

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
(11 NYCRR 361)
FOURTH AMENDMENT TO REGULATION NO. 146**

**ESTABLISHMENT AND OPERATION OF MARKET STABILIZATION
MECHANISMS FOR INDIVIDUAL AND SMALL GROUP HEALTH
INSURANCE AND MEDICARE SUPPLEMENT INSURANCE**

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, 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 Fourth 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, to read as follows:

(NEW MATTER UNDERLINED; DELETED MATTER IN BRACKETS)

Section 361.1(e)(1) 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.

Section 361.2(e)(4) is hereby amended to read as follows:

(4) amounts paid from the fund to the administrator for administration of the fund, as stated in section [361.5(a)(3) and (6)] 361.6(a)(3) and (6) 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(b) is hereby amended to read as follows:

(b) In each pool area:

- (1) one pool, for use until December 31, 1999, deals with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies; and
- (2) one pool deals with Medicare supplement insurance policies.

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

. (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, for pools that deal with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies, 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, for pools that deal with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies, ending as of December 31, 1999.

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

(1) [Initial collections from the pools shall be available from October 1993 until December 1999.] In October of 1993 and every three months thereafter, but only until December 31, 1999, for pools that deal with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies, 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(i) is hereby amended to read as follows:

(i) In order to implement the phase out of the demographic pools that deal with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies, pursuant to chapter 504 of the Laws of 1995, payments to and from [the] such 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>
1997	-	32 and ½ % reduction
1998	-	55% reduction

1999	-	77 and ½ % reduction
2000	-	100% reduction

The aggregate savings resulting from such decreased payments to the demographic pools [after December 31, 1996] that deal with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies shall be distributed pursuant to the methodology in section 361.4 of this Part[.] from January 1, 1997 through December 31, 1998 and pursuant to the methodology in section 361.5 of this Part after December 31, 1998.

Section 361.4(f)(5) is hereby amended to read:

(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) of this subparagraph:

(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 clause (a) of this subparagraph 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 percent reduction in demographic payments in that region to pools that deal with individual health insurance policies and small group health insurance policies, other than Medicare supplement insurance policies.

Sections 361.5 and 361.6 are hereby renumbered 361.6 and 361.7 and a new section 361.5 is added to read as follows:

361.5 Pooling of variations in costs attributable to variations in specified medical conditions (SMC) beginning in 1999.

(a) In each pool area, a specified medical condition pool is established in connection with individual health insurance and small group health insurance policies, other than Medicare supplement insurance policies. Each pool area operates independently; that is, all calculations and payments described below are made for each pool independently of any other pool.

(b) The average relative cost factor is determined for each carrier participating in a pool, with respect to its participation in each pool separately, as follows:

(1) Assign the relative cost factor, according to Table 7, to each individual covered by a particular carrier under all pooled insurance contracts for policies in force on the date as of which the average relative cost factor is being calculated (the calculation date), which is the beginning of each six month period starting January 1, 1999. The term "individual" shall mean each and every person

covered under the subscriber contract or policy form including, but not limited to, a spouse, dependent children or other persons covered as a result of their relationship to the person to whom the subscriber contract or policy form was issued or the employee or other person issued a certificate of coverage by virtue of their membership within a group which has purchased coverage. If the carrier does not maintain records of the exact number of spouses, children and other persons covered under family coverage contracts then the carrier shall assume there are 2.3 persons covered in addition to the one employee, subscriber or policyholder. In such cases, data filed with the pool administrator must be accompanied by an attestation of either the carrier's Chief Financial Officer or Chief Actuary that the carrier is unable to report accurate data concerning dependents.

(2) Each such individual who has had an eligible claim paid in the six month period immediately preceding the calculation date for an ICD9 Code listed on Table 7 should be assigned the relative cost factor corresponding to the ICD9 Code. Each individual will be assigned only one relative cost factor. If an individual has multiple conditions, assign the relative cost factor for the condition with the largest factor for the conditions pertaining to the individual. If an individual has had no claims paid for any of the ICD9 Codes listed in Table 7, the relative cost factor for individuals without specified medical conditions should be assigned. For the claim(s) to be considered eligible the individual must have either had an overnight inpatient hospital stay or, for "certain conditions", had total paid claims for the condition which together with paid claims for all other conditions exceed \$5,000 in the six month period. The "certain conditions" are AIDS/HIV, Asthma, Diabetes, Gaucher's Disease, Hemophilia, Lupus or Multiple Sclerosis. These conditions are marked with an asterisk in Table 7.

