Guidance for Large Group Comprehensive Medical Policy Form Filings (5/4/17)

Drafting Instructions

1. **Form Numbers:**
   - Each policy form used by the insurer or HMO shall be designated by a suitable form number which may be made up of numerical digits or letters, or both, in the lower left-hand corner of the first page of the form. The form number shall distinguish the form from all others used by the insurer or HMO.
   - The policy forms for large group products should be separate policy forms from the small group products. See the Product and Mandated Benefit Guidance for individual and small group policy form filings inside and outside the New York State of Health (NYSOH) for more information regarding small group policy form filings.

2. **Use of Model Language:**
   - Insurers and HMOs should use certain provisions of the model contract language for all large group products. See the checklist available on the DFS website for a description of usage of the model language
   - The model language includes drafting notes that provide guidance to insurers and HMOs. The drafting notes should be deleted when the model language is used.
   - Model language in brackets is variable. This means either: (1) the language does not need to be included; (2) the covered visits may be increased; or (3) the benefit is optional. The drafting notes explain the permissible variability.

3. **Use of Variable Material & Memorandum of Variability:**
   - Variable material for contract language is permissible as provided in the model language.
   - Insurers and HMOs may want to make telephone numbers and website addresses variable to enable amendments to readily be made in the event a telephone number or website address changes.
   - Insurers and HMOs submitting a memorandum of variable material should footnote or otherwise flag the variable contract provision so DFS can easily identify the contract provision to which each item in the memorandum of variable material relates.

4. **Policy Form Submission:**
   - Policy forms for separately licensed entities (e.g., Article 43 corporations, Article 42 insurers and HMOs) should not be filed within the same SERFF submission. Each licensed entity should make its own submission even if the policy forms are identical.

5. **Schedules of Benefits:**
   - Schedules of Benefits should be assigned a separate policy form number.

SERFF Submission Instructions

1. Insurers and HMOs should submit forms and rates together using the following Filing Types:
   - Certification by Checklist
   - Certification by Previously Approved Form
   - Certification by Template
   - Normal Pre-Approval

2. Insurers and HMOs should also select the appropriate Type of Insurance (TOI) and Sub-TOI.

Guidance for Specific Benefits and Contract Provisions

1. **Access to Care:**
   - HMOs and comprehensive insurance products that use a network of providers are required to provide the right to go out-of-network if the plan does not have an in-network provider with the appropriate training and experience.

2. **Age 29 Coverage:**
   - **Young Adult Option.** Insurers and HMOs should include language in their policy form or contract that provides an option for a young adult who has aged off his or her parent's group policy to independently purchase coverage through the parent's group policy or contract through the age of 29.
   - **Make Available Option.** Insurers and HMOs are required to offer a rider to groups that extends dependent coverage through the age of 29.

3. **Autism Spectrum Disorders:**
   - Applied behavioral analysis – Coverage is unlimited.
   - The cost-sharing for applied behavior analysis treatment and assistive communication devices may be subject to deductibles, copayments and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract (e.g., primary care physician (PCP) office visit or specialist office visit).

4. **Benefit Limits:**
   - Benefit limits may be per plan or calendar year for group coverage (as permitted by law) and should be consistent with how the coverage renews (per plan year or calendar year) unless otherwise required by law.

5. **Cost-Sharing:**
   - The cost-sharing for benefits may vary as otherwise permitted by the Insurance Law.
   - If the cost of the service is less than the copayment for the service, the insured is only responsible for the lesser amount.
   - The insured's coinsurance may not exceed 50%.

6. **Deductibles:**
   - Deductibles, in total, cannot exceed the out-of-pocket limit in Section 2707(b) of the Public Health Service Act, 42 U.S.C. § 300gg-6.

7. **Diabetic Equipment, Supplies & Self-Management Education:**
   - Such coverage may be subject to annual deductibles, copayments and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract (e.g., PCP office visit or specialist office visit).
   - This benefit should appear in the base policy or contract and should not be addressed through a prescription drug rider unless the prescription drug rider would provide a more generous benefit than the base policy or contract (i.e., lower cost-sharing).

8. **Dialysis:**
   - EPOs and HMOs that provide coverage for dialysis are required to cover dialysis when performed by a non-participating provider located outside their service area, subject to any applicable cost-sharing that applies to dialysis treatments by a participating provider. The out-of-network coverage may be limited to 10 visits per calendar year. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a participating provider and the non-participating provider's charge.

9. **Domestic Partner Coverage**:
   - Insurers and HMOs may offer groups the option for domestic partner coverage.
   - Coverage for domestic partners should include both same and opposite sex domestic partners.

10. **Emergency Care:**
    - Coverage is required to be provided in the United States, its possessions, Canada and Mexico.
    - Insurers and HMOs are required to hold insureds harmless for any nonparticipating provider charges for emergency services in hospital facilities that exceed the in-network copayment, coinsurance or deductible.

