NEW YORK CODES, RULES AND REGULATIONS

*** THIS DOCUMENT REFLECTS CHANGES RECEIVED THROUGH OCTOBER 24, 2003 ***

TITLE 11. INSURANCE DEPARTMENT

CHAPTER III. POLICY AND CERTIFICATE PROVISIONS

SUBCHAPTER B. PROPERTY AND CASUALTY INSURANCE

PART 65. * (REGULATION 68) REGULATIONS IMPLEMENTING THE COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT

11 NYCRR § 65.16 (2003)

§ * 65.16 Managed care programs

(a) Preamble. Chapter 726 of the Laws of 1993 added Section 5109 to the Insurance Law and permits no-fault insurers to offer no-fault managed care programs to their policyholders who may then choose to participate in such programs. The purpose of the law is to enable no-fault insurers and self-insurers to reduce costs and enhance the quality of medical and other health care services for those injured in automobile accidents by providing managed care alternatives for the delivery of such services. This section sets forth the requirements for the delivery of managed health care services by managed care organizations operating under managed care programs established by no-fault insurers.

(b) Applicability. This section shall apply to managed care organizations seeking certification or certified to provide managed care benefits pursuant to the provisions of article 51 of the insurance law and to all insurers that elect to provide the benefits described in paragraph one of subsection (a) of section 5102 of the insurance law through a managed care program.

(c) Definitions. The following shall govern the construction of the terms used in this Part:

(1) "insurer" means the insurance company or self-insurer, which provides the financial security required by article six or eight of the Vehicle and Traffic Law;

(2) "managed care" means the delivery of all or some medical or other health care services under systems designed to enhance efficiency and quality that emphasize or require utilization of specified health care providers and programs and may require pre-authorization of services;

(3) "managed care organization" means an individual or group certified by the superintendent to provide health care services pursuant to an approved managed care program;

(4) "managed care program" means a comprehensive plan offered by an insurer and approved by the superintendent to deliver some or all medical and other health care services under systems designed

to enhance the efficiency and quality of health care services that emphasize or require utilizing specific health care providers and which may require pre-authorization for the use of health care providers;

(5) "emergency care" means necessary medical care, treatment, services, products or accommodations provided or related expenses incurred for a sudden, unexpected onset of a medical condition of such nature that failure to render care could reasonably result in deterioration to the point of placing the eligible injured person's life in jeopardy or cause serious impairment to that person's bodily functions;

(6) "rural area" means any county not defined as an urban area in this subdivision;

(7) "urban area" means the following counties: Albany, Bronx, Broome, Chautauqua, Chemung, Dutchess, Erie, Kings, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Orange, Oswego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Suffolk and Westchester.

(d) Availability.

(1) Insurers may, but are not required to, make managed care coverage available. Because the offering of managed care coverage is contingent upon the insurer being able to form or contract with a certified managed care organization, an insurer may find it necessary, at least initially, to:

(i) limit the availability of managed care coverage to those insureds residing within the geographical areas serviced by the managed care organization; or

(ii) form or contract with more than one managed care organization, to increase the size of the geographical area in which managed care coverage can be offered.

(2) If an insurer chooses to make managed care coverage available, managed care coverage must be available to both those policyholders written voluntarily and those assigned by the New York Automobile Insurance Plan in those service areas where managed care coverage is available.

(3) If an insurer chooses to make managed care coverage available, acceptance of managed care coverage shall be solely the policyholder's choice. No insurer shall require an insured to agree to managed care policy provisions as a condition of providing coverage. At least as often as each policy renewal, the policyholder of an insurer making managed care coverage available shall have the option to choose whether or not personal injury protection coverage for the next policy period shall be subject to managed care. Insurers may, but are not required to, allow insureds to add or delete managed care coverage between policy renewal dates. However, if the eligible injured person is injured in an accident that takes place while the managed care coverage is

in effect, such person shall continue to receive health care benefits through the managed care program with respect to such injury.

(4) Managed care coverage is only available on policies on which the named insured is a natural person.

(5) No policy providing personal injury protection shall include both managed care coverage and a family deductible.