(3) Determine the carrier's average relative cost factor by taking the sum of the relative cost factors for all individuals covered by the carrier and dividing that sum by the total number of individuals covered by the particular carrier under all pooled insurance contracts or policies in force as of the calculation date.

(c) The regional average relative cost factor for all carriers combined is determined for each pool based upon the average relative cost factors of all carriers participating in that pool weighted by their total annualized premiums as of the calculation date.

Annualized premium means one of the following, as appropriate for a particular policy or contract:

<u>Frequency of Premium Payment</u>	<u>Definition of Annualized Premium</u>
<u>Annually</u>	<u>annual premium</u>
<u>Semi-annually</u>	<u>2 times the semi-annual premium</u>
<u>Quarterly</u>	<u>4 times the quarterly premium</u>
<u>Monthly</u>	<u>12 times the monthly premium</u>
<u>Other</u>	<u>consistent with the above</u>

(d) Initial payments to the pools.

(1) The average relative cost factor for each carrier participating in a pool shall be determined as of the beginning of each six month period, starting January 1, 1999. This is the calculation date. The regional average relative cost factor for each pool shall also be determined as of the beginning of a six month period, starting January 1, 1999. The claims data to be used for the January 1 calculation date shall be the claims data for the six month period ending on the December

31 prior to the January 1 calculation date. The claims data to be used for the July 1 calculation date shall be the claims data for the six month period ending on the June 30 prior to the July calculation date.

(2) If the average relative cost factor of a carrier participating in a specified medical condition pool, determined as of the beginning of a six month period starting on or after January 1, 1999, is less than the regional average relative cost factor for that pool as of the beginning of that six month period, the carrier shall pay to the specified medical condition pooling fund a percentage of its premium earned for pooled insurance during that period. For example, the determination of average relative cost factors as of January 1, 1999 based on the claims data for the six month period ending December 31, 1998 and membership data as of January 1, 1999 affects payments to the specified medical condition pooling fund attributable to the period January 1, 1999 through June 30, 1999. The premiums to be used to determine the payments to the specified medical condition pooling fund are the premiums for the current six month period (e.g. the premiums to be used for payments to the pool for the January 1, 1999 through June 30, 1999 period are the earned premiums for the six month period ending June 30, 1999). The percentage of premium earned during a particular six month period to be paid to the specified medical condition pooling fund is calculated as the product of subparagraphs (i), (ii) and (iii) below:

(i) 100.

(ii) 1.0 minus the ratio of the carriers average relative cost factor divided by the regional average relative cost factor.

(iii) the ratio of claims projected to be incurred during the six month period commencing at the calculation date under its pooled insurance to the premiums projected to be earned during that period for pooled insurance, without consideration of this additional percentage (i.e., the projected incurred loss ratio, exclusive of specified medical condition pooling).

(3) Payment to the specified medical condition pooling fund, in accordance with paragraph (2) of this subdivision, shall be due the first day of the second month after the end of each six month period. However, the payment dates preceding the effective date of this section will be due as provided in subdivision (i) of this section. Payment made after the due date shall include the amount calculated in accordance with paragraph (2) of this subdivision, plus interest at the rate of 1% per month, or portion thereof, beyond the date the payment was due.

(4) Individual carrier's payments to the specified medical condition pooling fund for calendar years 1999, 2000, 2001, and 2002 shall be limited to five percent of the carrier's incurred losses on its pooled business in each respective year.

(e) Initial collections from the pools.

(1) In August of 1999 and every six months thereafter, a carrier participating in a specified medical condition pool shall be entitled to collect from a specified medical condition pooling fund if its average relative cost factor for that pool at the beginning of the preceding six month period (i.e. January 1, 1999 calculation date and every six months thereafter) is greater than the regional average relative cost factor for that pool as of that date. However, collection dates preceding the effective date of this section shall be postponed as provided in subdivision (i) of this section.

