Assessment of Public Comments on the Fifty-Sixth Amendment to 11 NYCRR 52 (Insurance Regulation 62)

The New York State Department of Financial Services (the "Department") received comments from an association that represents insurers and health maintenance organizations ("issuers") requesting changes to or clarifications of the regulation.

Comment: The commenter sought clarification that Section 52.75(a)(1) of the regulation addresses policy form provisions while paragraph (4) addresses claim denials.

Response: The commenter's observation is correct and supported by a plain reading of the text. Thus, the Department did not make any changes to the regulation in response to this comment.

Comment: The commenter stated that, although issuers have removed gender edits when a diagnosis code indicates gender dysphoria is present in accordance with Insurance Circular Letter No. 12 (2017), the regulation would require the removal of all gender edits. The commenter also stated that the regulation may necessitate the review of CMS's National Correct Coding Initiative standards and the Department may need to issue formal guidance to issuers. The commenter observed that issuers do not necessarily request additional information to determine an insured's eligibility prior to denying a claim. The commenter further stated that the regulation would potentially impact any gender edits currently in use that comply with national coding standards. Finally, the commenter also alleged that the regulation conflicts with Medicare claims processing guidance.

Response: The regulation requires an issuer that receives a claim from an insured of one gender or sex for a service that is typically or exclusively provided to an individual of another gender or sex to take reasonable steps, including requesting additional information, to determine whether the insured is eligible for the services prior to denying the claim. The regulation is consistent with the guidance previously provided by the Department in Insurance Circular Letter No. 12 (2017). A gender edit is a coding determination that results in the automatic denial of a claim due to a conflict between the gender and diagnosis or procedure codes. The regulation neither requires the removal of all gender edits nor requires an issuer to request additional information for all claims.

Rather, it requires issuers to take reasonable steps to determine whether the insured is eligible for the services prior to denying the claim, which may include requesting additional information. The regulation does not preclude the use of gender edits that are consistent with national coding standards, CMS's National Correct Coding Initiative, or Medicare claims processing guidance, but requires an issuer to take reasonable steps to ensure that transgender individuals are protected from automatic denials. The Department expects issuers to comply with the regulation as they have already complied with the Department guidance issued in 2017. Thus, the Department did not make any changes to the regulation in response to these comments.

Comment: The commenter noted that New York City allows a gender neutral "X" to be listed on a birth certificate and noted that if New York State added gender "X" to enrollment transactions, issuers could remove edits that may inadvertently impact transgender individuals without losing gender edits for other erroneous claims.

Response: It is the Department's understanding that an enrollment transaction is the electronic transfer of enrollment information between an issuer and an employer or other entity, such as the New York State of Health, the Official Health Plan Marketplace. Enrollment transactions are outside the purview of the regulation. Thus, the Department did not make any changes to the regulation in response to this comment.

Comment: The commenter requested clarification regarding coverage for preexposure prophylaxis with effective antiretroviral therapy for persons who are at high risk of HIV acquisition. The commenter stated that the regulation requires such coverage for "high-risk populations," irrespective of the United States Preventive Services Task Force ("USPSTF") recommendation and requested the means to identify a high-risk population should the USPSTF rating or description change.

Response: The regulation requires an issuer to provide coverage for preventive care and screenings pursuant to Insurance Law Sections 3216(i)(17)(E), 3221(l)(8)(E) and (F), and 4303(j)(3), including coverage for preexposure prophylaxis with effective antiretroviral therapy to insureds who are at high risk of HIV acquisition. Insurance Law Sections 3216(i)(17)(E), 3221(l)(8)(E) and (F), and 4303(j)(3) require coverage for evidence-

based items or services for preventive care and screenings that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF. The USPSTF recommendation regarding preexposure prophylaxis, which has received an "A" rating, states that that clinicians should offer preexposure prophylaxis with effective antiretroviral therapy to persons who are at high-risk of HIV acquisition. The recommendation statement provides further detail regarding individuals who are at high-risk of HIV acquisition. As the proposed regulation cites to Insurance Law Sections 3216(i)(17)(E), 3221(l)(8)(E) and (F), and 4303(j)(3), issuers should use the USPSTF recommendation statement, including any updated statement, when determining which individuals are considered at high-risk of HIV acquisition. The Insurance Law already requires issuers to provide coverage for preexposure prophylaxis in this manner. The regulation merely codifies a specific current USPSTF recommendation as referenced in the Insurance Law. Thus, the Department did not make any changes to the regulation in response to this comment.

Comment: The commenter noted that the regulation requires policies to cover preventive care and screenings specified in any recommendation or guideline described in the Insurance Law through the last day of the "policy year," even if the recommendation or guideline changes during the policy year. The commenter noted that continuing a preventive service recommendation through the end of the policy year for individual comprehensive health insurance may be achievable as that coverage runs on a calendar year basis. The commenter noted that the same requirement would pose logistical difficulties for the Essential Plan or small group comprehensive health insurance policies given that the plan year is not required to run on a calendar year basis. The commenter recommended that issuers have flexibility to subject any claim with a date of service after the recommendation or guideline change to the new requirements.

Response: The regulation requires a policy that provides coverage for preventive care and screenings specified in any recommendation or guideline described in Insurance Law Sections 3216(i)(17)(E), 3221(l)(8)(E) and (F), and 4303(j)(3) to provide coverage through the last day of the policy year, even if the recommendation or guideline changes during the policy year. This requirement is consistent with the minimum standards for

coverage of preventive care set forth in 45 C.F.R. Section 147.130(b)(2)(i). Additionally, the regulation is consistent with 11 NYCRR Sections 52.17(a)(25)(ii) and 52.18(a)(8)(ii), which prohibit an issuer from making a unilateral modification to an existing hospital, surgical, or medical expense insurance policy except at the time of coverage renewal. Therefore, the Department did not make any changes to the regulation in response to this comment.