

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK  
REGULATION NO. 171  
(11 NYCRR 362)  
Part 362

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

I, GREGORY V. SERIO, 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, 4321, 4321-a, 4322, 4322-a, 4326 and 4327 of the Insurance Law do hereby promulgate a new Part 362 (Regulation 171) of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York to take effect upon publication in the State Register.

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§ 362-1 Preamble.

The programs described in this Part shall be known as the Healthy New York Program and the Direct Payment Stop Loss Relief Program.

(a) Chapter 1 of the Laws of 1999 establishes the Healthy New York program which is a new initiative designed to encourage small employers which do not provide health insurance coverage for their employees to offer such coverage and also designed to make coverage available to uninsured employees whose employers do not provide group health insurance coverage.

(b) At the time of enactment of Chapter 1 of the Laws of 1999, a significant number of New York residents were uninsured. Due in part to the rising cost of health insurance coverage, many small employers were unable to provide health insurance coverage to their employees. A significant portion of New York State's uninsured population was made up of individuals employed in small businesses.

(c) Through the creation of a standardized health insurance benefit package to be offered by all health maintenance organizations which is made more affordable through the availability of state funded stop loss reimbursement, the Healthy New York program should encourage more small employers and uninsured employed individuals to purchase health insurance coverage.

(d) Chapter 1 of the Laws of 1999 also established the Direct Payment Market Stop Loss Relief program designed to provide premium and market stability to New York's direct payment health insurance market through use of a stop loss mechanism.

(e) The rising cost of health care was a very serious problem that New York State and the nation were facing at the time of the enactment of Chapter 1 of the Laws of 1999. Increases in health insurance premiums were directly related to increases in the cost of health care. Such rising costs were exacerbated in the individual insurance market where the pool of insureds typically includes less healthy ("higher risk") individuals than those covered through their employers in the group insurance market.

(f) At the time of the enactment of Chapter 1 of the Laws of 1999, sections 4321 and 4322 of the Insurance Law required all health maintenance organizations to offer two distinct comprehensive standardized individual enrollee direct payment contracts. This requirement was mandated by law for the purpose of ensuring individual access to comprehensive insurance to meet their health care needs. However, the premium rates for these contracts were high and continuing to increase.

(g) Chapter 1 of the Laws of 1999 enacted sections 4321-a and 4322-a of the Insurance Law to create a program designed to ensure that individual consumers have continued access to comprehensive health insurance. The provisions require the establishment of two stop loss funds from which health maintenance organizations may receive reimbursement for certain claims paid on behalf of members covered under individual enrollee direct payment contracts. The availability of reimbursement through such stop loss funds should have a favorable impact on the cost of such coverage for the benefit of both existing enrollees and currently uninsured persons seeking to purchase such coverage.

§ 362-2 Rules generally applicable to the Healthy New York program.

§ 362-2.1 Definitions generally applicable to the Healthy New York program.

(a) *Health insurance* shall mean any coverage (whether insured or self-insured) providing both hospital and medical benefits on an expense-incurred or prepaid basis or any coverage providing hospital and medical indemnity benefits with specific dollar amounts if the dollar amounts exceed the amounts required to meet the definitions of basic hospital and basic medical insurance set forth in sections 52.5 and 52.6 of this title. Health insurance shall not include health benefits offered through public benefit programs. Health insurance also shall not include coverage established by the continuation provisions of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq. and the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq. established by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or the continuation provisions of subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of the New York State Insurance Law.

(b) *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.

(c) *Insurer* shall mean a corporation organized under article 43 of the Insurance Law or an organization licensed or organized under article 42 of the Insurance Law.

(d) *Participating insurer* means an insurer which voluntarily participates in the Healthy New York program in accordance with section 4326(b) of the Insurance Law.

(e) *Qualifying group health insurance contract* means a group contract issued to a qualifying small employer pursuant to section 4326(c)(2) of the Insurance Law.

(f) *Qualifying health insurance contract* shall mean a qualifying group health insurance contract or a qualifying individual health insurance contract.

(g) *Qualifying individual health insurance contract* means a contract issued directly to a qualifying individual pursuant to section 4326(c)(4) of the Insurance Law.

§ 362-2.2 Voluntary insurer participation.