(2) Subject to the limitation in paragraph (3) of this subdivision, a carrier who is entitled to collect from a specified medical condition pooling fund may collect the product of subparagraphs (i), (ii) and (iii) of this paragraph:

(i) the premiums earned under its pooled insurance during the six month period commencing on the calculation date of the average relative cost factor.

(ii) the ratio of the carrier's average relative cost factor for that pool at the calculation date to the regional average relative cost factor for that pool as of the calculation date minus 1.0.

(iii) the ratio of claims projected to be incurred during the six month period commencing at the calculation date under its pooled insurance to the premiums projected to be earned during that period for pooled insurance, without consideration of this additional percentage (i.e., the projected incurred loss ratio, exclusive of specified medical condition pooling).

(3) If the amount of money in the specified medical condition 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.

(f) Each carrier shall transmit every six months to the pool administrator, in forms and formats designated by the superintendent, the following data, within the following timeframes, for all pooled insurance policies within each region:

(1) The average relative cost factor computed in accordance with subdivision (b) of this section, as of the first day of the following six month period (e.g., July 1, 1999);

(2) The annualized premium as of the first day of the following six month period (e.g., July 1, 1999); and

(3) Premium earned during the six month period, (e.g. January 1, 1999 to June 30, 1999) identifying separately the earned premium charged for anticipated payments to the specified medical condition pooling fund.

(4) The ratio of claims projected to be incurred during the six month period commencing at the calculation date (e.g., January 1, 1999) under its pooled insurance to the premiums projected to be earned during that period for pooled insurance, without consideration of this additional percentage (i.e., the projected incurred loss ratio, exclusive of specified medical condition pooling).

(5) Such data reports shall be provided to the pool administrator no later than 30 days after the end of each six month period (e.g., July 30, 1999), beginning with the last six month period of 1999. For carriers providing such reports later than 30 days after the end of any six month period, payment for those carriers that pay into the pools will be plus 1% interest per month, and for those carriers that collect from the pools distributions will be reduced by 1% per month, unless waived by the superintendent for special circumstances. In addition, each carrier shall transmit to the pool administrator as provided in subdivision (i) of this section, the data stated in paragraphs (1) and (2) of this subdivision for the period July 1, 1998 to December 31, 1998 computed as of January 1, 1999, the data stated in paragraphs (1) and (2) of this subdivision for the period January 1, 1999 to June 30, 1999 computed as of July 1, 1999, and the data stated in paragraph (3) and (4) of this subdivision for the six month period ending June 30, 1999.

(g) In May of each year, a carrier's initial payments to or from a specified medical condition pooling fund as described in subdivisions (d) and (e) of this section for each of the two preceding years shall be reconciled with payments determined pursuant to paragraphs (1) – (6) of this subdivision (e.g., in May 2002, reconciliations will be done for 2000 and 2001 payments).

(1) A carrier's final average relative cost factor each year shall be determined based on the average of its average relative cost factors as of the beginning of each six month period of the previous calendar year, weighted by its total annualized premium as of each calculation date.

(2) The regional average relative cost factor during the previous calendar year is calculated as the average of the regional average relative cost factors for that pool as of the beginning of each six month period of the previous calendar year, weighted by the total annualized premium of all carriers participating in the pool as of the calculation date.

(3) For reconciliation purposes, a carrier's total payment to (+) or from (-) the specified medical condition pooling fund for the previous calendar year shall be determined as the product of subparagraphs (i) and (ii) of this paragraph:

(i) the claims incurred, as prepared for and consistent with the carrier's annual statement for the preceding calendar year, under its pooled insurance during that year exclusive of payments to or from the specified medical condition pools;

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

(4) Carriers shall pay additional amounts to, or collect additional amounts from, the specified medical condition pooling fund so that these amounts, combined with amounts initially paid or collected pursuant to subdivisions (d) and (e) of this section, equal the total payment to or from the specified medical condition pooling fund for reconciliation purposes.

(5) The additional payment to the specified medical condition pooling fund shall be paid by the carrier during the twelve months beginning with the next July 1 (e.g., for the May 2002 reconciliations of pool years 2000 and 2001, payments shall be made from July 1, 2002 through June 1, 2003). That amount shall be in addition to the carrier's payments to the specified medical condition pooling fund pursuant to subdivision (d) of this section.