(e) Exceptions. If a named insured elects managed care coverage, all covered persons, as defined in subsection (j) of section 5102 of the insurance law, except pedestrians and passengers (including permissive operators) who are not members of the named insured's household, shall receive all of their health care benefits through the approved managed care program, except when:

(1) emergency care is required, provided that all necessary treatment received outside the managed care organization within 24 hours after the accident shall be considered emergency care; or

(2) the company or the managed care organization determines that the eligible injured person requires treatment that is not within the scope of the managed care program established by the insurer; or

(3) the company or the managed care organization determines that the eligible injured person requires treatment that is within the scope of the managed care program, but the particular services needed are not accessible to that person within the managed care program.

Payments for health care benefits received under the exceptions noted in this subdivision shall be controlled by the fee schedules established in accordance with section 5108 of the insurance law.

(f) Deductibles and Coinsurance. If an eligible injured person obtains unauthorized care from providers not participating in the managed care organization or if the injured person does not comply with the pre-authorization requirements, notification requirements, or other terms and conditions of the managed care program, the insurer may apply a deductible in an amount not to exceed $ 2500 per person per accident as provided for in the Mandatory Personal Injury Protection Endorsement - Managed Care Coverage (New York) filed with the superintendent. In addition, or as an alternative, to such a deductible, the insurer may also require a coinsurance payment, not to exceed 25 percent, in such event. The payment of any deductible or coinsurance by an eligible injured person shall be considered basic economic loss and shall not be recoverable from any collateral source.

(g) No Penalties. No eligible injured person participating in a managed care program shall be required to pay or be issued a bill for any medical treatment provided through the managed care organization. No deductible or any co-insurance payment shall apply, provided that all

medical and other health care services are obtained in accordance with the managed care program, and in compliance with the pre-authorization and/or notification requirements of the managed care program.

(h) Premium reduction. The premium for personal injury protection insurance that is subject to a managed care option, including optional basic economic loss and additional personal injury protection coverage, shall, in accordance with the requirements of article 23 of the Insurance Law, be appropriately reduced to reflect the cost savings attributable to the managed care program.

(i) Fee Schedules.

(1) Costs for medical and other health care services provided by each managed care organization pursuant to an agreement with a particular insurer shall not, in the aggregate, exceed the costs that would otherwise have been payable by the insurer to health care providers using the fee schedules established by the superintendent or chair of the workers' compensation board.

(2) Payments for health care rendered by providers that do not participate in the insurer's managed care program shall be governed by fee schedules in accordance with section 5108 of the insurance law.

(3) An insurer that makes payments, to a provider for health care services performed pursuant to an approved managed care program, which are in excess of the fee schedules prescribed by the superintendent or the chair of the workers' compensation board, must implement a procedure to ensure that a covered person under the managed care program will not have any first-party benefits available to such person reduced by the amount of payments made in excess of those fee schedules had the schedule been utilized for payment for performing the same services.

(4) An insurer that makes payments, to a provider for health care services performed pursuant to an approved managed care program, which are in excess of the fee schedules prescribed by the superintendent or the chair of the workers' compensation board, must implement a procedure to compare, confirm and report that costs for medical and other health care services do not, in the aggregate, exceed costs that would be otherwise payable by application of those fee schedules.

(5) A managed care program may apply the fee schedules or negotiate fees with health care providers below the fee schedules prescribed by the superintendent or the chair of the workers' compensation board.

(6) A managed care program may not negotiate in-patient hospital rates.

(j) Eligibility.

(1) When a managed care program is approved pursuant to section 5109 of the insurance law and subdivision (r) of this section, approval shall pertain to no less than a specific county.

(2) If the approval is so limited and an insured does not reside within a county serviced by the managed care program, the insurer may not offer a managed care option to that insured.

(k) Disclosure.

(1) An insurer that elects to offer a managed care program shall provide the appropriate written Disclosure Statement (form N-F 14 or form N-F 14R) contained in Appendix 13-A of this Title.

(2) The Disclosure Statement (form N-F 14) shall be provided to:

(i) prospective policyholders at the time of application or with initial policy issuance; and

(ii) policyholders, who are not subject to managed care coverage, upon policy renewal.