(a) Insurers intending to offer qualifying health insurance contracts shall file a statement of such intent with the superintendent. Such statement shall include a description of the counties within which the insurer will offer qualifying health insurance contracts. This statement of intent must be submitted in conjunction with the complete policy form and rate filings at least 90 days prior to the date the insurer intends to commence accepting applications for the Healthy New York program.

(b) Insurers choosing to participate in the program must do so under the same terms and conditions as are applicable to health maintenance organizations.

(c) Participating insurers must offer both qualifying group health insurance contracts and qualifying individual health insurance contracts.

#### § 362-2.3 Enrollment.

(a) Applications for qualifying health insurance contracts shall be made directly to health maintenance organizations and participating insurers.

(b) Health maintenance organizations and participating insurers shall provide all necessary information and enrollment forms when requested by applicants.

(c) Health maintenance organizations and participating insurers shall collect the initial eligibility certifications required by section 4326(i) of the Insurance Law and necessary supporting documentation and shall be responsible for examination of such certifications and supporting documentation for verification that applicants meet applicable eligibility requirements.

(d) Unless the superintendent suspends enrollment in the Healthy New York program pursuant to section 4327(k) of the Insurance Law or approves a request to suspend qualifying individual enrollment pursuant to subsection (h) of this section, all applicants meeting eligibility criteria shall be accepted and coverage must be issued on the first day of the month next succeeding the date a complete application has been submitted for all applications submitted on or prior to the 20<sup>th</sup> day of such month. For applications submitted after the 20<sup>th</sup> day of a month, coverage shall be issued no later than the first of the month next following. Dependent children up to at least age 19 and full-time students up to at least age 23 shall be considered eligible dependents under qualifying health insurance contracts.

(e) Health maintenance organizations and participating insurers shall provide applicants which have failed to demonstrate eligibility with a written notice of denial which clearly sets forth the basis for the denial.

(f) Health maintenance organizations and participating insurers must submit monthly enrollment reports which detail total enrollment in the Healthy New York program in the format specified by the superintendent. Such reports shall identify the health maintenance organization's or participating insurer's total enrollment in the Healthy New York program as of the first day of the following month and must be submitted to the superintendent no later than the fifteenth day of the following month.

(g) In the event that the enrollment in the small employer or individual Healthy New York program is suspended pursuant to section 4327(k) of the Insurance Law, participating insurers and health maintenance organizations shall:

(1) notify applicants that enrollment has been suspended; and

(2) maintain a waiting list to be filled in the order of receipt in the event that enrollment is reactivated.

(h) Commencing June 1, 2001, if monthly enrollment reports indicate that a given health maintenance organization or participating insurer's total enrollment under qualifying individual health insurance contracts exceeds 50% of that health maintenance organization's or participating insurer's total enrollment in the Healthy New York program, the health maintenance organization or participating insurer may submit a request to the superintendent to suspend the issuance of its qualifying individual health insurance contracts. If approved by the superintendent, the suspension shall take effect on the date specified by superintendent and shall be for the period specified by the superintendent. A participating insurer or health maintenance organization that has received approval to issue such a suspension shall:

(1) notify applicants that enrollment has been suspended;

(2) maintain a waiting list to be filled in the order of receipt in the event that enrollment is reactivated; and

(3) on a quarterly basis, submit reports detailing the claims experience of the Healthy New York product. Such reports shall segregate the claims experience of qualifying individuals from the claims experience of qualifying small employers and individual proprietors.

(i) An enrollment suspension pursuant to section 4327(k) of the Insurance Law or pursuant to subsection (h) of this section shall not preclude the addition of dependents or new employees to existing qualifying health insurance contracts. Additionally, an enrollment suspension shall not prevent the enrollment of persons exercising a statutory right of conversion to a qualifying individual health insurance contract.

(j) Nothing herein is intended to preclude, diminish or in any way impair the involvement of chambers of commerce, trade associations and other similar entities in the Healthy New York Program in any manner otherwise permitted by law or regulation.

#### § 362-2.4 Transfer from other programs.

(a) *Transferable coverage* shall mean coverage issued pursuant to: (1) the New York State small business health insurance partnership program, established by section 922 of the Public Health Law; (2) the voucher insurance program, established by section 1121 of the Insurance Law; (3) the uninsured pilot programs, established by chapter 703 of the laws of 1988.

(b) Small employers or individuals with transferable coverage shall be eligible to participate in the Healthy New York program without regard to the eligibility requirements set forth in section 4326(c) of the Insurance Law if they submit an application for a qualifying health insurance contract within 90 days of termination of the transferable coverage.