(6) If the amount of money in the specified medical condition 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.

(7) In the event excess funds remain in the specified medical condition pooling fund after the second reconciliation of any calendar year in any region, such excess shall be refunded to carriers in the region in an amount equal to the respective carrier's proportion of the total amount paid in by all carriers in the region for that calendar year. This provision does not apply to excesses, if any, of deposit contributions based on demographics for 1999 over required contributions determined based on the provisions of this section. Such excesses shall be refunded to each carrier in the entire amount of the respective carrier's excess deposit payment.

(h) In order to implement the phase in of the specified medical condition pooling process pursuant to Chapter 504 of the Laws of 1995, the payments to, or from, the specified medical condition pools otherwise determined pursuant to subdivisions (e),(f) and (g) of this section shall be reduced by the percentages set forth below:

(1) 1999 - twenty two and one-half percent reduction.

(2) 2000 - and thereafter - no reduction.

(i) Reporting of data due for calendar years 1999, 2000, and 2001 and associated dates of submission and payments, may be determined by the superintendent in recognition of the effective date of this section.

(j) Table 7

<u>ICD9 Code</u>	<u>Condition</u>	<u>Relative Cost Factor</u>
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*AIDS	<u>AIDS/HIV</u>	<u>60.97</u>
<u>042</u>	<u>HIV DISEASE</u>	
<u>V08</u>	<u>ASYMPTOMATIC HIV INFECTION STATUS</u>	

TB	<u>Tuberculosis</u>	<u>26.39</u>
<u>011</u>	<u>PULMONARY TUBERCULOSIS</u>	
<u>012</u>	<u>OTHER RESPIRATORY TB</u>	
<u>013</u>	<u>CNS TUBERCULOSIS</u>	
<u>014</u>	<u>INTESTINAL TB</u>	
<u>015</u>	<u>TB OF BONE AND JOINT</u>	
<u>016</u>	<u>GENITOURINARY TB</u>	
<u>017</u>	<u>TUBERCULOSIS NEC</u>	
<u>018</u>	<u>MILIARY TUBERCULOSIS</u>	

HEPAT	<u>Hepatitis</u>	<u>18.35</u>
<u>070.1</u>	<u>HEPATITIS A W/O COMA</u>	
<u>070.2</u>	<u>HEPATITIS B WITH COMA</u>	
<u>070.3</u>	<u>HEPATITIS B W/O COMA</u>	
<u>070.4</u>	<u>VIRAL HEPATITIS NEC W COMA</u>	
<u>070.5</u>	<u>VIRAL HEPATITIS NEC W/O COMA</u>	
<u>070.6</u>	<u>VIRAL HEPATITIS NOS W COMA</u>	
<u>070.9</u>	<u>VIRAL HEPATITIS NOS W/O COMA</u>	

<u>136.3</u>	<u>PNEUMOCYSTOSIS</u>	<u>25.46</u>
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CANC1	<u>Cancer Class I</u>	<u>41.92</u>
<u>141</u>	<u>MALIG NEOPLASM TONGUE</u>	
<u>142</u>	<u>MAL NEOPLASM MAJOR SALIVARY</u>	
<u>144</u>	<u>MALIG NEOPLASM MOUTH FLOOR</u>	
<u>145</u>	<u>MALIG NEOPLASM MOUTH NEC/NOS</u>	
<u>146</u>	<u>MALIG NEOPLASM OROPHARYNX</u>	
<u>147</u>	<u>MALIG NEOPLASM NASOPHARYNX</u>	
<u>148</u>	<u>MALIG NEOPLASMPL HYPOPHARYNX</u>	
<u>149</u>	<u>OTH MALIG NEOPLASM OROPHARYNX</u>	
<u>150</u>	<u>MALIGNANT NEOPLASM ESOPHAGUS</u>	
<u>151</u>	<u>MALIGNANT NEOPLASM STOMACH</u>	
<u>152</u>	<u>MALIG NEOPLASM SMALL BOWEL</u>	
<u>153</u>	<u>MALIGNANT NEOPLASM COLON</u>	
<u>154</u>	<u>MALIG NEOPLASM RECTUM/ANUS</u>	
<u>155</u>	<u>MALIGNANT NEOPLASM LIVER</u>	
<u>156</u>	<u>MAL NEOPLASM GB/EXTRAHEPATIC</u>	
<u>157</u>	<u>MALIGNANT NEOPLASM PANCREAS</u>	
<u>158</u>	<u>MALIG NEOPLASM PERITONEUM</u>	
<u>159</u>	<u>OTH MALIG NEOPLASM</u>	