(3) The Disclosure Statement (form N-F 14R) shall be provided to policyholders, who are subject to managed care coverage, with each renewal of the policy.

(4) With the Disclosure Statement (forms N-F 14 and N-F 14R), the insurer shall provide a listing or updates, as appropriate, of the managed care facilities and allied providers that participate in the managed care program.

(5) The signed Disclosure Statement (form N-F 14) shall be received by the insurer prior to the effective date of managed care coverage.

(6) The insurer may require receipt of the signed Disclosure Statement (form N-F 14R) prior to the deletion of managed care coverage from the policy.

(7) When a signed Disclosure Statement (form N-F or N-F-14R) is required, the insurer shall, in order to assure that the insured may retain a copy of such statement, provide a duplicate Disclosure Statement or a perforated tear-off section for the insured's signature.

(l) Reminders.

(1) When managed care coverage has been selected by the insured, the declarations page must clearly indicate the applicability of the option by showing the following statement: "MANAGED CARE COVERAGE APPLIES".

(2) The New York Motor Vehicle Insurance Law Cover Letter (Form N-F 1) must be accompanied by a reminder notice to the eligible injured person who has selected managed care coverage, stating that the managed care option applies and that care must be obtained pursuant to the insurer's managed care program.

(m) Certification of managed care organizations.

(1) Any individual or group authorized to provide medical or other health care services in this state may, directly or through an authorized insurer, make written application on forms prescribed by the superintendent to become certified as a managed care organization to provide managed care to eligible injured persons.

(2) The application for managed care organization certification shall include the following information:

(i) credentialing criteria, and identification and credentials of all individuals or organizations that will provide services, together with appropriate evidence of compliance with any licensing or certification requirements for such individuals or organizations to practice in this state;

(ii) description of the service delivery network, including times, places and manner of providing medical and other health care services essential to treating motor vehicle accident victims, emphasizing trauma treatment, including, if applicable, primary and specialty physicians, ancillary service providers, hospitals and other facilities proposed for participation in the managed care organization;

(iii) description of the times, places and manner of providing other related optional services the applicant may wish to provide;

(iv) description of the proposed service area identifying the counties to be served, including: a rationale for selection of this service area; a discussion of the travel time and distance required for eligible injured persons to reach participating providers; and necessary documentation to demonstrate that appropriate providers are accessible within a travel time or distance of the lesser of 20 miles or 40 minutes in urban areas or 40 miles or 60 minutes in rural areas, unless the applicant demonstrates to the satisfaction of the superintendent that alternative travel times or distances are more appropriate in a particular geographic area;

(v) description of the mechanisms used by the managed care organization to assure quality of care and to conduct utilization review, if applicable;

(vi) description and specimen copies of all contracts, including remuneration and related arrangements, between the managed care organization and individual healthcare service providers. Such contracts shall include adequate protection for eligible injured persons against liability for the costs of services covered by the managed care program and rendered by the participating provider. Such contracts shall also require that such provider shall cooperate with an eligible

injured person's reasonable requests regarding injury sustained in a motor vehicle accident, including assistance in a legal action and preparation of a forensic report incorporating the provider's opinion on the issues of causation and permanency within 30 days after completion of treatment;

(vii) description of the organizational structure of the managed care organization;

(viii) if incorporated, a copy of the applicant's articles of incorporation and by-laws which reflect the power and purpose to operate a managed care organization for no-fault managed care;

(ix) if unincorporated, a copy of the applicant's proposed certificate of incorporation, partnership agreement or authorization to do business in New York, as applicable;

(x) statement of the current financial condition of the applicant, including balance sheet and detailed financial plan covering the projected operations of the managed care organization, and a statement describing any significant financial difficulties or impairments experienced by the applicant within the five years preceding the application;

(xi) description of internal dispute resolution mechanisms, emphasizing speed and fairness;

(xii) identification and positions of directors, officers, controlling persons, owners, or partners of the proposed managed care organization, and information to enable the superintendent to determine that the applicant and such individuals have the character and competence to perform as a managed care organization;

(xiii) identification and credentials of the medical director, who must be a New York State licensed physician and whose responsibilities shall include supervision of the quality assurance program and advice regarding adoption and enforcement of policies concerning medical services and treatment standards;

(xiv) a description of any relationship (direct or indirect) between the managed care organization and any insurer, including a copy of any contract between the parties; and

(xv) such additional information relating to the organization and operation of the managed care organization as the superintendent may require.

