



STATE OF NEW YORK
INSURANCE DEPARTMENT
160 WEST BROADWAY
NEW YORK, NEW YORK 10013

Circular Letter No. 7 (1997)
March 25, 1997

TO: All Insurers Including Article 43 Corporations Licensed to Write Accident and Health Insurance In New York State, Except Health Maintenance Organizations
RE: The Managed Care Reform Act (Chapter 705 of the Laws of 1996)

The Managed Care Reform Act (the Act), in part, amends the Insurance Law to address disclosure requirements, provider due process requirements, provider contract limitations, grievance procedure requirements and provider access and continuity of care requirements. It also adds a new Article 49 to the Insurance Law requiring certain utilization review agents to report to the Superintendent and revises coverage for emergency services. The Act also amended the Public Health Law to impose similar requirements upon health maintenance organizations.

The purpose of this Circular Letter is to assist insurers to comply with those provisions of the Managed Care Reform Act applicable to them. It provides a summary of the Act. Insurers must also review the Law to assess its specific requirements.

I. DISCLOSURE OF INFORMATION (INSURANCE LAW 3217-a; INSURANCE LAW 4324)

APPLICABILITY

The disclosure requirements apply to comprehensive expense reimbursed health insurance contracts, managed care health insurance contracts and any contract for which the Superintendent deems disclosure appropriate.

Comprehensive expense reimbursed health insurance contracts include major medical and major medical type policies, including those with a "preferred provider" feature. The term does not include basic hospital insurance or basic medical insurance, as defined in Regulation 62. However, a policy which provides basic hospital and basic medical insurance and coverage for provider office visits on an expense-incurred basis is deemed a comprehensive expense reimbursed health insurance contract for purposes of the disclosure requirements.

The term also does not include Medicare supplement insurance or a policy covering only long term care benefits, nursing home benefits, home care benefits, dental or vision care benefits, accidental death and dismemberment

benefits, prescription drug benefits or disability income benefits.

Managed care health insurance contracts are defined in substance as the following:

- * a contract which utilizes a closed panel of providers and a primary care physician as care manager or "gatekeeper";
or
- * an individual health insurance contract which has a preferred provider feature with a primary care physician acting as care manager; or
- * a group health insurance contract which covers no more than 300 lives and which utilizes a preferred provider feature with a primary care physician as care manager and which imposes a coinsurance of greater than 25% for care received outside the provider network and which is sold to five or more groups. It is incumbent on the insurer to ascertain whether its group health insurance contract meeting the above requirements is sold or will be sold to five or more groups so as to trigger the required disclosure.

TO WHOM IS THE INFORMATION DISCLOSED

The information is to be disclosed to each insured person and, upon request, to a prospective insured person.

DISCLOSURE DOCUMENTS

The disclosure information may be incorporated into the insurance contract or certificate or may appear in a separate disclosure statement. An insurer issuing a group insurance policy should not use the group policy to satisfy the disclosure requirements unless the policy also serves as the certificate of coverage. A group policy is generally delivered to a single policyholder, usually an employer. Since the intent of the disclosure requirements is to provide information to insureds and prospective insureds, the document delivered to the insured or covered person, i.e. the certificate, is a more appropriate venue for meeting the disclosure requirements.

An insurer may use the contract/certificate to address some of the required disclosure and supplement it with a separate disclosure statement.

Disclosure statements should be submitted to the Life and Health Bureau to be placed on file for informational purposes.

INFORMATION REQUIRED TO BE DISCLOSED

(1) Coverage parameters (benefits, exclusions, limitations, maximums) and the definition of "medical necessity" used in coverage determinations.

(2) Prior authorization or other requirements to obtain services.

(3) Description of utilization review (UR) policies, consistent with the requirements of Article 49, including

- * when UR will be performed;
- * toll free number of the UR agent;
- * time frames for UR decision-making;
- * reconsideration rights;
- * appeal rights (both standard and expedited);
- * right to designate a representative;
- * notice that denials will be made by qualified clinical personnel; and
- * notice that denials will include information about the basis of the decision and appeal rights.

(4) Provider payment methodologies.

The insurer should disclose and explain in general terms all payment methodologies it employs with providers, such as fee for service, discounted fee for service, capitation and use of withholds. The Law requires that description of

payment methodologies be prepared annually. The annual updating may be accomplished through use of a supplemental document.

(5) Explanation of the insured's financial responsibility for payment of premiums, deductibles, copayments, etc.

(6) If applicable, an explanation of an insured's financial responsibility for out-of-network services and services received without prior authorization.

(7) A description of the grievance procedure including:

- * the right to file a grievance for any dispute between the insurer and an insured;
- * the right to file an oral grievance for disputes involving referrals or covered benefits;
- * the toll-free number for filing an oral grievance;
- * time frames and circumstances for expedited and standard grievances;
- * the right to appeal and the procedures for appeal;
- * time frames and circumstances for expedited and standard appeals;
- * the right to designate a representative;
- * notice that clinical decisions will be made by qualified clinical personnel; and
- * that all notices of determination will provide the basis for determination and appeal rights.