	<u>GI/PERITONEUM</u>
<u>160</u>	<u>MAL NEOPLASM NASAL</u> <u>CAVITY/SINUS</u>
<u>161</u>	<u>MALIGNANT NEOPLASM LARYNX</u>
<u>162</u>	<u>MAL NEOPLASM TRACHEA/LUNG</u>
<u>163</u>	<u>MALIGNANT NEOPLASMPL PLEURA</u>
<u>164</u>	<u>MAL NEOPLASM THYMUS/MEDIASTIN</u>
<u>170</u>	<u>MAL NEOPLASM BONE/ARTIC CART</u>
<u>174</u>	<u>MALIG NEOPLASM FEMALE BREAST</u>
<u>175</u>	<u>MALIG NEOPLASM MALE BREAST</u>
<u>176</u>	<u>KAPOSI'S SARCOMA</u>
<u>185</u>	<u>MALIGN NEOPLASMPL PROSTATE</u>
<u>186</u>	<u>MALIGN NEOPLASMPL TESTIS</u>
<u>188</u>	<u>MALIGN NEOPLASMPL BLADDER</u>
<u>189</u>	<u>MAL NEOPLASM URINARY NEC/NOS</u>
<u>191</u>	<u>MALIGNANT NEOPLASM BRAIN</u>
<u>192</u>	<u>MAL NEOPLASM NERVE NEC/NOS</u>
<u>194</u>	<u>MAL NEOPLASM OTHER ENDOCRINE</u>
<u>195</u>	<u>MAL NEOPLASM OTH/ILL-DEF SITE</u>
<u>196</u>	<u>MALIG NEOPLASM LYMPH NODES</u>
<u>197</u>	<u>SECONDRY MAL NEOPLASM GI/RESP</u>
<u>198</u>	<u>SEC MALIG NEOPLASM OTH SITES</u>
<u>199</u>	<u>MALIGNANT NEOPLASM NOS</u>
<u>200</u>	<u>LYMPHOSARC/RETICULOSARC</u>
<u>201</u>	<u>HODGKIN'S DISEASE</u>
<u>202</u>	<u>OTH MAL NEOPLASM LYMPH/HISTIO</u>
<u>203</u>	<u>MULTIPLE MYELOMA ET AL</u>
<u>235</u>	<u>UNCERTAIN BEHAV NEOPLASM</u> <u>GI/RESP</u>
<u>236</u>	<u>UNCERTAIN BEHAV NEOPLASM GU</u>
<u>237</u>	<u>UNCERTAIN NEOPLASM</u> <u>ENDOCRINE/NERV</u>
<u>238</u>	<u>UNCERTAIN BEHAV NEOPLASM</u> <u>NEC/NOS</u>

CANC2 Cancer Class II

25.92

<u>172</u>	<u>MALIGNANT MELANOMA SKIN</u>
<u>179</u>	<u>MALIG NEOPLASM UTERUS NOS</u>
<u>182</u>	<u>MALIG NEOPLASM UTERUS BODY</u>
<u>183</u>	<u>MAL NEOPLASM UTERINE ADNEXA</u>
<u>184</u>	<u>MAL NEOPLASM FEMALE GEN</u> <u>NEC/NOS</u>
<u>190</u>	<u>MALIGNANT NEOPLASM EYE</u>
<u>193</u>	<u>MALIGN NEOPLASM THYROID</u>
<u>233</u>	<u>CA IN SITU BREAST/GU</u>
<u>234</u>	<u>CA IN SITU NEC/NOS</u>