(3) A certified managed care organization shall provide the superintendent with at least 30 days notice of any material change proposed in its operations prior to implementation of such change.

(4) The initial certification period for a managed care organization shall be 18 months and subsequent re-certifications shall be for a period of two years. The application for initial certification shall be accompanied by a nonrefundable application fee of $ 5,000, and a re-certification application shall be accompanied by a nonrefundable application fee of $2,500.

(5) The superintendent may certify any qualified entity as a managed care organization, if the superintendent determines that it has sufficient capabilities to enable the delivery of managed care services on a competent and quality basis and with meaningful scope, and if otherwise it meets the requirements of this subdivision, including:

(i) a health maintenance organization issued a certificate of authority under article 44 of the public health law or licensed under article 43 of the insurance law; or

(ii) any insurer licensed to write accident and health insurance, including a corporation organized under article 43 of the insurance law, which has a participating or preferred network of providers.

(6) To the extent that a managed care organization has been reviewed, approved or certified by another state agency as to accessibility, quality or continuity of care, or for any of the other matters within the superintendent's review, the superintendent shall consider the review, approval or certification of another state agency so as not to duplicate those reviews, approvals or certifications. However, nothing in this paragraph shall be deemed to limit the superintendent's authority to impose and review additional requirements or standards different than those imposed by another state agency to the extent those requirements or standards are necessary or appropriate for implementation of this subdivision.

(7) When granted, managed care organization certification shall be valid for 18 months, unless sooner amended, suspended or revoked by the superintendent. Subsequent re-certifications shall be valid for two years, unless sooner amended, suspended or revoked by the superintendent.

(8) The superintendent shall refuse to certify, or may revoke, suspend or amend the certification of any managed care organization, if the superintendent finds that:

(i) the managed care organization fails to meet the requirements of this subdivision; or

(ii) service under an approved managed care program is not being provided in accordance with its terms as described in the application for managed care organization certification and managed care program approval.

(9) All filings seeking the superintendent's certification of a managed care organization shall be directed in triplicate to:

New York State Insurance Department
Property and Casualty Insurance Bureau
No-fault Managed Care Unit
160 West Broadway
New York, New York 10013

(n) Emergency care. The insurer shall, either directly or through a managed care organization, furnish guidelines and describe the mechanism to be implemented for notification of and transition from emergency care received by an eligible injured person from a non-participating provider.

(o) Utilization management. The insurer shall demonstrate that, either directly or through a managed care organization, its managed care program incorporates an organized system for utilization review and management, which must include procedures that:

(1) require that only appropriately licensed health care providers, under the supervision of a medical director, make clinical decisions and determinations regarding the propriety of treatment;

(2) prevent inadequate, inappropriate or excessive treatment;

(3) prescribe methods and standards, based upon sound medical and other scientific principles, for quality assurance and pre-authorization of care;

(4) provide a response to any request for pre-authorization of services, when a prior authorization process is required, no later than 48 hours after receipt of such request; and

(5) provide necessary medical and other health care services, on a prompt and convenient basis, to eligible injured persons.

(p) Quality assurance program.

(1) The insurer's managed care program shall include provisions, either directly or through a managed care organization, for the implementation of a quality assurance program that includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in administration of the managed care program, in the delivery of services to eligible injured persons, and in minimizing conflicts of interest.

(2) The quality assurance program shall contain provisions that exclude from participation those providers who violate reasonable treatment standards.

(3) The quality assurance organizational arrangements and ongoing procedures must be fully described in written form, and provided to:

(i) all staff involved in the operation of the managed care program or the managed care organization;

(ii) every health care provider participating in such program or organization; and

(iii) each eligible injured person, upon request.

