.2(m)(3) is hereby amended to read as follows:

(3) Medicare risk contracts, cost contracts, and health care prepayment plans, as defined in sections 1876 and 1833 of the Federal Social Security Act and Medicare + Choice contracts as defined in section 1851 of the Federal Social Security Act.

Section 361.2 is hereby amended by adding new subdivisions (o) and (q) and relettering existing subdivision (o) as (p) to read as follows:

(o) Regional specified medical condition index means the combined average specified medical condition index for the specified medical condition pool for all carriers participating in the pool, using the same methodology as defined in Section 361.4(f) of this Part for a single carrier.

~~[(o)]~~(p) *Small group health insurance policy* means a group remittance policy written by a carrier pursuant to section 4304 of the Insurance Law and a group health insurance policy covering from two to 50 employees or members, exclusive of dependents and spouses, and policies issued to or through association groups as defined in section 360.2(a) of this Title. In determining the size of a small group, reference should be made to section 360.4(i) and (j) of this Title. Insurers may choose to classify individual proprietors within the small group category provided that any such classification is applied consistently to all individual proprietors. A small group health insurance policy does not include a policy covering only: long term care benefits, nursing home benefits, home care benefits, dental or vision care services, hospital or surgical indemnity benefits with specific dollar amounts, unless the dollar amounts exceed the amounts required to meet the definitions of basic hospital and basic medical insurance in sections 52.5 and 52.6 of this Title, accident only indemnity benefits, accidental death and

dismemberment benefits, prescription drug benefits, disability income benefits or specified disease benefits.

(g) Specified medical condition index means the index for a particular carrier. The index for a particular carrier reflects the cost of incurred claims for specified medical conditions relative to the contributions to the specified medical condition pooling fund as required by section 361.4 of this Part. The methodology to determine this index is defined in section 361.4(f) of this Part.

The title of Section 361.3 is hereby amended to read as follows:

361.3 Pooling of variations in costs attributable to variations in demographics prior to January 1, 2000.

Section 361.3(a) is hereby amended to read as follows:

(a) In each pool area, two demographic pools are established for use until December 31, 1999. Each pool operates independently; that is, all calculations and payments described below are made for each pool independently of any other pool.

Section 361.3(e)(1) is hereby amended to read as follows:

(e) *Initial payments to the pools.* (1) Initial payments to the pools shall be made until December 31, 1999. The average demographic factor for each carrier participating in a pool shall be determined as of the beginning of each calendar quarter, starting as of April 1, 1993 and ending as of December 31, 1999. The regional demographic factor for each pool shall also be determined as of the beginning of each calendar quarter, starting as of April 1, 1993 and ending as of December 31, 1999.

Section 361.3(f)(1) is hereby amended to read as follows:

(f) *Initial collections from the pools.* (1) Initial collections from the pools shall be available from October 1993 until December 1999. In October of 1993 and every three months thereafter, until December 31, 1999, a carrier participating in a demographic pool shall be entitled to collect from a demographic pooling fund if its average demographic factor for that pool at the beginning of the second preceding calendar quarter is greater than the regional demographic factor for that pool as of that date.

Section 361.3(f)(2) is hereby amended to read as follows:

(2) Subject to the limitation in the next sentence, and in subdivision (i) of this section, a carrier which is entitled to collect from a demographic pooling fund may collect the product of subparagraphs (i) and (ii) of this paragraph:

(i) the claims incurred under its pooled insurance during the second preceding calendar quarter, minus any amounts collected or collectible in accordance with section 361.4(c) and (d) of this Part, for medical care rendered during that quarter;

(ii) 1.0 minus the ratio of the regional demographic factor for that pool at the beginning of the second preceding calendar quarter to the carrier's average demographic factor for that pool as of that date. If the amount of money in the demographic pooling fund is not sufficient to pay all carriers the amounts they are entitled to collect in accordance with this paragraph, the amounts they are entitled to collect are reduced proportionately to match the fund.

Section 361.3(h)(2) is hereby amended to read as follows:

(2) For reconciliation purposes, a carrier's total payment to (-) or from (+) the demographic pooling fund for the previous calendar year shall be determined ,subject to the limitation in subdivision (i) of this section as the product of subparagraphs (i) and (ii) of this paragraph:

(i) the claims incurred under its pooled insurance during that year, excluding amounts collected or collectible in accordance with section 361.4(c) and (d) of this Part for medical care rendered during that year or any previous year;

(ii) 1.0 minus the ratio of the regional demographic factor for that pool during that year to the carrier's average demographic factor for that pool during that year.