<u>239</u>	<u>UNSPECIFIED NEOPLASM</u>	
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<u>LEUK</u>	<u>Leukemia</u>	<u>92.92</u>
<u>204</u>	<u>LYMPHOID LEUKEMIA</u>	
<u>205</u>	<u>MYELOID LEUKEMIA</u>	
<u>206</u>	<u>MONOCYTIC LEUKEMIA</u>	
<u>207</u>	<u>OTHER SPECIFIED LEUKEMIA</u>	
<u>208</u>	<u>LEUKEMIA-UNSPECIF CELL</u>	

<u>THYR</u>	<u>Disorders of Thyroid</u>	<u>15.71</u>
<u>242</u>	<u>THYROTOXICOSIS</u>	
<u>244</u>	<u>ACQUIRED HYPOTHYROIDISM</u>	
<u>245</u>	<u>THYROIDITIS</u>	
<u>246</u>	<u>OTHER DISORDERS OF THYROID</u>	

<u>*250</u>	<u>DIABETES MELLITUS</u>	<u>26.22</u>
<u>*272.7</u>	<u>LIPIDOSES (GAUCHER'S DISEASE)</u>	<u>122.21</u>
<u>277</u>	<u>METABOLISM DISORDER NEC/NOS</u>	<u>45.98</u>
<u>282.6</u>	<u>SICKLE-CELL ANEMIA</u>	<u>25.14</u>
<u>284</u>	<u>APLASTIC ANEMIA</u>	<u>72.01</u>

<u>*HEMO</u>	<u>Hemophilia</u>	<u>89.55</u>
<u>P</u>		
<u>286.0</u>	<u>CONGENITAL FACTOR VIII DISORDER</u>	
<u>286.1</u>	<u>CONGENITAL FACTOR IX DISORDER</u>	
<u>286.2</u>	<u>CONGENITAL FACTOR XI DISORDER</u>	

<u>AX/BU</u>	<u>Anorexia/Bulimia</u>	<u>20.29</u>
<u>307.1</u>	<u>ANOREXIA NERVOSA</u>	
<u>307.51</u>	<u>BULIMIA</u>	

<u>*340</u>	<u>MULTIPLE SCLEROSIS</u>	<u>18.65</u>
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<u>PARAL</u>	<u>Paralysis</u>	<u>52.17</u>
<u>342</u>	<u>HEMIPLEGIA</u>	
<u>344.0</u>	<u>QUADRIPLEGIA NOS</u>	
<u>344.1</u>	<u>PARAPLEGIA NOS</u>	

<u>343</u>	<u>INFANTILE CEREBRAL PALSY</u>	<u>32.85</u>
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<u>EPIL</u>	<u>Epilepsy</u>	<u>28.06</u>
<u>345.4</u>	<u>PSYCHOMOTOR EPILEPSY</u>	
<u>345.5</u>	<u>PARTIAL EPILEPSY NEC</u>	
<u>345.9</u>	<u>EPILEPSY NOS</u>	

<u>358.0</u>	<u>MYASTHENIA GRAVIS</u>	<u>17.72</u>
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CHRNH	Chronic Rheumatic Heart Disease	<u>42.02</u>
<u>394</u>	<u>DISEASES OF MITRAL VALVE</u>	
<u>395</u>	<u>DISEASES OF AORTIC VALVE</u>	
<u>396</u>	<u>MITRAL/AORTIC VALVE DISORDERS</u>	
<u>398</u>	<u>OTH RHEUMATIC HEART DISEASE</u>	

<u>410</u>	<u>ACUTE MYOCARDIAL INFARCTION</u>	<u>30.50</u>
<u>411</u>	<u>OTHER ACUTE ISCHEMIC HEART DISEASE</u>	<u>14.86</u>
<u>413</u>	<u>ANGINA PECTORIS</u>	<u>11.47</u>
<u>414</u>	<u>OTHER CHRONIC ISCHEMIC HEART DISEASE</u>	<u>31.93</u>
<u>416</u>	<u>CHRONIC PULMONARY HEART DISEASE</u>	<u>40.16</u>
<u>424</u>	<u>OTHER ENDOCARDIAL DISEASE</u>	<u>27.93</u>
<u>426</u>	<u>CONDUCTION DISORDERS</u>	<u>18.92</u>
<u>427</u>	<u>CARDIAC DYSRHYTHMIAS</u>	<u>16.93</u>

