

Filing Guidance

Priority of Review and Filing Types

What is the Priority of Review?*

A filing can achieve expedited review if it is submitted under one of the following filing types:

[Certification by Checklist](#)
[Certification by Previously Approved Form](#)
[Certification by Template](#)
[Prior Approval Prefiling](#)
[Rate Adjustment Pursuant to Section 3231\(e\)\(1\)](#)
[Rate Adjustment Pursuant to Section 4308\(c\)](#)
[Section 3201\(b\)\(6\) Deemer](#)

Filing types available for submission to the Health Bureau that receive the standard priority of review are:

[Advertising \(for Medicare Supplement filings\)](#)
[Filed for Reference](#)
[Group Prefiling Notification](#)
[Network Adequacy](#)
[Normal Pre-Approval](#)
[Out-of-State \(applicable to domestic insurers only\)](#)
[Underwriting Guidelines](#)

Filing types available for various reports that must be filed with the Health Bureau are:

[Comp Med Membership Survey](#)
[Experience Monitoring / Reporting](#)
[Healthy New York Stop Loss](#)
[HHS MLR Annual Rebate Report](#)
[LTC Claims Denial Report](#)
[LTC Replacement and Lapse Report](#)
[LTC Rescission Report](#)
[Med Supp Market Stabilization](#)
[Med Supp Refund Calculation Report](#)
[Multiple Med Supp Report](#)

SERFF filings receive a higher priority of review than paper filings regardless of the filing type chosen above.

What is each Filing Type and When can I use it?

Below is a description of each of these methods and when each is available for use. Please note that pursuant to Insurance Law § 3201 (a), “policy form” includes a policy, contract, certificate, amendment, endorsement, rider, application, or enrollment form.

Special filing types, instructions, checklists and exhibits to be used for individual and small group comprehensive medical products (On and Off Exchange) and stand-alone dental products are announced each spring on the DFS [website](#).

Expedited Review Filing Types

Certification by Checklist

Description: This filing type may only be used when an appropriate product checklist is available on the Department's web site. Use of this filing type is beneficial to companies that are making a policy form submission where the company has diligently completed the product checklist and followed all applicable regulations and statutes in its preparation of the filing.

Availability: The Certification by Checklist process may be used for:

- all form and rate submissions,¹ and
- all form only submissions², but
- not applicable to rate only submissions.³

Certification by Previously Approved Form

Description: This process may be used by insurers that are making a policy form submission where the major portion of the policy form was previously approved but the new submission reflects some proposed changes to the same policy form. The policy form upon which the new submission is based must have been approved within three years of the date of the new submission. Under this method, the insurer knows in advance that the major portion of the policy form is acceptable and that review will be primarily based on the proposed changes.

Availability: Only if the previous form was approved within three years of the date of submission, the Certification by Previously Approved Form process may be used for:

- all form only submissions², or
- all form and rate submissions¹, but
- not for rate only submissions.³

Certification by Template

Description: This process may be beneficial to companies that frequently file policy form submissions. A template consists of language commonly included by an insurer in its various form filings without variation. The template upon which the new submission is based must have been approved within three (3) years of the date of the new submission. Under this method, the insurer knows in advance that the major portion of the policy form is acceptable and that review will be primarily based on the proposed changes.

Availability: The Certification by Previously Approved Form process may be used for:

- all form only submissions,² or
- all form and rate submissions,¹ but
- not for rate only submissions.³

Prior Approval Prefiling

Description: This filing type is used for advance filings by Article 42 insurers, Article 43 Corporations, and Health Maintenance Organizations (HMOs) that plan to submit a rate adjustment filing pursuant to Insurance Law §§ 3231(e)(1) or 4308(c). This prefilling must contain a draft of the initial notice to policy/certificate holders of proposed premium rate adjustments and a draft of the narrative summary explaining the reason(s) for the proposed rate. This prefilling is required to be submitted at least 10 calendar days before submitting a premium rate adjustment application. The final forms of the initial notice and the narrative summary must be included with

the insurer's rate adjustment application. Refer to [Insurance Circular Letter No. 12 \(2011\)](#) for more information.

Availability: The Prior Approval Prefiling filing type is a rate only submission.

Rate Adjustment Pursuant to Section 3231(e)(1)

Description: This filing type may be used for insurers to file rate adjustments for Medicare Supplement insurance. This filing type is not used for rate adjustments for long term care insurance or individual and small group comprehensive medical insurance (On or Off Exchange).

Availability: This filing type may only be used for the following rate only submission for rate adjustment filings by commercial insurers (Article 42), not by a non-profit corporation (Article 43) or an HMO.

Rate Adjustment Pursuant to Section 4308(c)

Description: This filing type may be used for corporations or HMOs to file rate adjustments for Medicare Supplement insurance or large group HMOs. This filing type is not used for rate adjustments for long term care insurance or individual and small group comprehensive medical insurance (On and Off Exchange).