PLEASE NOTE: Insurance Law 4802(b)(1) also requires that notice of the grievance procedure appear in the managed care health insurance contract.

(8) Description of the procedures for obtaining emergency services including:

- * a definition of emergency services;
- * notice that emergency services do not require prior approval; and
- * a description of the insured's responsibility for emergency services received outside the service area; if applicable.

(9) If applicable, a description of how an insured selects, accesses and changes primary and specialty care providers and how an insured determines whether a provider is taking new patients.

(10) For managed care health insurance contracts, disclosure also includes the following:

- * notice regarding the insured's right to access and the procedures for accessing an out-of-network provider when there is no network provider with the appropriate training and experience;
- * notice regarding the insured's right to obtain and the procedures for obtaining a "standing referral" to a specialist;
- * notice of the circumstances in which an insured may utilize a specialist as care manager and the procedures to obtain such a specialist; and
- * notice of the circumstances in which an insured may access a specialty care center and the procedures to obtain access.

(11) How the needs of non-English speaking insureds are addressed.

(12) All appropriate addresses and phone numbers for insureds to obtain information and authorization.

(13) For Article 43 corporations only, a description of the mechanisms for insureds to participate in corporate policy development.

(14) If applicable, a listing by specialty of all participating providers. The list may appear in a separate document. The list must be updated annually and must indicate the board status of physicians. An insurer that offers a product in more than one geographic region or on a statewide basis may provide a listing limited to the geographic region of the

insured or prospective insured. However, the listing must provide instructions on how to obtain a listing of the entire participating provider network.

INFORMATION TO BE DISCLOSED UPON REQUEST

- (1) Names, business addresses, positions of the board members, officers and members of the insurer or corporation.
- (2) A copy of the most recent annual certified financial statement, balance sheet and a summary of receipts and disbursements prepared by a CPA.
- (3) A copy of the current individual contract(s).
- (4) Required consumer complaint information pursuant to Insurance Law 210, as amended by Chapter 474 of the Laws of 1996.
- (5) Procedures for protecting confidentiality of medical records and other information.
- (6) If applicable, inspection of drug formularies. The insurer must also respond to requests as to whether a particular drug is covered.
- (7) If applicable, a description of the quality assurance mechanism used by the insurer.
- (8) Procedures for determining whether particular drugs, devices or treatments in clinical trials are experimental or investigational.
- (9) If applicable, provider affiliation with participating hospitals.
- (10) If requested in writing, specific written clinical review criteria and other clinical information used in utilization review for a specific disease or condition.
- (11) If applicable, written application procedures and minimum qualifications for providers to be considered for participation in an insurer's network for a managed care product.

EFFECTIVE DATE

The disclosure requirements take effect April 1, 1997 and apply to contracts issued, renewed, modified, altered or amended on or after that date.

II. PROVIDER UNAVAILABILITY RANCE LAW 3217-a(d); INSURANCE LAW 4324(d)]

FOR ALL CONTRACTS REQUIRING USE OF A PRIMARY CARE PROVIDER AS CARE MANAGER, INCLUDING MANAGED CARE HEALTH INSURANCE CONTRACTS

If a primary care provider becomes unavailable, the insurer must notify each insured who has selected that provider within fifteen days of its becoming aware of the provider's unavailability.

FOR MANAGED CARE HEALTH INSURANCE CONTRACTS ONLY

In addition to the requirement discussed above, if an insured is in an ongoing course of treatment with a participating provider who subsequently becomes unavailable and the insurer is aware of such course of treatment, then the insurer must provide notice to the insured within fifteen days of its becoming aware of the unavailability.

The notice must include procedures to receive continued care from the participating provider during a transitional period. The notice must also address the procedure for choosing an alternate provider.

EFFECTIVE DATE

These provisions take effect on April 1, 1997 and apply to contracts issued, renewed, modified, altered or amended on after that date.

III. PROVIDER CONTRACT LIMITATIONS (INSURANCE LAW 3217-b; INSURANCE LAW 4325)

GAG RULE

An insurer may not, by contract or written policy or procedure, restrict a provider from disclosing information to insureds, designated representatives or prospective insureds regarding a course of treatment or the requirements of the insurer's products or from advocating on behalf of an insured for approval or coverage of a particular service.

REPORTING

An insurer may not, by contract or written policy, restrict a provider's right to file complaints or reports to government agencies on practices of the insurer which the provider believes affect quality of or access to health care.

INDEMNIFICATION

An insurer may not, by contract or agreement, transfer liability to the provider for the insurer's acts or omissions.