HFAIL	Heart Failure	<u>22.51</u>
<u>428.0</u>	<u>CONGESTIVE HEART FAILURE</u>	
<u>428.1</u>	<u>LEFT HEART FAILURE</u>	

<u>430</u>	<u>SUBARACHNOID HEMORRHAGE</u>	<u>77.45</u>
<u>431</u>	<u>INTRACEREBRAL HEMORRHAGE</u>	<u>43.24</u>

ARTHE	Atherosclerosis	<u>30.69</u>
<u>440.0</u>	<u>AORTIC ATHEROSCLEROSIS</u>	
<u>440.1</u>	<u>RENAL ARTERY ATHEROSCLEROSIS</u>	

ANEUR	Aneurysm	<u>56.29</u>
<u>441</u>	<u>AORTIC ANEURYSM</u>	
<u>442</u>	<u>OTHER ANEURYSM</u>	

<u>*493</u>	<u>ASTHMA</u>	<u>13.64</u>
<u>496</u>	<u>CHRONIC AIRWAY OBSTRUCTION NEC</u>	<u>21.37</u>
<u>531</u>	<u>GASTRIC ULCER</u>	<u>17.30</u>
<u>555.0</u>	<u>REGIONAL ENTERITIS, SMALL INTESTINE</u>	<u>41.47</u>
<u>571</u>	<u>CHRONIC LIVER DISEASE/CIRRHOSIS</u>	<u>34.64</u>
<u>572</u>	<u>SEQUELA OF CHRONIC LIVER DISEASE</u>	<u>65.44</u>

577.1	<u>CHRONIC PANCREATITIS</u>	33.50
585	<u>CHRONIC RENAL FAILURE</u>	52.53

MATRN	<u>Maternity</u>	10.01
630	<u>HYDATIDIFORM MOLE</u>	
631	<u>OTHER ABNORMAL PRODUCT OF CONCEPTION</u>	
632	<u>MISSED ABORTION</u>	
633	<u>ECTOPIC PREGNANCY</u>	
634	<u>SPONTANEOUS ABORTION</u>	
640	<u>HEMORRHAGE IN EARLY PREGNANCY</u>	
641	<u>ANTEPART HEMORRHAGE & PLACENTA PREVIA</u>	
642	<u>HYPERTENSION COMPLICATING PREGNANCY</u>	
643	<u>EXCESS VOMITING IN PREGNANCY</u>	
644	<u>EARLY/THREATENED LABOR</u>	
645	<u>PROLONGED PREGNANCY</u>	
646	<u>OTHER COMPLICATIONS OF PREGNANCY</u>	
647	<u>INFECTIVE DISORDER IN PREGNANCY</u>	
648	<u>OTHER CURRENT CONDITIONS IN PREGNANCY</u>	
650	<u>NORMAL DELIVERY</u>	
651	<u>MULTIPLE GESTATION</u>	
652	<u>MALPOSITION OF FETUS</u>	
653	<u>DISPROPORTION</u>	
654	<u>ABNORMAL PELVIC ORGAN IN PREGNANCY</u>	
655	<u>FETAL ABNORMALITY AFFECTING MOTHER</u>	
656	<u>OTH FETAL PROBLEM AFFECTING MOTHER</u>	
657	<u>POLYHYDRAMNIOS</u>	
658	<u>OTHER AMNIOTIC CAVITY PROBLEM</u>	
659	<u>OTHER INDICATIONS FOR CARE IN DELIVERY</u>	
660	<u>OBSTRUCTED LABOR</u>	
661	<u>ABNORMAL FORCES OF LABOR</u>	
662	<u>LONG LABOR</u>	
663	<u>UMBILICAL CORD COMPLICATIONS</u>	
664	<u>PERINEAL TRAUMA W/DELIVERY</u>	
665	<u>OTHER OBSTETRICAL TRAUMA</u>	
666	<u>POSTPARTUM HEMORRHAGE</u>	