Section 361.3 is hereby amended to add a new subdivision (i) to read as follows:

(i) In order to implement the phaseout of the demographic pools pursuant to Chapter 504 of the Laws of 1995, payments to and from the

demographic pools otherwise determined by subdivisions (e) (f) and (h) of this section shall be reduced by the percentages set forth below:

<u>Year</u>	<u>Amount of Reduction</u>
<u>1997</u>	<u>- 32 and 1/2 % reduction</u>
<u>1998</u>	<u>- 55% reduction</u>

The savings resulting from such decreased payments to the demographic pools after December 31, 1996 shall be distributed pursuant to the methodology in section 361.4 of this Part.

The title of Section 361.4 is hereby amended to read as follows:

361.4 Pooling of the cost of treating specified medical conditions prior to January 1, 1999.

Section 361.4(b) is hereby amended to read as follows:

(b) Each carrier shall pay to the pooling fund each quarter, beginning with the second quarter of 1993, and ending December 31, 1998, an amount determined as the product of paragraphs (1), (2), and (3) of this subdivision:

(1) An amount determined by the superintendent each year by September 1st, with respect to payments required during the subsequent calendar year. For 1993, this amount will be \$5.

(2) The number of family units with coverage of a single individual under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, as of the beginning of the quarter, plus twice the number of family units with dependents coverage by the carrier under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, as of the beginning of the quarter.

(3) A coverage factor, as follows:

Type of Contract	Coverage Factor
Basic Hospital or Basic Hospital/Surgical	0.75
Wraparound or Supplemental Major Medical	0.25

Section 361.4(c) is hereby amended to read as follows:

(c) Each carrier may collect from the pooling fund in lump sum an amount listed in Table 1, subdivision (e) of this section, for claims incurred prior to January 1, 1997 and in lump sum an amount listed in Table 3, subdivision (e) of this section for claims incurred between January 1, 1997 and December 31, 1997 (but in no event more than the carrier is required to pay for the care of the listed medical condition), by submitting a claim in the calendar year following the calendar year in which the claim was incurred except that the deadline for filing 1997 claims is extended from December 31, 1998 to July 31, 2000, upon certification to the superintendent by the carrier that:

(1) an individual has been diagnosed as having one of the medical conditions listed in Table 1 or Table 3 , subdivision (e) of this section as applicable, and the course of medical care identified in Table 1 or Table 3 has been recommended and completed;

(2) the identified individual is covered by the carrier under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, for the identified medical care; and

(3) no other carrier or other third-party payor has primary responsibility for the cost of that medical care;

In the event that the individual changes carriers or is covered by more than one carrier under pooled insurance contracts or policies, other than Medicare supplement insurance policy, during the course of the identified medical care, payment from the pooling fund of the amount listed in Table 1 or Table 3 , subdivision (e) of this section, shall be pro-rated among the carriers based upon each carrier's proportionate share of the cost of the identified medical care. Insurers and HMOs may not base decisions as to whether a course of medical care is covered by an insurance or HMO policy or contract on the presence of that course of medical care in Table 1 or Table 3

, subdivision (e) of this section, or the absence of that course of medical care from Table 1 or Table 3.

Distributions from the pooling fund of the amounts listed in Table 1 or Table 3, subdivision (e) of this section, shall be made based upon the month in which the claim attributable to expenses was incurred by the carrier. Older claims, based on the date the medical service was provided, will be given priority for payment over more recent claims.

Section 361.4(d) is hereby amended to read as follows:

(d) Each carrier may collect from the pooling fund each month an amount listed in Table 2, subdivision (e) of this section, for claims incurred prior to January 1, 1997 and each month an amount listed in Table 4, subdivision (e) of this section for claims incurred between January 1, 1997 and December 31, 1997, but in no event more than the carrier is required to pay for the care of the listed medical condition, by submitting a claim in the calendar year following the calendar year in which the claim was incurred except that the deadline for filing 1997 claims is extended from December 31, 1998 to July 31, 2000, upon certification to the superintendent by the carrier that:

(1) an individual has been diagnosed as having one of the medical conditions listed in Table 2 or Table 4, subdivision(e) of this section as applicable;

(2) the identified individual is covered by the carrier under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, with respect to medical care for the identified medical condition as of the end of each month for which reimbursement is sought; and

(3) no other carrier or other third-party payor has primary responsibility for the cost of that medical care.