(4) The organizational arrangements for the quality assurance program must be clearly defined and must include at least the following:

(i) a peer review committee or comparable designated committee, responsible for quality assurance activities, which meets at appropriate intervals and is accountable to an identified governing authority of the managed care organization;

(ii) participation by an appropriate base of providers and support staff;

(iii) supervision by the medical director; and

(iv) minutes or records of the meetings of the peer review or quality assurance committee, describing the actions of the committee, including medical charts reviewed, problems discussed, recommendations made, administrative sanctions of health providers, and any other pertinent discussions and activities.

(5) Quality assurance procedures shall include defined methods for the identification and resolution of clinical and administrative problems, both actual and potential, with problem identification input from multiple sources (including medical chart reviews, complaints, and utilization review) covering all medical and other health care services provided by the managed care program.

(6) Quality assurance activities shall include the documentation and development of timely and appropriate recommendations to address actual and potential clinical and administrative problems. The insurer or the managed care organization shall demonstrate that recommendations of the committee responsible for quality assurance activities are reviewed and followed up in an appropriate and timely manner.

(7) Physicians and other health care providers participating in any managed care organization and managed care program shall be licensed, certified and currently registered, as legally required of the respective professions by New York State.

(8) Laboratory, pathology, radiology, diagnostic and other services provided through a managed care organization shall be properly supervised.

(9) Clinical records shall be afforded confidentiality in accordance with applicable state law, including laws on confidentiality of HIV records, and unwarranted access shall be prevented. Records may be retained electronically if the system provides for:

(i) prevention of unwarranted entry or access; and

(ii) production of hard copy when required for a legitimate purpose.

(10) The managed care organization shall require and assure that medical and other health care records are retained for at least six years after the date service is rendered, or in the case of a minor for at least six years after majority.

(q) Dispute resolution procedures.

(1) The insurer's managed care program shall include written procedures for the expeditious appeal of health care and coverage determinations, including the denial of coverage for any failure to comply with notice requirements.

(2) The insurer or the managed care organization shall review and respond in writing to grievances or complaints and advise the individual filing the grievance of its determination:

(i) within three business days after receipt of all relevant information on all matters involving services the eligible injured person is presently receiving, is seeking authorization to receive, or may need or request reasonably soon; or

(ii) within 15 business days after receipt of all relevant information on all other matters.

(3) If the claim is not resolved completely in favor of the eligible injured person, the determination shall be considered a denial of claim by the insurer but, in addition to such determination, such person shall also be provided with a Denial of Claim form (Form N-F 10) as required by section 65.15 (g) of this Part.

(4) The insurer, either directly or through a managed care organization, shall document the receipt and disposition of each grievance and shall retain those records at least three years.

(r) Approval of managed care programs.

(1) No insurer or self-insurer may offer no-fault managed care coverage prior to receiving the superintendent's approval for the use of its managed care program. Self-insurers seeking to use a managed care program shall file for the superintendent's prior approval a program that provides managed care coverage in substance as prescribed by section 65.12 of this Part. The superintendent may approve any managed care program, if the superintendent determines that it has sufficient capabilities to ensure the delivery of managed care services in an accessible manner, on a quality basis and with meaningful scope, and if it

otherwise meets the requirements of this subdivision. The superintendent's approval of a managed care program shall be for a stated duration, and can be amended, suspended or revoked for cause.

(2) All managed care programs may only utilize the services of certified managed care organizations.

(3) All filings seeking the superintendent's approval of a managed care program shall be submitted in triplicate to:

New York State Insurance Department
Property & Casualty Insurance Bureau
No-fault Managed Care Unit
160 West Broadway
New York, New York 10013

(4) All filings seeking the superintendent's approval of a managed care program shall describe in detail the managed care program, setting forth its significant features, methods and procedures, including at least the following:

(i) complete list of the managed care organizations that constitute the managed care program;

(ii) description of the proposed service area identifying the counties to be served, including: a rationale for selection of that service area; a discussion of the travel times and distances required for eligible injured persons to reach participating providers; and documentation necessary to demonstrate that appropriate providers are accessible within a travel time or distance of the lesser of 20 miles or 40 minutes in urban areas or 40 miles or 60 minutes in rural areas, unless the applicant demonstrates to the satisfaction of the superintendent that alternative travel times or distances are more appropriate in a particular geographic area; and a map sufficiently detailed to accurately indicate service area boundaries and locations of participating providers;