<u>667</u>	<u>RETAIN PLACENTA W/O HEMORRHAGE</u>	
<u>668</u>	<u>COMPLICATED ANESTHESIA IN DELIVERY</u>	
<u>669</u>	<u>OTHER COMPLICATIONS OF LABOR/DELIVERY</u>	
<u>670</u>	<u>MAJOR PUERPERAL INFECTION</u>	
<u>671</u>	<u>VENOUS COMPLICATIONS IN PREGNANCY</u>	
<u>672</u>	<u>PUERPERAL PYREXIA NOS</u>	
<u>673</u>	<u>OB PULMONARY EMBOLISM</u>	
<u>674</u>	<u>PUERPERAL COMPLICATIONS NEC/NOS</u>	
<u>675</u>	<u>INFECTIONS OF BREAST IN PREGNANCY</u>	
<u>676</u>	<u>OTHER BREAST/LACT DISORDERS W/PREGNANCY</u>	
<u>V22</u>	<u>NORMAL PREGNANCY</u>	
<u>V23</u>	<u>SUPERVISION HIGH-RISK PREGNANCY</u>	
<u>V24</u>	<u>POSTPARTUM CARE/EXAM</u>	

<u>707.0</u>	<u>DECUBITUS ULCER</u>	<u>49.94</u>
<u>707.1</u>	<u>CHRONIC ULCER OF LEG</u>	<u>34.87</u>
<u>*710.0</u>	<u>SYSTEMIC LUPUS ERYTHEMATOSUS</u>	<u>23.17</u>
<u>710.1</u>	<u>SYSTEMIC SCLEROSIS</u>	<u>54.12</u>

<u>ARTHR</u>	<u>Arthritis</u>	<u>25.25</u>
<u>714.0</u>	<u>RHEUMATOID ARTHRITIS</u>	
<u>715.0</u>	<u>GENERAL OSTEOARTHRITIS</u>	

<u>737.3</u>	<u>SCOLIOSIS</u>	<u>51.72</u>
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<u>CSCAN</u>	<u>Anomalies of Cardiac Septal Closure</u>	<u>61.35</u>
<u>745.1</u>	<u>TRANSPOS OF GREAT VESSEL</u>	
<u>745.2</u>	<u>TETRALOGY OF FALLOT</u>	
<u>745.3</u>	<u>COMMON VENTRICLE</u>	
<u>745.4</u>	<u>VENTRICULAR SEPTAL DEFECT</u>	
<u>745.5</u>	<u>SECUNDUM ATRIAL SEPTAL DEFECT</u>	
<u>745.6</u>	<u>ENDOCARD CUSHION DEFECTS</u>	

<u>746</u>	<u>OTHER CONGENITAL ANOMALIES OF HEART</u>	<u>73.20</u>
<u>747</u>	<u>OTHER CONGENITAL ANOMALIES OF CIRCULATORY SYSTEM</u>	<u>39.23</u>

PREMI	Premature Infants	60.49
<u>765</u>	<u>SHORT GESTATION/LOW BIRTHWEIGHT</u>	
<u>770.0</u>	<u>CONGENITAL PNEUMONIA</u>	

<u>769</u>	<u>RESPIRATORY DISTRESS SYNDROME</u>	<u>60.12</u>
<u>952</u>	<u>SPINAL CORD INJURY W/O FRACTURE</u>	<u>75.15</u>

<u>Members without Specified Medical Condition</u>		<u>0.73</u>
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*Condition may be satisfied via overnight inpatient stay OR \$5,000 in paid claims in the 6 month period where a portion are for the given diagnosis.

NEC = Not Elsewhere Classified

NOS = Not Otherwise Specified

Section 361.6(a)(8) is amended to read as follows:

(8) establishing equitable assessments on carriers participating in the pools as needed to make the payments from the pools stated in paragraphs (3) and (6) of this subdivision, in section 361.3(f) of this Part, [and] in section 361.4(c) and (d) of this Part and in section 361.5(d) of this Part.

I, Gregory V. Serio, Superintendent of Insurance of the State of New York, do hereby certify that the foregoing is the Fourth 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), promulgated by me on May 6, 2002, 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 take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on February 27, 2002. No other publication or prior notice is required by statute.

Gregory V. Serio
Superintendent of Insurance

May 6, 2002