11. **Extension of Benefits:**
    - The extension of benefits provision for group coverage in 11 NYCRR 52.18(b)(4) provides that if an insured is totally disabled on the day the coverage ends, the insurer will continue to pay for an insured's hospital confinement or surgery performed in the next 31 days for injury, sickness or pregnancy causing the total disability.
    - The extension of benefits provision for group coverage in 11 NYCRR 52.18(b)(5) also provides that if an insured is totally disabled on the day the

coverage ends due to the termination of active employment, the insurer will continue to pay for the insured's care during an uninterrupted period of disability until the insured is either no longer disabled or 12 months from the date the policy is terminated.

- It is reasonable to conclude that an insured is "totally disabled" if the insured is an inpatient in the hospital because the definition of "totally disabled" is that the person is prevented because of injury or disease from engaging in any work or other gainful activity. As such, if an insured is hospitalized at the time the policy is terminated, the previous insurer should continue to pay for the hospital stay until such time that the insured is no longer totally disabled or until the end of the requisite period.

12. External Appeal Rights for Out-of-Network Denials:

- **Out-of network service denial.** HMOs and comprehensive insurance products that use a network of providers (e.g., EPO and PPO) are required to provide external appeal rights if the plan is unable to provide a requested service in-network and the plan recommends an in-network service that the plan asserts is not materially different from the requested service.
- **Out-of-network referral denial.** HMOs and comprehensive insurance products that use a network of providers (e.g., EPO and PPO) are required to provide external appeal rights if the plan denies a referral or authorization to a non-participating provider because a participating provider with the appropriate training and experience to meet an insured's health care needs is able to provide the requested service.

13. HMO Look Alike: (EPO coverage that does not meet the definition of a managed care plan.)

- EPOs may use a gatekeeper and, when doing so, should adhere to all HMO protections.

14. Home Health Care:

- Insurers and HMOs are required to cover 40 or more home health care visits.

15. Hospice Make Available Benefit:

- Insurers and HMOs are required to make available coverage for at least 210 days of inpatient hospice care in a hospice or in a hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies, and five visits for bereavement counseling.

16. Mammography, Screening and Diagnostic Imaging for the Detection of Breast Cancer (Including Diagnostic Mammograms, Breast Ultrasounds, and MRIs):

- Screening and diagnostic imaging for the detection of breast cancer (including diagnostic mammograms, breast ultrasounds, and MRIs) must be covered at no cost-sharing.

- **High Deductible Health Plans (HDHPs).** To be used with a Health Savings Account (HSA), federal requirements provide that HDHPs should include a deductible that is applied to all benefits under the policy, except preventive care. Internal Revenue Bulletin 2004-15 (Notice 2004-23) Health Savings Accounts—Preventive Care, provides a list of services that are considered preventive care and thus may be exempt from the deductible in a HDHP. The Bulletin specifically provides that preventive care is not limited to the list (the list is illustrative, not exhaustive). Further, the list specifically recognizes diagnostic procedures ordered in connection with routine examinations and also separately lists breast cancer screenings as preventive services. As such, HDHPs that exempt screening and diagnostic imaging for breast cancer from the deductible for compliance with Chapter 74 of the Laws of 2016 should be qualified to be used with an HSA.
- **Tomosynthesis (3D mammograms).** Tomosynthesis (3D mammograms) fall under the definition of mammography screening and must be covered at no cost-sharing when medically necessary.

17. Maternal Depression Screening:

- Insurers and HMOs may not limit an insured's direct access to screening and referral for maternal depression from a provider of obstetrical, gynecologic or pediatric services.

18. Maternity Care:

- Maternity care coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Coverage also includes parent education, training and assistance in breast or bottle feeding, and any maternal or newborn clinical assessments.
- Coverage is provided for one home care visit (not counting against the insured's home health care visit limit) if the mother is discharged prior to 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. The home care visit is not subject to cost-sharing.
- Coverage includes the services of a midwife.
- Coverage includes breastfeeding support, counseling and supplies, including the cost of renting or purchasing one breast pump per pregnancy for the duration of breast feeding, with no cost-sharing.

19. Mental Health Care and Substance Use:

- Outpatient mental health services and substance use services include but are not limited to partial hospitalization program services and intensive outpatient program services.
- Insurers and HMOs should provide coverage in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of substance use disorder.