In the event that the individual is covered by more than one carrier under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, payments from the pooling fund of the amount listed in Table 2 or Table 4, subdivision (e) of this section, shall be pro-rated among the carriers based upon each carrier's proportionate share of the cost of medical care for the identified medical condition.

Distributions from the pooling fund of the amounts listed in Table 2 or Table 4, subdivision (e) of this section, shall be made based upon the month in which the claim attributable to expenses was incurred by the carrier. Older claims, based on the date the medical service was provided, will be given priority for payment over more recent claims.

Section 361.4(e) is hereby amended to add a new Table 3, Table 4, Table 5 and Table 6 to read as follows:

Table 3

<u>Medical Condition</u> <u>Or Criteria</u>	<u>Course of Medical Care</u> <u>or Primary Diagnoses</u>	<u>Maximum</u> <u>Pool</u> <u>Payment</u>
<u>AIDS</u>	<u>ICD-9 code 042, 043, 044, 136.3, 117.5, 112.81 through 112.85, 176; or use of any of attached Drugs in Table 5 for treatment of AIDS</u>	<u>\$ 10,000</u>
<u>Irreversible, progressive liver disease</u>	<u>Liver transplantation</u>	<u>80,000</u>
<u>Irreversible, progressive heart disease</u>	<u>Heart transplantation</u>	<u>76,000</u>
<u>Irreversible, progressive pancreas disease</u>	<u>Pancreas transplantation</u>	<u>56,000</u>
<u>Irreversible, progressive lung disease</u>	<u>Pulmonary transplantation</u>	<u>136,000</u>
<u>Irreversible, progressive kidney disease</u>	<u>Kidney transplantation not covered by Medicare</u>	<u>56,000</u>
<u>Medical necessity</u>	<u>Bone marrow and stem cell procedures; CPT codes 38240</u>	

	<u>or 38241</u>	<u>120,000</u>
<u>Multiple Sclerosis</u>	<u>ICD9 Code 340 plus use of medicines J1825 or J1830</u>	<u>7,500</u>
<u>Neonatal distress</u>	<u>ICU care for more than 30 days</u>	<u>96,000</u>
<u>Gaucher's disease</u>	<u>Use of medicines J0205, J1785 or NDC codes 58468178101, 58468106001 or 58468198301</u>	<u>75,000</u>
<u>Hemophilia with clotting factor VIII or IX</u>	<u>ICD9 code 286.0, 286.1, 286.2, 286.4, 286.7 plus use of medicines J7190, J7191, J7129, J7194, or J7196; or treatment with drugs listed in Table 6</u>	<u>50,000</u>

Table 4

<u>Medical Condition</u>	<u>Monthly Payment</u>
<u>ALS leading to ventilator dependency for more than 30 days</u>	<u>\$13,000</u>
<u>Severe trauma leading to ventilator dependency for more than 30 days</u>	<u>13,000</u>
<u>Severe muscular dystrophy leading to ventilator dependency for more than 30 days</u>	<u>13,000</u>
<u>Ventilator dependency with procedure code CPT 94657 of</u>	