Availability: This filing type may only be used for the following rate only submission for rate adjustment filings by a non-profit corporation (Article 43) or an HMO, not by a commercial insurer (Article 42).

Section 3201(b)(6) Deemer

Description: This filing type is available for submissions that contain policy forms. Section 3201(b)(6) provides specific timeframes for action on the filing or it may be deemed approved or denied. For example, within 90 days of receipt, the Department must approve, deny or detail additional information to make a determination. However, if the filing is incomplete or noncompliant, the Department may close the file within 60 days of receipt.

Availability: The Section 3201(b)(6) Deemer process may be used for:

- all form only submissions,² or
- all form and rate submissions,¹ but
- not for rate only submissions.³

Standard Review Filing Types

Advertising (for Medicare Supplement filings)

Description: This filing type should be used to file only Medicare Supplement advertising. Advertising is not filed for any other products such as long term care insurance, however, insurers are required to keep advertising for all products in compliance with Regulation 34 (11 NYCRR Part 215).

Availability: This filing type is a form only submission and is used for Medicare Supplement insurance advertising only.

Filed for Reference

Description: This filing type is available for submissions that contain documents that do not meet the description of a policy form as defined by Insurance Law § 3201(a). Initial rate filing or a rate adjustment filing should not use this filing type.

Availability: The Filed for Reference filing type is available with the following submissions that do not contain policy forms, initial rates or rate adjustments:

- form only (such as outline of coverage and other disclosure material),²
- form and rate (statement of variability),¹ and
- rate only (rate filings for use outside of New York).³

Group Prefiling Notification (11 NYCRR 52.32)

Description: Insurers writing group coverage (other than statutory Disability Benefits Law coverage) may provide coverage for a specific policyholder prior to the filing and approval of policy forms. The filing type is used to submit the required notice of the effective date of coverage and the benefits. This procedure may only be used:

- (1) on a single case basis;
- (2) when it is not reasonably possible for the insurer to obtain approval prior to the effective date of coverage; and
- (3) when the insurer has a reasonable expectation of approval of the appropriate forms by the Department.

The insurer must seek formal approval of the policy forms and rates. Insurers are strongly encouraged to submit policy forms and rates within 60 days of the date the insurer agreed to provide coverage using the appropriate filing type.

For products subject to guaranteed availability requirements, any approval of subsequent form filings submitted for a prefilling will be subject to the condition that the forms will be offered on a general availability basis and not limited to a particular group or groups. Any non-grandfathered health plans⁴ that were previously approved on a single case basis and are in effect on or after January 1, 2014, must be made generally available to any other large group that seeks that same coverage.

To minimize the need to use the prefilling process, insurers are strongly encouraged to use variable material for inclusion in the group policy forms, especially with respect to cost-sharing provisions in the policy form or schedule of benefits.

The prefilling process should not be used for any innovative or unique products, features, or benefits. In general, an innovative or unique product, feature, or benefit would include one that has not been previously approved and would be new to the New York accident and health insurance marketplace. For innovative or unique products, features, or benefits, insurers should meet with the Department early in the product development process prior to making a submission.

Availability: Group Prefiling Notification filing type is a form only submission and may only be used with group coverage other than statutory Disability Benefits Law coverage. It may not be used with individual or blanket coverage.

Network Adequacy

Description: This filing type is used for submission of provider networks for medical, stand-alone dental and/or vision products. Submission instructions, standards and guidance are available on the [Department website](#).

Availability: The Network Adequacy filing type is a form only submission.

Normal Pre-Approval

Description: This filing type is the standard filing type for a filing containing forms and/or rates that do not qualify for one of the expedited filing types listed above.

Availability: The Normal Pre-Approval filing type may be used for:

- all form only submissions,²
- all form and rate submissions,¹ and
- rate only submissions including commission schedules and experience rating formula filings, but excluding any rate adjustment filing subject to Section 3231(e)(1) or 4308(c).³

Out-of-State (applicable to domestic insurers only)

Description: Domestic insurers are required to file all accident and health policy forms intended for use outside New York with the Department before their issuance under Section 3201(b)(2). This filing type may not be used for submissions pursuant to Regulation 123 (11 NYCRR 59) where coverage is issued out-of-state to cover New York residents.

Availability: The Out-of-State filing type is a form only submission.

Underwriting Guidelines

Description: 11 NYCRR 52.40 requires that an insurer's underwriting rules be submitted to DFS. Historically, insurers have included their underwriting guidelines as part of the rate manual. Due to the substantial changes to the market because of the Patient Protection and Affordable Care Act (ACA), DFS requires insurers to separately file their underwriting guidelines for reference for comprehensive hospital, medical and surgical coverage issued in the individual, small group and large group markets.

Availability: The Underwriting Guidelines filing type is a form only submission.

Report Filing Types

Comp Med Membership Survey

Description: This filing type is used to collect enrollment information for all individual and small group On & Off Exchange (including Healthy New York) comprehensive health insurance policies and large group comprehensive health insurance policies.