(c) An applicant shall be ineligible for transfer preference if other health insurance is purchased or otherwise becomes effective after the termination of the transferable coverage and prior to the effective date of coverage under the qualifying health insurance contract.

§ 362-2.5 Annual re-certification 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 re-certification 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 re-certification.

(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 re-certification.

(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 non-renewal 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 re-certify. Such reminder notice shall notify the participant that coverage will be non-renewed if the participant fails to provide a re-certification 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 non-renewal pursuant to paragraph (d) of this section. Such notice of non-renewal or termination shall set forth the basis for the non-renewal 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) 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 re-certification.

§ 362-2.6 Health plan contact information.

(a) Health maintenance organizations and participating insurers shall submit the to the superintendent: (1) the name, address and telephone number of a health plan contact person

assigned to the Healthy New York program; (2) the address and toll-free telephone number to direct consumer inquiries regarding the Healthy New York program; and (3) the service area in which the Healthy New York program will be available. Any revisions or updates to such information shall be submitted to the superintendent.

§ 362-3 Rules relating to small employer participation (other than individual proprietors).

§ 362-3.1 Definitions applicable to small employers (other than individual proprietors).

(a) *Employee* shall mean any person employed 20 or more hours weekly by a qualifying small employer.

(b) *Eligible employee* shall mean any employee earning \$30,000 or less (adjusted annually as per section 4326(c)(1)(F) of the Insurance Law) in annual wages and any other person as determined by the employer based upon one or more of the following criteria: geographic situs of employment, earnings, method of compensation, hours and occupational duties.

(c) *Part-time worker* shall mean any person employed less than 20 hours weekly by a qualifying small employer.

§ 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.

(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 twelve 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 towards the cost of the coverage on behalf of their employees.

(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 thirty 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 forty-five days from the date of hire and it must be the same for all newly hired workers.

§ 362-4 Rules relating to working uninsured individuals and individual proprietor participation.

§ 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) 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 re-certification.

(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.

§ 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 (11 NYCRR 52.18(f)).

(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 twelve 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 twelve 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 re-certification.

(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 re-certification, 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 thirty day grace period for payment of premiums.

#### § 362-4.3 Verification of 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 4326(c)(3)(A)(iii) of the Insurance Law. Income received by the applicant, their legal spouse and any other family members 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) income from farm and non-farm 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 monetary 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 non-cash benefits, such as employee fringe benefits, food or housing received in lieu of wages, and receipts from federal non-cash 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.

§ 362-5 Rules relating to the Direct Payment Market Stop Loss Relief program and state funded stop loss relief for the Healthy New York program.

§ 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 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;

(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 subsection (a) of section 4322-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 subsection (a) of section 4321-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 subsection (a) of section 4327 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 subsection (a) of section 4327 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.

§ 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% 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 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 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 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 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 the twenty-four 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 an health maintenance organization writes the out-of-network portion of their individual enrollee out-of-plan direct payment contract through an affiliate insurer, then 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.

#### § 362-5.3 Rating of products eligible for claims reimbursement.

(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 (11 NYCRR 52).

(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 products for the purpose of applying loss ratio standards.

§ 362-5.4 Stop loss fund administration.

(a) The superintendent shall establish the funds and oversee fund administration. The functions of the superintendent in this regard may include, but shall not be limited to, the following:

(1) choosing a firm or firms, other than a carrier participating in the funds, to administer the funds, based on an evaluation of competitive bids;

(2) granting approval of the general systems and procedures used by the firm or firms to administer the funds, including in particular the procedures utilized to verify the appropriateness of payments from the funds to the health maintenance organizations or participating insurers;

(3) making payment of reasonable fees from the funds to the firm or firms for administration of the funds;

(4) changing the administrating firm or firms, or the administrative systems and procedures, if necessary;

(5) collecting necessary data from health maintenance organizations and participating insurers;

(6) arranging for periodic audits of health maintenance organizations and participating insurers and for the payment of reasonable fees for such audits from the funds; and

(7) granting approval of the format and content of the administrating firm or firms annual report regarding the affairs and operation of the funds, and such other reports as deemed necessary by the superintendent.

(b) Health maintenance organizations and participating insurers must respond to requests for information from the superintendent and/or the fund administrator(s) within 15 business days.

§ 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. 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.