30 units or more in given calendar year

13,000

TABLE 5

HIV/AIDS

<u>FDB Label Name</u>	<u>NDC Labeler Code</u>	<u>NDC Product Code</u>	<u>Manufacturer/ Package Size</u>
COMBIVIR TABLET	00173	0595	00
COMBIVIR TABLET	00173	0595	02
CRIXIVAN 200MG CAPSULE	00006	0571	42
CRIXIVAN 200MG CAPSULE	00006	0571	43
CRIXIVAN 400MG CAPSULE	00006	0573	54
CRIXIVAN 400MG CAPSULE	00006	0573	62
EPIVIR 10MG/ML ORAL SOLN	00173	0471	00
EPIVIR 150MG TABLET	00173	0470	01
FORTOVASE 200MG SOFTGEL	00004	0246	48
HIVID 0.375MG TABLET	00004	0220	01
HIVID 0.75MG TABLET	00004	0221	01
INVIRASE 200MG CAPSULE	00004	0245	15
INVIRASE 200MG CAPSULE	54569	4242	01
NORVIR 100MG CAPSULE	00074	8492	02
NORVIR 100MG CAPSULE	00074	9492	54
NORVIR 100MG CAPSULE	54569	4335	00
NORVIR 100MG CAPSULE	54888	3782	00
NORVIR 80MG/ML SOLUTION	00074	1940	63
RESCRIPTOR 100MG TABLET	00009	3761	03
RETROVIR 100MG CAPSULE	00081	0108	56
RETROVIR 100MG CAPSULE	00173	0108	55
RETROVIR 100MG CAPSULE	00173	0108	56
RETROVIR 10MG/ML SYRUP	00173	0113	18
RETROVIR 300MG TABLET	00173	0501	00
VIDEX 100MG PACKET	00087	6614	43
VIDEX 100MG TABLET CHEWABLE	00087	6852	01
VIDEX 100MG TABLET CHEWABLE	00087	6627	43
VIDEX 150MG TABLET CHEWABLE	00087	6653	01
VIDEX 150MG TABLET CHEWABLE	00087	6626	43
VIDEX 157MG PACKET	00087	6616	43
VIDEX 250MG PACKET	00087	6616	43
VIDEX 25MG TABLET CHEWABLE	00087	6628	43
VIDEX 4GM PEDIATRIC SOLN	00087	6833	41
VIDEX 50MG TABLET CHEWABLE	00087	6651	01
VIDEX 50MG TABLET CHEWABLE	00087	6624	43
VIRACEPT 250MG TABLET	63010	0010	27
VIRACEPT POWDER	63010	0011	90
VIRAMUNE 200MG TABLET	00054	4647	21
VIRAMUNE 200MG TABLET	00054	4647	25
VIRAMUNE 200MG TABLET	00054	8647	25
VIRAMUNE 200MG TABLET	54868	3844	00
VIRAMUNE SUSP 50MG/5ML	00054	3905	58
ZERIT 20MG CAPSULE	00003	1965	01
ZERIT 30MG CAPSULE	00003	1968	01
ZERIT 30MG CAPSULE	54569	4053	00
ZERIT 40MG CAPSULE	00003	1967	01
SUSTIVA 50MG CAPSULE	00056	0470	30
SUSTIVA 100MG CAPSULE	00056	0473	30
SUSTIVE 200MG CAPSULE	00056	0474	92