EFFECTIVE DATE

This section took effect January 1, 1997. Although it renders any provider contract provision or written policy that is in violation null and void, the Department expects insurers to amend existing provider contracts or written policies to delete or revise nonconforming provisions on a timely basis.

IV. GRIEVANCE PROCEDURE (INSURANCE LAW 4802)

APPLICABILITY

Grievance procedure requirements apply to managed care health insurance contracts only. The grievance process does not apply to determinations made during the performance of utilization review.

GENERAL REQUIREMENTS

(1) The grievance procedure is to be set forth in the contract and in a written notice provided to the insured any time the insurer denies access to a referral or determines that a benefit is not covered under the contract.

(2) The notice must include:

- * the process to file a grievance;
- * the time frames for making a determination; and
- * the insured's right to designate a representative

(3) Insurers subject to the grievance procedure requirements will be required to report to the Superintendent the number of grievances filed and the disposition of such grievances for inclusion in the annual consumer guide required by Insurance Law 210, as amended by Chapter 474 of the Laws of 1996.

IMPLEMENTATION

Any necessary contract revisions should address all required elements and be submitted for review and approval.

EFFECTIVE DATE

The grievance procedure requirements take effect April 1, 1997 and apply to all contracts issued, renewed, modified,

altered or amended on or after that date.

V. "PROVIDER DUE PROCESS" (INSURANCE LAW 4803)

APPLICABILITY

"Provider due process" requirements apply only to insurers offering managed care health insurance contracts.

GENERAL REQUIREMENTS

(1) Upon request, an insurer must disclose to providers the written application procedures and minimum qualifications for participation. The qualifications are to be developed after consultation with appropriately qualified providers.

(2) An insurer must provide notice and an opportunity to be heard to a participating provider whose contract is being terminated. Non-renewal of a provider contract does not constitute a termination for purposes of this section. Also, the notice and hearing requirements do not apply to cases involving imminent harm to patient care, fraud or a final determination by a disciplinary agency that impairs the provider's ability to practice.

A hearing panel which comports to the statutory requirements must be utilized.

(3) An insurer must develop procedures to notify participating providers of its mechanisms for evaluating provider performance and shall consult with providers in developing profiling data.

(4) An insurer may not terminate or nonrenew a participating provider contract solely because the provider has advocated for an insured, appealed an insurer's decision or filed a complaint, or otherwise exercised his or her rights conferred by statute.

EFFECTIVE DATE

The "provider due process" requirements took effect January 1, 1997. Although it renders any provider contract provision that is in violation null and void, the Department expects insurers to amend existing provider contracts to delete or revise nonconforming provisions on a timely basis.

VI. ACCESS TO SPECIALTY CARE (INSURANCE LAW 4804)

APPLICABILITY

The access to specialty care provisions apply only to managed care health insurance contracts.

GENERAL REQUIREMENTS

(1) An insurer must allow access to a nonparticipating provider if it determines that it does not have a network provider appropriate to meet the needs of the insured, at no additional expense to the insured.

(2) An insurer must have a procedure for "standing referrals" for an insured requiring ongoing care from a specialist.

(3) An insurer must have a procedure that allows both new and existing insureds who are diagnosed with either a life-threatening condition or disease or a degenerative or disabling condition or disease requiring specialized care over a prolonged period a referral to an appropriate specialist to act as "care manager" for that insured.

(4) An insurer must have a procedure that allows an insured diagnosed with a life threatening condition or disease or a degenerative or disabling condition or disease requiring specialized care over a prolonged period a referral to an appropriate specialty care center.

(5) For "standing referrals", referrals to specialists as care managers and referrals to specialty care centers, an insurer shall require an approved treatment plan upon consultation, where appropriate, with the primary care provider, the

specialist and the insured or his or her designee.

(6) If a provider's participation with the insurer is terminated for a reason which allows the provider the right to a hearing, the insurer must allow an insured in an ongoing course of treatment with that provider to continue such treatment during a transitional period of up to 90 days from the date the insured is notified that the provider is no longer participating or for pregnant women in the second trimester of pregnancy, for a period that includes post-partum care related to the delivery.

(7) The insurer must allow a new enrollee with a life-threatening disease or condition or a degenerative or disabling condition access to his or her current provider to continue ongoing treatment during a transitional period of up to 60 days from enrollment. New enrollees in the second trimester of a pregnancy must be allowed to continue care with their existing provider through post-partum care directly related to delivery.

(8) The "continuity of care" requirements described in items 6 and 7, above, apply only if the provider agrees to accept the insurer's payment as full payment; agrees to the insurer's quality assurance requirements; agrees to provide the insurer with medical information related to the care and agrees to abide by the insurer's policies and protocols such as preauthorization requirements.