- Coverage for medication-assisted treatment (including methadone treatment) is provided as part of the outpatient substance use services benefit. Coverage is based on the site of service and includes coverage in the acute phase or subsequent phases on a maintenance basis.
- Coverage for suboxone and subutex are provided as part of the prescription drug benefit if coverage is provided for prescription drugs.
- Residential treatment facilities, including comprehensive care centers for eating disorders, are required to be covered if a policy covers similar intermediate levels of care for treatment of medical or surgical conditions. Similar intermediate levels of care may include coverage of skilled nursing facilities or inpatient rehabilitation benefits. Services that are otherwise covered under a policy may not be excluded when provided by a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law.
- Family counseling is not generally required to be covered except the limited benefit for 20 family visits relating to substance use found under the outpatient substance use services benefit.
- Insurers and HMOs may not apply any financial requirement or other quantitative treatment limitations to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement of the type applied to substantially all medical/surgical benefits in the same classification. See 45 C.F.R. § 146.136(c)(2)(i).
- Insurers and HMOs may not impose more stringent utilization review requirements (e.g., preauthorization) for mental health or substance use disorder benefits than imposed on medical/surgical benefits. See 45 C.F.R. § 146.136(c)(4).

20. Networks:

- Insurers and HMOs may use a preferred network for some or all benefits. However, many benefits mandated by Sections 3221 and 4303 of the Insurance Law include requirements that the cost-sharing be consistent with other benefits within the policy. Insurers and HMOs with preferred networks should comply with the consistent cost-sharing requirement for those benefits in both tiers.
- Insurers and HMOs should explain in the filing how the tiered network is developed and describe the criteria used to determine how providers are placed into each tier.

21. Out-of-Pocket Limit:

- The cost-sharing may not exceed the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code. For 2018, the amounts are $7,350 for individual coverage and $14,700 for other than individual coverage (e.g., individual/spouse, parent and child/children and family). See Section 2707(b) of the Public Health Service Act, 42 U.S.C. § 300gg-6.

22. Prescription Drug Coverage (if provided by the insurer or HMO):

- Plans may have a one, two, or three tier prescription drug benefit structure.
- Maintenance drugs are generally defined in the model contract language. However, insurers and HMOS have flexibility in determining what drugs are considered maintenance drugs.
- Insurers and HMOs may require insureds to use designated pharmacies for certain prescription drugs to treat certain conditions and may add to or subtract from the list of designated pharmacy prescription drugs in the model language.
- Insurers and HMOs should cover at least one drug in every United States Pharmacopeia (USP) category and class. Insurers and HMOs should not place all prescription drugs to treat a specific condition on the highest cost tier.
- Insurers and HMOs may include a provision that permits the insurer or HMO to charge an additional amount ("ancillary charge") when a prescription drug covered under the policy or contract on a higher tier is dispensed at the insured's or provider's request when a chemically equivalent prescription drug is available on a lower tier, unless the prescription drug on a higher tier is medically necessary.
    - The insured, the insured's designee or provider may request coverage for the prescription drug at the higher tier. A denial of coverage of the prescription drug at the higher tier (e.g., imposition of the ancillary charge) is subject to the utilization review and external appeal process described in Article 49 of the Insurance Law and Public Health Law.
    - If a prescription drug that requires preauthorization is subject to the ancillary charge and a request for preauthorization is made, the insurer or HMO should review the request for the prescription drug at the higher tier. If a chemically equivalent prescription drug is available on a lower tier and the ancillary charge will be applied, the insurer or HMO should issue a utilization review denial in accordance with the requirements of Section 4903 of the Insurance Law and Public Health Law.
    - Insurers and HMOs should include a description of the ancillary charge process, including how the insured or the insured's provider may request coverage of the higher tier prescription drug, along with the list of prescription drugs subject to the charge, on their websites.

23. Preventive Services:

- For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, insurers and HMOs should provide the coverage for such items or services no later than six months from when the recommendation is made.

24. Service Areas:

- Insurers and HMOs should offer all plans across their entire service area (the geographical area where they provide health insurance coverage) unless otherwise approved by the Superintendent. Insurers and HMOs seeking to

offer a limited network plan should submit a written proposal to the Superintendent. HMOs should also submit such proposals to the Department of Health.

25. Surgical Services:

- Exclusions for specific types of surgeries (e.g., Bariatric Surgery, Reconstructive, etc.) are not permitted.
- Insurers and HMOs may impose a medical necessity review for covered surgical services.

26. Telemedicine Programs:

- Telemedicine programs are permitted.

27. Termination:

- Coverage will terminate as of the last day premiums were paid.
- The policy or contract form should specify whether a grace period is applicable.

28. Tobacco Use Screening, Counseling & Medications:

- The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Insurers and HMOs are required to cover screening for tobacco use and at least two tobacco cessation attempts per year at no cost-sharing. A tobacco cessation attempt includes:
  - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group or individual counseling) without prior authorization; and
  - All FDA-approved tobacco cessation medications (including prescription and over-the-counter medications) for a 90-day treatment when prescribed by a health care provider without prior authorization.

29. Wellness:

- Wellness programs are permitted and are defined as programs designed to promote health and prevent disease that may contain rewards and incentives for participation. Insurers and HMOs should provide a detailed description of the wellness program and any reward being offered as part of the wellness program. The description should include how the insured accesses and participates in the wellness program, a description of the wellness activities, and the rewards. All wellness programs and any rewards should have a nexus to accident and health insurance.