TABLE 6

FACTOR VIII AND IX NDC CODES

<u>NDC</u>	<u>Drug name</u>	<u>Manufacturer</u>
<u>52769-0460-01</u>	<u>AntiHemop HU INJ 306-1170</u>	<u>AM RED CRO</u>
<u>13143-0321-63</u>	<u>Factor VIII inj 500-1200</u>	<u>MEL BIOLOG</u>
<u>00026-0664-30</u>	<u>KOATE-HP 500IU</u>	<u>BAYER BIOL</u>
<u>00053-7605-02</u>	<u>HUMATE-P 500IU</u>	<u>CENTEON</u>
<u>13143-0321-55</u>	<u>MELATE 500IU</u>	<u>MEL BIOLOG</u>
<u>52789-0480-01</u>	<u>ANTIHEMOP HU ING 308-1170</u>	<u>AM RED CRO</u>
<u>00026-0664-50</u>	<u>KOATE-HP INJ 1000IU</u>	<u>BAYER BIOL</u>
<u>00053-7605-04</u>	<u>HUMATE-P HU ING 1000IU</u>	<u>CENTEON</u>
<u>00053-7656-04</u>	<u>MONOCLA-P HU INJ 1000IU</u>	<u>CENTEON</u>
<u>13143-0321-56</u>	<u>MELATE 1000IU</u>	<u>MEL BIOLOG</u>
<u>00026-0664-80</u>	<u>KOATE HP 1500IU</u>	<u>BAYER BIOL</u>
<u>00053-7656-01</u>	<u>MONOCLA-P HU 250AHFU</u>	<u>CENTEON</u>
<u>00063-7658-01</u>	<u>MONOCLATE 600AHFU</u>	<u>ARMOUR</u>
<u>55688-0106-02</u>	<u>HYATE:C INJ 400-700U</u>	<u>SPEYWOOD</u>
<u>00026-0670-20</u>	<u>KOGENATE 250 AHFU</u>	<u>BAYER PHAR</u>
<u>00053-8110-01</u>	<u>BIOCLATE 250IU</u>	<u>CENTEON</u>
<u>00053-8120-01</u>	<u>HELIXATE 260IU</u>	<u>CENTEON</u>
<u>00944-2938-01</u>	<u>RECOMBINATE 220-400</u>	<u>BAXHYLAND</u>
<u>00026-0670-30</u>	<u>KOGENATE 500AHFU</u>	<u>BAYER BIOL</u>
<u>00053-8110-02</u>	<u>BIOCLATE 500IU</u>	<u>CENTEON</u>
<u>00053-8120-02</u>	<u>HELIXATE 500IU</u>	<u>CENTEON</u>
<u>00944-2938-02</u>	<u>RECOMBINATE 401-800</u>	<u>BAXHYLAND</u>
<u>00026-0670-30</u>	<u>KOGENATE 500AHFU</u>	<u>BAYER BIOL</u>
<u>00053-8110-02</u>	<u>BIOCLATE 600IU</u>	<u>CENTEON</u>
<u>00053-8120-02</u>	<u>HELIXATE 500IU</u>	<u>CENTEON</u>
<u>00944-2938-02</u>	<u>RECOMBINATE 401-800</u>	<u>BAXHYLAND</u>
<u>00028-0670-50</u>	<u>KOGENATE 1000AHFU</u>	<u>BAYER BIOL</u>
<u>00053-8110-04</u>	<u>BIOCLATE 1000IU</u>	<u>CENTEON</u>
<u>00944-2938-03</u>	<u>RECOMBINATE 801-1240</u>	<u>BAXHYLAND</u>
<u>49889-3800-02</u>	<u>ALPHANINE SD 250-1600</u>	<u>ALPHA THER</u>
<u>00053-7668-01</u>	<u>MONONINE 250IU</u>	<u>CENTEON</u>
<u>00053-7668-02</u>	<u>MONONINE 500IU</u>	<u>CENTEON</u>
<u>00053-7668-04</u>	<u>MONONINE 1000IU</u>	<u>CENTEON</u>
<u>58394-0003-01</u>	<u>BENEFIX 250IU</u>	<u>GENETICSIN</u>
<u>58394-0002-01</u>	<u>BENEFIX 500IU</u>	<u>GENETICSIN</u>
<u>58394-0001-01</u>	<u>BENEFIX 1000IU</u>	<u>GENETICSIN</u>
<u>00026-0626-20</u>	<u>KONYNE 80 500IU</u>	<u>BAYER BIOL</u>
<u>00944-0581-01</u>	<u>PROPLEX T FACT IX</u>	<u>BAXHYLAND</u>
<u>49669-3200-02</u>	<u>PROFILNILE 500IU</u>	<u>ALPHA THER</u>
<u>00026-0626-50</u>	<u>KONYNE 80 1000IU</u>	<u>BAYER BIOL</u>
<u>49689-3200-03</u>	<u>PROFILNILE 1000IU</u>	<u>ALPHA THER</u>
<u>54129-0244-02</u>	<u>BEBULIN VH 200-1200</u>	<u>IMMUNO</u>

Section 361.4 is hereby amended to add a new subdivision (f) to read as follows:

(f) The pooling of the cost of treating specified medical conditions for claims incurred in 1998 shall occur as follows:

(1) Separately for each carrier, add the dollar amounts shown in Table 3, subdivision (e) of this section for each individual specified medical condition claim incurred during 1998 and listed in Table 3 and six times the dollar amounts shown in Table 4, subdivision (e) of this section for each individual specified medical condition claim incurred during 1998 and listed in Table 4. No individual can be counted more than once. If an individual has multiple conditions, assign to such individual the condition with the largest dollar amount. This total shall be the carrier's own total maximum specified medical condition claims.

(2) Separately for each carrier, the total maximum specified medical condition claims from paragraph (1) of this subdivision shall be divided by that carrier's 1998 contributions to the specified medical condition pool (as required by Section 361.4(b) of this Part) to obtain that carrier's specified medical condition index.