IMPLEMENTATION

In addition to establishing procedures to allow for "standing referrals", use of specialty centers, continuity of care, etc., the insurer is required by other provisions of the Act to disclose to insureds and prospective insureds their rights and responsibilities with regard to these situations. The contract/certificate or the disclosure statement provisions designed to address these requirements should be sufficiently detailed so as to apprise insureds of the conditions under which access to the providers addressed by the Act will be allowed.

EFFECTIVE DATE

The access to specialty care requirements take effect April 1, 1997 and apply to all contracts issued, renewed, modified, altered or amended on or after that date.

VII. UTILIZATION REVIEW (UR) (INSURANCE LAW ARTICLE 49)

APPLICABILITY

The Act establishes a reporting or registration requirement for UR agents with either the Superintendent of Insurance or the Commissioner of Health depending on the nature of the agent. UR is generally defined as the review to determine whether health care services are medically necessary. It includes prospective, concurrent and retrospective review. UR agents required to report to the Superintendent are those insurers subject to either Article 32 or Article 43 of the Insurance Law (i.e., those writing accident and health insurance coverage) and any independent agent under contract with such an insurer. All other UR agents must register with the Commissioner, unless expressly exempted by the statute.

Because only UR agents who are insurers subject to Articles 32 or 43 and UR agents contracting with such insurers register with the Superintendent, insurers subject to other provisions of Insurance Law who are conducting UR under their policies (e.g., property and casualty insurers performing UR as part of an automobile no-fault insurance policy or a worker's compensation policy) would be subject to Public Health Law requirements for registration.

GENERAL REQUIREMENTS

- (1) Each UR agent must biennially report to the Superintendent.
- (2) The report must be in a sworn statement.
- (3) The report must contain the following information:

(a) the UR plan as defined in the statute to include:

- * the process for development of written clinical review criteria;
- * the types of written clinical information considered in clinical review;
- * a description of the practice guidelines used to determine medical necessity;
- * the procedures for scheduling evaluation of written clinical review criteria; and
- * the qualifications and experience of the professionals developing the criteria, those responsible for evaluating the criteria and those using the criteria for UR.

(b) the situations when UR might be delegated to a hospital or other facility;

(c) the process for appealing adverse determinations;

(d) the procedures by which decisions on preauthorization requests will comply with statutory timeframes;

(e) the emergency care policy, including when emergency treatment or an emergency admission shall be made;

(f) a description of the personnel conducting UR, including a discussion of when UR may be conducted by administrative personnel, health care professionals and clinical peer reviewers;

(g) a description of the mechanisms to assure adequate training and supervision of administrative personnel;

(h) a description of the mechanisms to assure that health care professionals conducting UR are appropriately credentialed and trained;

(i) the mechanism whereby only a clinical peer reviewer, as defined in statute, renders an adverse determination;

(j) provisions to ensure the availability of appropriate personnel by toll free number;

(k) policies and procedures to ensure compliance with all laws regarding confidentiality of medical records;

(l) a copy of the disclosure material on UR required by 3217-a and 4324 and Article 49 of the Insurance Law; and

(m) the mechanism used by the agent to assure that all subcontractors, subvendors, agents or employees affiliated with the UR agent will adhere to the statutory requirements.

IMPLEMENTATION

The required report should be submitted to:

Edward Reich
Life and Health Bureau
New York State Insurance Department
Agency Building One Empire State Plaza
Albany, New York 12257

The report will be reviewed for completeness in order to determine that each required element is addressed. If the report is complete, the Superintendent will confirm in writing, that the report has been filed.

EFFECTIVE DATE:

The UR reporting requirements take effect April 1, 1997.

VIII. COVERAGE FOR SERVICES TO TREAT AN EMERGENCY CONDITION "PRUDENT LAYPERSON STANDARD" RANCE LAW 3216(i)(9); INSURANCE LAW 3221(k)(4); INSURANCE LAW

APPLICABILITY

The amended emergency services coverage provisions apply to all policies and contracts which provide coverage for inpatient hospital care.

GENERAL REQUIREMENTS

For applicable policies and contracts, coverage for services to treat an emergency condition provided in hospital facilities must be provided.

An emergency condition is defined in statute as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- (b) serious impairment to such person's bodily functions;
- (c) serious dysfunction of any bodily organ or part of such person; or
- (d) serious disfigurement of such person.

IMPLEMENTATION

All affected policies, contracts and certificates must be revised accordingly.

EFFECTIVE DATE

The emergency services coverage requirements take effect April 1, 1997 and apply to all contracts issued, renewed, modified, altered or amended on or after that date.

CONCLUSION

The Department wishes to assist insurers in implementation of the Managed Care Reform Act and will convene a meeting with insurers to address implementation issues. The Department will provide interested parties with information by separate mailing. In the interim, questions concerning this Circular Letter should be directed to Deborah Kozemko or Lisette Johnson of the Life and Health Bureau at (518) 474-4098.