*** § 3231. Rating of individual and small group health insurance policies; approval of superintendent.** (a) (1) No individual health insurance policy and no group health insurance policy covering between one and fifty employees or members of the group or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen exclusive of spouses and dependents, hereinafter referred to as a small group, providing hospital and/or medical benefits, including medicare supplemental insurance, shall be issued in this state unless such policy is community rated and, notwithstanding any other provisions of law, the underwriting of such policy involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual health insurance coverage, including medicare supplemental coverage, or small group health insurance coverage, including medicare supplemental insurance, but not including coverage issued on or after January first, two thousand fourteen, specified in subsection (l) of section three thousand two hundred sixteen, of this article must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the insurer to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (g) of section three thousand two hundred sixteen or subsection (p) of section three thousand two hundred twenty-one of this article. Group hospital and/or medical coverage, including medicare supplemental insurance, obtained through an out-of-state trust covering a group of fifty or fewer employees, or between one and one hundred employees for policies issued or renewed on or after January first, two thousand sixteen, or participating persons who are residents of this state must be community rated regardless of the situs of delivery of the policy. Notwithstanding any other provisions of law, the underwriting of such policy may involve no more than the imposition of a pre-existing condition limitation if permitted by this article, and once accepted for coverage, an individual or small group cannot be terminated due to claims experience.

Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (p) of section three thousand two hundred twenty-one of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy form is the same based on the experience of the entire pool of risks of all individuals or small groups covered by the insurer without regard to age, sex, health status, tobacco usage or occupation, excluding those individuals or small groups covered by medicare supplemental insurance. For medicare supplemental insurance coverage, "community rated" means a rating methodology in which the premiums for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, tobacco usage or occupation.

(b) (1) The superintendent may set standard premium tiers and standard rating relativities between tiers applicable to all policies subject to this section. The superintendent may set a standard relativity applicable to child-only policies issued pursuant to section 1302(f) of the affordable care act, 42 U.S.C. § 18022(f). The relativity for child-only policies shall be actuarially justifiable using the aggregate experience of insurers to prevent the charging of unjustified premiums. The superintendent may adjust such premium tiers and relativities periodically based upon the aggregate experience of insurers. (2) An insurer shall establish separate community rates for individuals as opposed to small groups. (3) If an insurer is required to issue a policy to individual proprietors pursuant to subsection (i) of this section, such policy shall be subject to subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the insurer in its rate filing so long as the insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the insurer's community rates. (2) Beginning on January first, two thousand fourteen, for every policy subject to this

section that provides physician services, medical, major medical or similar comprehensive-type coverage, except for medicare supplement plans, insurers shall use standardized regions established by the superintendent.

(d) (1) Notwithstanding any other provision of this chapter to the contrary, no policy form subject to this section shall be issued or delivered, nor any insurance contract entered into, unless and until the insurer has filed with the superintendent a schedule of premiums, not to exceed twelve months in duration, to be paid under the policy forms and obtained the superintendent's approval thereof. The superintendent may refuse such approval if he or she finds that such premiums are excessive, inadequate, or unfairly discriminatory. The superintendent may consider the financial condition of such insurer in approving or disapproving any premium. In determining whether to approve the schedule of premiums filed, the superintendent shall, subject to the provisions of section three thousand two hundred thirty-three of this article, consider the prior experience of the insurer's community pool and the insurer's projections relating to claim costs, utilization and administrative expenses and shall not adjust the insurer's rates based upon the rates approved for other insurers.

(2) An insurer shall provide specific claims experience to a municipal corporation, as defined in subsection (f) of section four thousand seven hundred two of this chapter, covered by the insurer under a community rated policy when the municipal corporation requests its claims experience for purposes of forming or joining a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter. Notwithstanding the forgoing provisions, no insurer shall be required to provide more than three years' claims experience to a municipal corporation making this request.

(e) (1) (A) An insurer desiring to increase or decrease premiums for any policy form subject to this section shall submit a rate filing or application to the superintendent.

An insurer shall send written notice of the proposed rate adjustment, including the specific change requested, to each policy holder and certificate holder affected by the adjustment on or before the date the rate filing or application is submitted to the superintendent. The

notice shall prominently include mailing and website addresses for both the department of financial services and the insurer through which a person may, within thirty days from the date the rate filing or application is submitted to the superintendent, contact the department of financial services or insurer to receive additional information or to submit written comments to the department of financial services on the rate filing or application. The superintendent shall establish a process to post on the department's website, in a timely manner, all relevant written comments received pertaining to rate filings or applications. The insurer shall provide a copy of the notice to the superintendent with the rate filing or application. The superintendent shall immediately cause the notice to be posted on the department of financial services' website. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. The superintendent may modify or disapprove the rate filing or application if the superintendent finds that the premiums are unreasonable, excessive, inadequate, or unfairly discriminatory, and may consider the financial condition of the insurer when approving, modifying or disapproving any premium adjustment. The determination of the superintendent shall be supported by sound actuarial assumptions and methods, and shall be rendered in writing between thirty and sixty days from the date the rate filing or application is submitted to the superintendent. Should the superintendent require additional information from the insurer in order to make a determination, the superintendent shall require the insurer to furnish such information, and in such event, the sixty days shall be tolled and shall resume as of the date the insurer furnishes the information to the superintendent. If the superintendent requests additional information less than ten days from the expiration of the sixty days (exclusive of tolling), the superintendent may extend the sixty day period an additional twenty days to make a determination. The application or rate filing will be deemed approved if a determination is not rendered within the time allotted under this section. An insurer shall not implement a rate adjustment unless the insurer provides at least sixty days advance written notice of the premium rate adjustment approved by the superintendent to each policy holder and certificate holder affected by the rate adjustment.