Availability: The Comp Med Membership Survey filing type is a rate only submission.

Experience Monitoring / Reporting

Description: This filing type may be used for the annual filing of the following:

- experience data as required under 11 NYCRR 52.44(a) and (b) for individual policies;
- experience monitoring/reporting as required under 11 NYCRR 59.7(b), or
- experience data for individual and group Medicare Supplement policies as required under 11 NYCRR 52.40(k).

Availability: The Experience Monitoring/Reporting filing type is a rate only submission. Use this filing type ONLY if the experience data is submitted separately from a rate adjustment request.

Healthy New York Stop Loss

Description: This filing type is used to submit reports for reimbursement from the Healthy New York Funds.

Availability: The Healthy New York Stop Loss filing type is a rate only submission.

HHS MLR Annual Rebate Report

Description: Insurance Law §§ 3231(e)(1) and 4308(c) require an annual loss ratio report to be submitted to the Department by June 30 of the following year for policies subject to these sections, except Medicare Supplement insurance policies. For products subject to these sections and which are subject to the Department of Health and Human Services (HHS) medical loss ratio (MLR) annual reporting form and rebate testing, submitting a copy of the HHS MLR annual reporting form by June 30 will satisfy the reporting requirement of these sections. Insurers completing this form should follow the HHS methodology and instructions using the reporting forms prescribed by HHS. See also Circular Letter No. 15 (2011) and the loss ratio reporting guidance posted on the Department's website. For Medicare Supplement products refer to filing types Experience Monitoring/Reporting and Med Supp Refund Calculation Report.

In addition, this submission would then be amended by August 1st to indicate whether, in accordance with HHS requirements, the insurer has paid any rebates to policyholders. If rebates have been or will be paid, the amount of such rebates by each market segment (i.e., aggregation pool) is to be reported to DFS using this amendment process.

Availability: The HHS MLR Annual Rebate Report filing type is a rate only submission.

LTC Claims Denial Report

Description: This filing type is used for insurers filing one of the three required reports relating to long term care insurance with the Department. The Claims Denial report is due March 1 each year.

Availability: The LTC Claims Denial Report filing type is a form only submission.

LTC Replacement and Lapse Report

Description: This filing type is used for insurers filing the three required reports relating to long term care insurance with the Department. The Lapse and Replacement report is due June 30 each year.

Availability: The LTC Replacement and Lapse Report filing type is a form only submission.

LTC Rescission Report

Description: This filing type is used for insurers filing the three required reports relating to long term care insurance with the Department. The Rescission report is due March 1 each year.

Availability: The LTC Rescission Report filing type is a form only submission.

Med Supp Market Stabilization

Description: This filing type is used to submit reports for all Medicare Supplement Policies subject to Chapter 501 of the Laws of 1992 pertaining to community rating and open enrollment.

Availability: The Med Supp Market Stabilization filing type is a rate only submission.

Med Supp Refund Calculation Report

Description: This filing type is used to submit the report required for all individual and group Medicare Supplement policies per 11 NYCRR 52.44(c), entitled Premium Refund or Credit Calculation for Individual and Group Medicare Supplement Policies. The report is due by May 1 of each year. The reporting and refund calculation form is found in 11 NYCRR 52.28 for each type in a standard Medicare Supplement benefit plan. See also the loss ratio reporting guidance posted on the Department's website.

Availability: The Med Supp Refund Calculation filing type is a rate only submission.

Multiple Med Supp Report

Description: On or before March 1st of each calendar year, each issuer is required to report the information specified in 11 NYCRR 58.1(h) for every NYS resident for which the issuer has in force more than one Medicare supplement insurance policy or certificate. The information shall be reported using the form included in the regulation.

Availability: The Multiple Med Supp Report filing type is a form only submission.

* The Health Bureau has periodically modified its filing process to help expedite the prior approval of policy forms and rates, including the following:

- Circular Letter No. 4 (2003) announced a new procedure for expedited prior approval by Certifications (Certification by Checklist, Previously Approved Form, and Certification by Template).
- Circular Letter No. 9 (2004) announced that the Bureau would begin receiving electronic filings via **SERFF** and how those filings would be prioritized.

¹ “*Form and rate*” filings are the predominant filing method because the overwhelming majority of changes in benefit language result in corresponding changes in premium. If changes in language have no rate impact, an actuarial certification to that effect is still required, making that submission a form and rate submission. (see [the Filing Guidance on Submissions with No Rate Impact](#))

² “*Form only*” filings are limited to applications or enrollment forms or documents filed for reference/informational purposes.

³ “*Rate only*” filings are limited to changes in rates to existing products (for example, rate increases, rate decreases, or changes in ratio calculation rules or procedures).

⁴ A grandfathered health plan is hospital, medical, or surgical expense insurance coverage in which an individual was enrolled on March 23, 2010, for as long as the coverage maintains grandfathered status in accordance with Section 1251(e) of the Affordable Care Act, 42 U.S.C. §18011(e).