(3) The regional specified medical condition index for all carriers in a specific region shall be subparagraph (i) divided by subparagraph (ii) of this paragraph:

(i) The sum for all carriers in the region of the total maximum specified medical condition claims as determined in paragraph (1) of this subdivision.

(ii) The sum for all carriers in the region of the 1998 contributions to the specified medical condition pool in that region.

(4) The carriers participating in the regional specified medical condition pool shall only be entitled to collect from the pool if the carrier's own specified medical condition index, determined by paragraph (2) of this subdivision, is greater than the regional specified medical condition index, determined by paragraph (3) of this subdivision, for that pool as of the end of 1998. Individual specified medical condition claims will no longer be reimbursed by the pool in 1998.

(5) A carrier entitled to collect from the 1998 specified medical condition pooling fund as determined by paragraph (4) of this subdivision may collect the product of subparagraphs (i) and (ii) of this paragraph:

(i) That carrier's percentage of the specified medical condition funds, determined by dividing clause (a) by clause (b) below:

(a) the amount by which the carrier's specified medical condition index is greater than the regional specified medical condition index weighted by the carrier's own 1998 specified medical condition contributions to the regional pool (determined by subtracting the regional specified medical condition index from the specified medical condition index for that carrier and then multiplying the result of the subtraction by the carrier's own 1998 specified medical condition contributions to the regional pool).

(b) the sum of the amounts determined in (a) above for all carriers in the regional pool who are entitled to collect from the 1998 specified medical condition pooling fund.

(ii) The sum of the 1998 specified medical condition funds available for distribution in that region plus the amount of funds for 1998 representing the 55% reduction in demographic payments in that region.

(6) A carrier shall only be entitled to collect from the 1998 specified medical condition pooling fund an amount calculated pursuant to the method established in paragraphs (4) and (5) of this subdivision upon certification to the superintendent by the carrier by no later than July 31, 2000, that with respect to the claims reported to the administrator and used in paragraph (1) of this subdivision that:

(i) Regarding the medical conditions listed in Table 3, subdivision (e) of this section;

(a) an individual has been diagnosed as having one of the medical conditions or criteria listed in Table 3, subdivision (e) of this section, and the course of medical care identified in Table 3 has been recommended and completed;

(b) the identified individual is covered by the carrier under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, for the identified medical care; and

(c) no other carrier or other third-party payor has primary responsibility for the cost of that medical care;

(ii) Regarding the medical conditions listed in Table 4 subdivision (e) of this section;

(a) an individual has been diagnosed as having one of the medical conditions listed in Table 4, subdivision (e) of this section;

(b) the identified individual is covered by the carrier under a pooled insurance contract or policy, other than a Medicare supplement insurance policy, with respect to medical care for the identified medical condition as of the end of each month for which reimbursement is sought; and

(c) no other carrier or other third-party payor has primary responsibility for the cost of that medical care.

Section 361.4 is hereby amended to add a new subdivision (g) to read as follows:

(g) A carrier must report the number of claims that have been incurred for 1998 separately for each category listed in Table 3, subdivision (e) of this section and Table 4, subdivision (e) of this section in a manner prescribed by the superintendent.

Section 361.5 is hereby amended to add a new subdivision (c) to read as follows:

(c) Carriers participating in the pools must respond to questions or objections raised by the superintendent or a designated pool administrator within 15 days.

I, Neil D. Levin, Superintendent of Insurance of the State of New York, do hereby certify that the foregoing Third Amendment to Regulation 146 (11 NYCRR 146) was duly adopted by me on this day pursuant to the authority granted by Sections 201, 301, 1109, 3201, 3216, 3217, 3221, 3231, 3232, 3233, 4235, 4304, 4305, 4317, 4318, 4321, 4322, Article 45 of the Insurance Law, Chapter 501 of the Laws of 1992 and Chapter 504 of the Laws of 1995, to be effective upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, this Third Amendment to Regulation 146 was previously adopted as an emergency measure on February 15, 2000, May 11, 2000 and August 3, 2000 and expired on November 1, 2000. The Notice of Proposed Rule-Making for this Amendment was published in the State Register on September 27, 2000. No other publication or prior notice is required by statute.

Neil D. Levin
Superintendent of Insurance

Dated: November 2000