DO YOU KNOW YOUR RIGHTS UNDER THE INSURANCE LAW?

The Insurance Law and Public Health Law include important protections for health care providers with respect to network participation, provider contracting, claims processing, and prompt payment for health care services. Some protections apply to all HMO and insurance coverage, while others apply only to HMO coverage and to managed care contracts offered by insurers.

Prompt Payment of Health Care Claims (NYS Insurance Law 3224-a): The "Prompt Payment Law" was enacted to provide protection to both patients and health care providers in by requiring the timely payment of claims by insurers and health maintenance organizations. Insurers and HMO's are ultimately responsible for compliance with this law despite any contractual delegation of the claims payment process

- HMOs and insurers are required to pay claims for health care services within **45 days of receipt**, except in cases where the obligation to make payment is not reasonably clear or there is evidence that the bill may be fraudulent.
- If the obligation to pay is disputed, then an HMO or insurer must notify the member or provider, in writing, within 30 calendar days of the receipt of the claim that the health plan is not obligated to pay and the reasons therefore.
- If the obligation to pay is not reasonably clear, then an HMO or insurer must, within 30 calendar days of the receipt of the claim, make a written request to the member or provider for additional information needed to determine liability to pay the claim.
- Upon receipt of the information requested, or an appeal of a claim for the denied health care services, an HMO or insurer shall comply with the 45 day payment requirement.
- If an HMO or insurer violates the prompt payment law, the HMO or insurer must pay interest on the claim at the higher of 12% per annum or the rate set by the commissioner of taxation and finance for corporate taxes pursuant to New York Tax Law Section 1096(e)(1). Interest is calculated from the date the claim or health care payment should have been made.
- You can report a prompt payment violation to the New York State Insurance Department. (http://www.dfs.ny.gov/insurance/dfs_insurance.htm)

Claims Processing (Insurance Law 3224-b):

- HMOs and insurers must accept and initiate the processing of all health care claims submitted by physicians that are consistent with the current version of the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions and the centers for Medicare and Medicaid services (CMS) health care common procedure coding system (HCPCS).

- HMOs and insurers must provide the name of the commercially available claims editing software product that the health plan utilizes and any significant edits on their provider websites and in provider newsletters. Health plans must also provide such information upon the written request of a participating physician.

Required Group, Blanket, & Article 43 Benefits (Insurance Law 3221 and 11 NYCRR 52.24):

- Any Group (commercial/HMO), Blanket or Article 43 insurer **must provide outpatient** chemical abuse and dependence services as a benefit under its contract.
  Coverage must include:
  - 60 out-patient visits per year (including at least 20 visits for family members)

- Any Group (commercial/HMO), Blanket or Article 43 insurer that provides coverage for inpatient hospital care must also **make available** inpatient coverage for the diagnosis and treatment of alcohol and substance abuse and dependence.
  Coverage must include at least:
  - 7 days detoxification per year
  - 30 days of in-patient treatment per year

- In New York State coverage for the treatment of chemical abuse and dependence must be provided for services rendered in an OASAS certified facility, even if the services were rendered by a provider who would not otherwise be reimbursed under a policy. An insurer may limit coverage to facilities which are certified by OASAS.

A Consumers Right to Obtain Information (Insurance Law Sections 3217-a & 4324 and Public Health Law Section 4408):

The following information must be disclosed to consumers who have coverage with an HMO or insurer and upon request to prospective members:

- Health Care Coverage: A description of health care benefits, benefit maximums, limitations and exclusions from coverage, including the definition of medical necessity. A description of which health care services require prior authorization and how to request prior authorization.

- Financial Responsibility: A consumer's financial responsibility for payment of premiums, coinsurance, co-payments and deductibles, along with annual limits on your financial responsibility, caps on payments for covered services and your financial responsibility for non-covered services. A description of how the health plan reimburses providers. An explanation of a consumer's financial responsibility for payment when a provider is not part of their health plan's network.

- The Grievance Procedure, including how to file a grievance, notice of a consumer's right to designate a representative for the grievance process and how to appeal a grievance determination.

- The Utilization Review Procedure when services are denied as not medically necessary, experimental or investigational, including how to file an appeal, notice of a consumer's right to designate a representative to appeal on their behalf, notice of the right to a redetermination and any further appeal rights.

- Access to Care: How to obtain various services and when prior authorization is and is not required. Any other requirements for treatments or services.
- Contacting Your Health Plan: Your health plan must provide a list of all appropriate mailing addresses and telephone numbers to be used by members to obtain information or authorization.

Other information must be disclosed upon request to consumers who have coverage with an HMO or insurer and to prospective members including, but not limited to:

- A list of names, business addresses, and official positions of the membership of the board of directors, officers and members of the corporation.
- A copy of the most recent individual direct payment subscriber contracts.
- Information relating to consumer complaints.
- The procedures for protecting the confidentiality of medical records.
- Drug formularies used by the health plan, including, if requested, whether individual drugs are included or excluded from coverage.
- The description of the procedures followed in making decisions about whether a drug, medical device, or treatment in a clinical trial is experimental or investigational.
- Individual health care practitioner affiliations with participating hospitals.
- Specific clinical review criteria relating to a particular disease including clinical information considered during utilization review.
- The written application procedures and minimum qualification requirements for health care providers to participate in the health plan's network.