(B) The expected minimum loss ratio for a policy form subject to this section, for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance policy, or, with the approval of the superintendent, an aggregation of policy forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than July thirty-first of each year, every insurer subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the insurer to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue dividends, premium refunds or credits, or any combination of these.

(2) (A) Until September thirtieth, two thousand ten, as an alternate procedure to the requirements of paragraph one of this subsection, an insurer desiring to increase or decrease premiums for any policy form subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that: (i) the anticipated minimum loss ratio for a policy form shall not be less than eighty-two percent of the premium; and (ii) the insurer submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that the insurer is in compliance with the provisions of this paragraph, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the insurer in establishing premium rates for policy forms subject to this section. An insurer shall not utilize the alternate procedure pursuant to this paragraph to implement a change in rates to be effective on or after October first, two thousand ten.

(B) Each calendar year, an insurer shall return, in the form of aggregate benefits for each policy form filed pursuant to the alternate

procedure set forth in this paragraph at least eighty-two percent of the aggregate premiums collected for the policy form during that calendar year. Insurers shall annually report, no later than June thirtieth of each year, the loss ratio calculated pursuant to this paragraph for each such policy form for the previous calendar year. In each case where the loss ratio for a policy form fails to comply with the eighty-two percent loss ratio requirement, the insurer shall issue a dividend or credit against future premiums for all policy holders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal eighty-two percent of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy holder who had a policy which was in effect at any time during the applicable year. The dividend or credit shall be prorated based on the direct premiums earned for the applicable year among all policy holders eligible to receive such dividend or credit. An insurer shall make a reasonable effort to identify the current address of, and issue dividends or credits to, former policy holders entitled to the dividend or credit. An insurer shall, with respect to dividends or credits to which former policy holders that the insurer is unable to identify after a reasonable effort would otherwise be entitled, have the option, as deemed acceptable by the superintendent, of prospectively adjusting premium rates by the amount of such dividends or credits, issuing the amount of such dividends or credits to existing policy holders, depositing the amount of such dividends or credits in the fund established pursuant to section four thousand three hundred twenty-two-a of this chapter, or utilizing any other method which offsets the amount of such dividends or credits. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include an insurer's calculation of the dividends and credits, as well as an explanation of the insurer's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of

cancellation or termination by a policy holder.

(3) All policy forms subject to this subsection, other than medicare supplemental insurance policy forms, issued or in effect during calendar year two thousand ten shall be subject to a minimum loss ratio requirement of eighty-two percent. Insurers may use the alternate filing procedure set forth in paragraph two of this subsection to adjust premium rates in order to meet the required minimum loss ratio for calendar year two thousand ten. The rate filing or application shall be submitted no later than September thirtieth, two thousand ten.

(f) (1) In the case of disapproval or modification of a requested rate change by more than twenty percent for any policy to which prior approval applies, the insurer shall have the right to request a hearing before the superintendent, or his or her representative, in order for the insurer to present any evidence, arguments or other information as to why the insurer believes the superintendent's disapproval or modification is not appropriate. Such hearing shall not be a required condition prior to any challenge to the disapproval or modification pursuant to the civil practice law and rules, but if an insurer challenges the superintendent's disapproval or modification pursuant to the civil practice law and rules, the insurer shall not be entitled to such hearing. An insurer entitled to such hearing must make a written request for such hearing no later than thirty days after the date of the superintendent's decision. The hearing shall be held as soon as practicable thereafter, but not sooner than twenty days from receipt of the request for the hearing. A stenographic record of all hearings shall be made. The superintendent shall provide the insurer with a written response to the insurer's presentation at the hearing no later than forty-five days after the date of the hearing. The superintendent's written response pursuant to this subsection shall be subject to challenge as provided for in article seventy-eight of the civil practice law and rules.

(2) Such hearing shall not be required in any case where the superintendent returns the initial filing within thirty days on the basis that the premium increase or decrease requested by the insurer is unreasonable.

(g) * (1) (A) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred

thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups having one hundred or fewer employees or members exclusive of spouses and dependents. For a policy issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection. (B) Subparagraph A of this paragraph shall not apply to either the renewal of a policy issued to a group or the issuance, between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of a policy, and any renewal thereof, to a group, provided that the following three requirements are met: (I) the group had been issued a policy that was in effect on July first, two thousand fifteen; (II) the group had member employers, who, on or after July first, two thousand fifteen, have between fifty-one and one hundred employees, exclusive of spouses and dependents; and (III) the group is either: (i) comprised entirely of one or more municipal corporations or districts (as such terms are defined in section one hundred nineteen-n of the general municipal law); or (ii) comprised entirely of nonpublic schools providing education in any grade from pre-kindergarten through twelfth grade.