(iii) description of the service delivery network, including (if applicable) primary and specialty physicians, ancillary service providers, hospitals and other facilities proposed for participation in the managed care program, and demonstration that the proposed network is adequate to meet the needs of covered persons and includes a sufficient number of each category of provider throughout the proposed service area to give injured persons adequate flexibility to choose an authorized provider from among those health care providers who participate in the managed care program;

(iv) a complete list of the names, addresses, telephone numbers, and area of specialty of all medical and other health care providers participating in the managed care

program, including a description of the times, places, and manner of providing services;

(v) a description and representative copies of all contracts, including remuneration and related arrangements, between the managed care organization and the insurer;

(vi) a description of the protocol to be followed for an injured person to obtain treatment outside of the managed care program when covered services are not available or accessible within the program;

(vii) a description of the protocol to be followed in the event that a covered person had been receiving treatment from a nonparticipating provider and was subsequently injured in a motor vehicle accident, aggravating the pre-existing condition being treated, so as to reasonably coordinate care among the providers;

(viii) description of the protocol to be followed to report notice of accident, notice of treatment and to provide pre-authorization, if required, including a 24-hour toll-free recorded telephone number to receive such notices, and a description of the system to be implemented under which eligible injured persons may obtain information on a 24-hour basis regarding the availability of necessary health care services;

(ix) a wallet-sized identification card;

(x) identification and credentials of the managed care program's medical director, who must be a New York State licensed physician and whose responsibilities shall include supervision of the quality assurance program and advice regarding adoption and enforcement of policies concerning medical services and treatment standards;

(xi) description of the mechanism to be used to coordinate the various managed care organizations to achieve a uniform standard of patient care;

(xii) a prominent notice, provided with appropriate claims forms following the accident, reminding eligible injured persons about the managed care program, noting a toll-free telephone number for responses to any questions, including obtaining updated provider listings;

(xiii) description of the quality assurance program that will be utilized by the managed care program;

(xiv) description of the internal dispute resolution procedures that will be utilized to resolve disputes involving coverage and treatment in regard to the managed care organizations or managed care program;

(xv) all marketing materials pertaining to the managed care program;

(xvi) a handbook, written in an understandable manner, to be distributed to insured persons explaining the significant aspects of the managed care program, including all information needed by an eligible injured person to access emergency and non-emergency services and the procedures for filing grievances or complaints. Such handbook shall also contain a policy statement indicating that participating providers under a managed care program shall cooperate with an eligible injured person's reasonable requests regarding an injury sustained in a motor vehicle accident, including assistance in a legal action and preparation of a forensic report incorporating the provider's opinion on the issues of causation and permanency within 30 days after completion of treatment;

(xvii) reasonable projections that the aggregate cost of providing services to all eligible injured persons under the managed care program should be less than the total permissible cost, were those same services provided and paid pursuant to the fee schedules prescribed by the superintendent or Chair of the Workers' Compensation Board;

(xviii) description of how the managed care program will address the needs of non-English speaking persons;

(xix) a demonstration that the managed care program provides appropriate financial incentives or other approaches to reduce costs and minimize improper utilization without sacrificing quality of service; and

(xx) such other and additional information as the superintendent may require.

(5) Any material changes proposed to the managed care program shall be filed with the superintendent for review at least 30 days prior to implementation.

(s) Program evaluation. Insurers offering approved managed care programs shall monitor and evaluate such programs in terms of performance, quality, cost savings, and consumer satisfaction. Insurers shall report their findings by January 31, 1997 to the superintendent, who may require interim reports and prescribe the form and manner of such reports.

* NB Reinstated effective February 1, 2000 per Medical Society of New York v. Neil D. Levin as Superintendent of Insurance, 712 NY2d 745 (Supreme Court, New York County).

Section statutory authority: Insurance Law, §5109, §A51, §5102; Vehicle & Traffic Law, §T3A6, §T3A8; Insurance Law, §A23, §5108; Public Health Law, §A44; Insurance Law, §A43

Repealed and added 65.16 on 8/15/95; repealed 65.16 on 11/03/99.