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REPORT

New Reform Law Affects New York Managed Care Plans, Providers, and Members

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On July 28 Gov. David Paterson (D) signed into law three Governor's Program Acts designed to improve health insurance in New York. One of these laws, A. 8402 (the **"Act"**),[1] seeks to reform managed care by providing additional rights and protections to members, providers and health plans.[2] Most of the provisions discussed below take effect January 1, 2010 (unless otherwise noted below). Health plans will have to make some changes in their process before the effective date. The changes are discussed with each section below.

Some New Member Rights and Protections

The Act grants members of managed care plans additional rights and protections. Specifically, members enrolled in health maintenance organization **("HMO")** look-alike programs, such as Exclusive Provider Organizations, will now have the same benefits as HMO members with respect to grievances and appeals as well as access to specialty care. This means that Article 42 and Article 43 insurers will have to develop grievance and appeal processes by the effective date of these provisions, January 1, 2011.

Further, once the Act takes effect, policyholders will receive improved refunds when health plans miscalculate their premium needs. New York requires that policies issued to individuals and small groups return aggregate benefits of at least 75% of aggregated premiums each year.

Specifically, when a health plan fails to meet a minimum loss ratio and thus owes policyholders refunds or dividends, the health plan will now have to issue refunds to all current and former policyholders as opposed to issuing dividends or premium credits to only those policyholders as of December 31 of the applicable year (which is what insurers were previously allowed to do). This will entail considerable extra effort in order to quantify the amount of the refund on an individual or group basis and requires the health plan to seek out former policy holders.

Additionally, the Act imposes stricter mandates on health plans with respect to paying participating providers on an out-of-network basis—no longer can a health plan reimburse participating hospitals on a non-participating basis just because the admitting physician is not participating, nor can it pay a participating physician on a non-participating basis just because the care was rendered at a non-participating hospital.

Members who utilize home health care services after a hospital stay also should experience improvements as a result of this new Act, as it reduces time limits for health plans to make pre-certification and concurrent determinations with respect to home health care ser-

[1] This Act is the same as S 5472-A.

[2] One of the other acts included in the Governor's Program expands the state's mini-COBRA law by extending the continuation of coverage period from 18 to 36 months (A. 8400), and the other act passed by Gov. Paterson mandates that health plans offer an option to continue coverage for unmarried adults through age 29 under a parent's health insurance policy (A. 9038).

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vices from three days to one day and provides for an expedited appeal process beginning October 1, 2009.

Effective January 1, 2011, there will be a new limit of 120 days for insurance subscribers to submit claims, with certain exceptions.

Finally, members of managed care plans benefit from the Act because under the External Review Law, provisions have been added for 'rare disease' treatments.[3] Specifically, external reviews can be requested in the event that the member has a rare disease and the external review agent can take into account whether the treatment rejected by the health plan is ''likely to benefit'' the patient.

Some New Provider Rights and Benefits

The new Act also benefits providers. Specifically, it requires that clean claims submitted electronically must be paid by the health plan in 30 days, as opposed to 45 days currently[4]. Some health plans may have to adjust their claims payment cycles to accommodate this shortened time period.

There are also new limits on health plans' ability to deny or pend claims based on failure to receive coordination of benefits questionnaires. Such claims must now be adjudicated within the time limits required for clean claims.

Additionally, the Act extends limits on health plan overpayment recovery efforts that previously only applied to physicians to all types of providers. Following the enactment of the Act, the health plan must give 30 days' notice to all providers regarding a recovery and is limited to reviewing claims going back 24 months, with certain exceptions.[5] Prior to this change, there were no time limits on how far back a health plan could go when the provider was not a physician (other than any limits agreed to by contract and the limits imposed by the statute of limitations). Health plans will have to start their audit process earlier.

Professional providers also benefit from the Act because it mandates that health plans provide participating professional providers 90 days' notice of most adverse reimbursement changes,[6] and it also allows such providers to terminate their contract by giving notice within 30 days of receiving notice of the reimbursement change. There was no prior law on this subject

Further, the Act protects certain types of physicians—if any newly licensed or relocated physician becomes part of a group in which all other physicians are participating with a health plan, then such physician will be deemed provisionally credentialed with that health plan in the event that the health plan does not complete the credentialing process within 90 days of receiving the new physician's application.[7] This section of the law becomes effective October 1, 2009.

The Act also affords providers the right to initiate their own appeals for concurrent adverse determinations under the External Review Law. Previously, only patients, or providers acting as agents of patients, could initiate appeals of concurrent adverse determinations. This allows providers to be more proactive in assisting their patients with appeals.

Lastly, effective for dates of service after April 1, 2010, providers will have to submit claims within 120 days from date of service, with a grandfather provision for existing contracts provided such contract allows a minimum of 90 days for submission. (Prior law imposed limits only on some types of claims.)

There are exceptions for late filing in certain circumstances, but the health plan has a right to decrease reimbursement by 25 percent for such late filings. Health plans and providers may agree on a different time limit provided it is no less than 90 days.

Some New Health Plan Provisions

The Act also provides that, effective immediately, a health plan need pay at least 98 percent of its claims each calendar year in a timely fashion in order to avoid late payment penalties (excluding violations resulting from member/provider complaints).

In the past, health plans were fined for each claim that was not paid within 45 days of receipt. Fines were generally $500 per late paid claim. Considering the volume of claims, the fines were significant even for health plans that generally were able to pay the vast majority of claims promptly.

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[3] 'Rare disease' means a life threatening or disabling condition or disease that (1)(A) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network, or (B) affects fewer than 200,000 United States residents per year, and (2) for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than the enrollee's treating physician, shall certify in writing that the condition is a rare disease as defined in this statute.

[4] Paper claims are subject to a 45 day limit.

[5] This does not apply to recovery for duplicate payments.

[6] For the purposes of this section of the law, the term 'adverse reimbursement change' means a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional.

[7] However, a provisionally credentialed physician may not be designated as an insured's primary care physician until the physician has been fully credentialed.

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