* NB Effective until December 28, 2028

* (1) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have one hundred or fewer employees or members exclusive of spouses and dependents. For policies issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection.

* NB Effective December 28, 2028

(2) If a policy is issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including an association group, that includes one or more individual or individual proprietor members, for rating purposes the insurer shall include such members in its individual pool of risks in establishing premium rates for such members.

(h) * (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. Provided, however, the provisions of this paragraph shall not apply to: (A) the renewal of stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen to small groups covering between fifty-one and one hundred employees or members of the group; and (B) the issuance between January first, two thousand sixteen and December thirty-first, two thousand sixteen, of stop loss, catastrophic or reinsurance coverage, and any renewal thereof, to a small group covering between fifty-one and one hundred employees or members of the group, provided that such group had stop loss, catastrophic or reinsurance coverage issued and in effect on January first, two thousand fifteen.

* NB Effective until December 28, 2028

* (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section.

* NB Effective December 28, 2028

(2) This subsection shall not apply to coverage insuring a plan which was in effect on or before December thirty-first, nineteen hundred ninety-one and was issued to a group which includes member small

employers or other member small groups, including but not limited to association groups, provided that (A) acceptance of additional small member employers (or other member groups comprised of fifty or fewer employees or members, exclusive of spouses and dependents) into the group on or after June first, nineteen hundred ninety-two and before April first, nineteen hundred ninety-four does not exceed an amount equal to ten percent per year of the total number of persons covered under the group as of June first, nineteen hundred ninety-two, but nothing in this subparagraph shall limit the addition of larger member employers; (B) (i) after April first, nineteen hundred ninety-four, the group thereafter accepts member small employers and member small groups without underwriting by any more than the imposition of a pre-existing condition limitation as permitted by this article and the cost for participation in the group for all persons covered shall be the same based on the experience of the entire pool of risks covered under the entire group, without regard to age, sex, health status or occupation; and (ii) once accepted for coverage, an individual or small group cannot be terminated due to claims experience; (C) the insurer has registered the names of such groups, including the total number of persons covered as of June first, nineteen hundred ninety-two, with the superintendent, in a form prescribed by the superintendent, on or before April first, nineteen hundred ninety-three and shall report annually thereafter until such groups comply with the provisions of subparagraph (B) of this paragraph; and (D) the types or categories of employers or groups eligible to join the association are not altered or expanded after June first, nineteen hundred ninety-two.

(3) An insurer may apply to the superintendent for an extension or extensions of time beyond April first, nineteen hundred ninety-four in which to implement the provisions of this subsection as they relate to groups registered with the superintendent pursuant to subparagraph (C) of paragraph two of this subsection; any such extension or extensions may not exceed two years in aggregate duration, and the ten percent per year limitation of subparagraph (A) of paragraph two of this subsection shall be reduced to five percent per year during the period of any such extension or extensions. Any application for an extension shall demonstrate that a significant financial hardship to such group would result from such implementation.

(i)(1) If an insurer issues coverage to an association group (including chambers of commerce), as defined in subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, the insurer must issue the same coverage to individual proprietors which purchase coverage through the association group as the insurer issues to groups which purchase coverage through the association group; provided, however, that an insurer which, on the effective date of this subsection, is issuing coverage to individual proprietors not connected with an association group, may continue to issue such coverage provided that the coverage is otherwise in accordance with this subsection and all other applicable provisions of law.

(2) For coverage purchased pursuant to this subsection, through December thirty-first, two thousand thirteen, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand thirteen, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. Coverage purchased or renewed pursuant to this subsection on or after January first, two thousand fourteen shall be classified in the individual rating category.

(3) An insurer may require members of the association purchasing health insurance to verify that all employees electing health insurance are legitimate employees of the employers, as documented on New York state tax form NYS-45-ATT-MN or comparable documentation. In order to be eligible to purchase health insurance pursuant to this subsection and obtain the same group insurance products as are offered to groups, a sole employee of a corporation or a sole proprietor of an unincorporated business or entity must (A) work at least twenty hours per week, (B) if purchasing the coverage through an association group, be a member of the association for at least sixty days prior to the effective date of the insurance policy, and (C) present a copy of the following documentation to the insurer or health plan administrator on an annual basis:

(i) NYS tax form 45-ATT, or comparable documentation of active employee status;

(ii) for an incorporated business, the prior year's federal income tax

Schedule C for an incorporated business subject to Subchapter S with a sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or

(iii) for a business in business for less than one year, a cancelled business check, a certificate of doing business, or appropriate tax documentation; and

(iv) such other documentation as may be reasonably required by the insurer as approved by the superintendent to verify eligibility of an individual to purchase health insurance pursuant to this subsection.

(4) Notwithstanding the provisions of item (I) of clause (i) of subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, for the purposes of this section, an association group shall include chambers of commerce with less than two hundred members and which are 501C3 or 501C6 organizations.

* NB There are 2 § 3231's