



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

NOTE: WITHDRAWN EFFECTIVE DECEMBER 4, 2003

**Circular Letter No. 1 (2000)
January 7, 2000**

TO: All Motor Vehicle Self-insurers and Insurers Licensed to Write Motor Vehicle Insurance in New York State

RE: Revision of Insurance Department Regulation 68

The Insurance Department recently promulgated a revision to Insurance Department [Regulation 68](#), the regulation that implements New York's No-Fault law. The revised regulation makes adjustments to the manner in which No-Fault claims are presented and processed in order to address practices that have resulted in fraud and abuse in the New York automobile insurance marketplace. It has been estimated that fraudulent and/or abusive No-Fault claim submissions cost consumers in New York State at least one hundred million dollars annually.

The purpose of this Circular Letter is to provide guidance to insurers and self-insurers in implementing the regulation in a manner consistent with its intent of preventing fraud and abuse while ensuring that valid claims of eligible injured claimants are processed and paid in a timely manner. Insurers and self-insurers are expected to provide adequate and timely notice to insureds and other individuals who may be impacted by the changes set forth in this regulation. Such notice shall include prominent notice in policyholder materials and notice set forth in policy forms.

By acting responsibly in applying these new rules, insurers will contribute to a reduction in acts of fraud and abuse, which should ultimately result in lower costs to all New York consumers.

Notice Requirements and Standards

The new regulations contain new time limits for providing notice of the motor vehicle accident to an insurer or self-insurer and for the submission of No-Fault claims. The Department recognizes that in some instances applicants for benefits will not be able to comply with these new requirements. By way of example, insurers and self-insurers should note that the Department recognizes that in cases where a pedestrian is injured, the injured person may be unable to ascertain the name of the vehicle's insurer within the prescribed period for notice. Similarly, an unrelated injured passenger may have difficulty ascertaining the name of the vehicle's insurer.

To address these types of situations and to prevent injured claimants from unfairly losing benefits due to circumstances beyond their control, the Department has included in the revised regulation an important change to the regulation provision which excuses late notice when warranted by underlying facts. Where there is a failure to meet the new time frames, a claimant that demonstrates "clear and reasonable justification" for the failure to comply must be excused from the requirement. Insurers are obligated to apply this reasonableness standard consistent with the goals of the No-Fault system, which will require a case-by-case factual review of each instance where an explanation for late notice is made. Application of the notice requirement without individual consideration when warranted will be deemed adversarial conduct by an insurer which is contrary to the intent of the No-Fault law.

INSURERS ARE ADVISED THAT THE DEPARTMENT WILL CLOSELY MONITOR COMPLIANCE WITH THIS STANDARD AND WILL TAKE APPROPRIATE DISCIPLINARY ACTION AGAINST THOSE INSURERS FOUND TO HAVE UTILIZED THE NEW NOTICE REQUIREMENTS TO AVOID THE PAYMENT OF CLAIMS.

Insurers are expected to:

- 1. supply clear and timely notice to their policyholders emphasizing the new policy conditions before implementation of these new conditions;**
- 2. clearly define reasonableness standards to their claims staff; and**
- 3. implement expedited internal review procedures for affected claims to ensure that they are consistent and fair to all applicants for No-Fault benefits.**

There must be a clear recognition of the individual circumstances that may result in legitimate delayed notice or submission of claims, such as those outlined above.

Insurers and self-insurers are also reminded that usage of the examination under oath procedure must not be ordered routinely, but should only be used when specifically warranted under reasonable, objective guidelines. Insurers and self-insurers shall maintain such guidelines on-site and available for inspection by Department personnel on request.

Effective Dates

The revision actually contains four subparts, that contain respectively, (1) Subpart 68-A, New endorsements; (2) Subpart 68-B, Rules applicable to self-insurers; (3) Subpart 68-C, Claims practice rules; and (4) Subpart 68-D, Arbitration provisions. While the regulation takes effect on February 1, 2000, not all claims made on and after February 1, 2000 will be subject to the new requirements on that date.

Since Subpart 68-A contains revised endorsements with new notice provisions effective on all policies issued on and after February 1, the new provisions will not be applicable to claims until the policies are issued and renewed using the revised endorsements. However, Regulation 68-B, which applies to self-insurers and also contains the new notice provisions, will apply to all such claims on and after February 1, since claimants of self-insurers are not subject to policy issuance requirements.

The claims practice rules contained in Subpart 68-C will be applicable, with some exceptions, effective February 1, 2000. For example, the insurer may require a health care provider to complete the new NF-3 form for any claim submitted after February 1. However, it should allow those providers to submit a previously executed assignment form for any treatment prior to that date. Insurers are expected to act reasonably in applying these new rules.

The new arbitration rules in Subpart 68-D will be applied for all arbitration requests received by the American Arbitration Association on and after February 1. However, the new rules regarding attorneys' fees will become effective on February 1 and will apply even to arbitration requests received prior to that date. New rules regarding the payment of an attorney's fee by the insurer have been implemented in order to discourage health care providers from billing insurers for amounts that exceed permissible charges pursuant to section 5108 of the Insurance Law. Accordingly, if a health care provider presents a bill that exceeds the proper fee schedule calculation in violation of the health care fee schedule requirements of section 5108 and if the dispute has been transmitted for arbitration, the insurer will not be required to pay that provider's attorney's fee regardless of the date of the bill. However, this provision is not applicable to cases resolved prior to the initiation of arbitration or conciliation.

Insurers are reminded of the applicable penalties for engaging in unfair claims payment practices; late payment of bills will subject insurers to the 2% per month interest penalty and possible Insurance Department administrative penalties for dilatory claims payment practices. In addition, claims resolved through the arbitration process subject insurers to arbitration administrative expenses.

Please acknowledge receipt of this circular letter, no later than January 21, 2000, to:

Ms. Hoda Nairooz
Senior Examiner
Property Bureau
New York State Insurance Department
25 Beaver Street
New York, New York 10004

Any question regarding this Circular Letter should be directed to Ms. Nairooz at (212) 480-5662.

Very truly yours,

Mark Presser
Assistant Deputy Superintendent & Chief
Property Bureau