



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
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ALBANY, NEW YORK 12257

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Governor

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Acting Superintendent

Circular Letter No. 7 (2005)
March 24, 2005

TO: All Insurers Licensed to Write Accident and Health Insurance in New York State ("Commercial Insurers"), Article 43 Corporations and Health Maintenance Organizations

RE: Explanation of Benefits (EOB) Requirements

STATUTORY REFERENCE: New York Insurance Law Section 3234

New York Insurance Law Section 3234 provides, in pertinent part, that every insurer, including an HMO, is required to provide its insured or subscriber with an EOB in response to a filed claim under any policy providing hospital or medical expense benefits. One exception to the requirement that an EOB be issued under section 3234 is where the service is rendered by a participating provider and full reimbursement for the claim, other than a copayment that is ordinarily paid to the provider at the time of service, is paid directly to the participating provider.

Recent market conduct examinations have revealed many instances where commercial insurers, Article 43 corporations and HMOs (hereinafter "insurers") are not issuing EOBs to insureds and subscribers for fully or partially denied claims as required by Section 3234 of the New York Insurance Law. In other instances, it was noted that improper EOBs or "EOB substitutes" are being issued by insurers for such claims.

Insurers have various payment arrangements with their providers. In addition, the contract between the insurer and its participating provider frequently contains a "hold harmless" provision that directs the participating provider to seek payment solely from the insurer for services covered under the insured's or subscriber's policy. The basis for the non-compliance observed during these market conduct examinations appears to be an incorrect determination by the insurers that these provider payment arrangements and "hold harmless" provisions place the claim within the "full reimbursement" exception set forth in Section 3234(c) of the Insurance Law.

The purpose of this Circular Letter is to set forth some instances identified in the market conduct examinations when an insurer is required to issue an EOB to an insured or subscriber under Section 3234 of the Insurance Law. These instances include the following:

1. An EOB must be issued to an insured or subscriber whenever a claim involves a service rendered by a nonparticipating provider.
2. An EOB must be issued to an insured or subscriber if, for whatever reason, the insured or subscriber submits a claim for a service rendered by a participating provider.

3. An EOB must be issued to an insured or subscriber whenever a claim submitted by a participating provider involves a denial based on the participating provider's failure to follow the insurer's protocol for coverage, even where the contract between the provider and the insurer contains a "hold harmless" provision.

For example, an EOB would be required when the denial of a claim is based on the provider's failure to obtain pre-approval of a service from the insurer where it is the provider's obligation to obtain such approval.

4. An EOB must be issued to the insured or subscriber when an insurer denies a claim on the basis that the coverage for the insured or subscriber was no longer in effect on the date of the service.
5. An EOB must be issued to the insured or subscriber when a participating provider bills for covered services for which the provider has not contracted with the insurer. The EOB must be issued irrespective of whether the insured or subscriber has signed a waiver acknowledging that the provider was not contracted to provide the service.
6. Per Section 3234(c) of the Insurance Law, an EOB must be issued to the insured or subscriber on demand.

In all cases where an EOB is required to be issued to the insured or subscriber it must contain, at a minimum, all of the information required by Section 3234 (b) of the Insurance Law.

An EOB is not required to be issued to an insured or subscriber under the following circumstances:

1. An EOB is not required when there is a prepaid capitation arrangement between an insurer and a participating provider and the provider submits a claim for a service that falls within the capitation payment. In this case, the claim is considered to be "paid in full" upon payment of the capitation to the provider.
2. An EOB is not required unless there has been a final adjudication of the claim. For example, if an insurer is requesting additional information from its participating provider before it can render a coverage determination, an EOB is not required until the coverage determination is made.
3. An EOB is not required for instances where a global fee arrangement has been negotiated with a participating provider, but the participating provider itemizes or "unbundles" a claim for the services encompassed by the global fee.
4. An EOB is not required if the insurer makes a level of service adjustment to the claim (down-coding or up-coding) and the participating provider contract has a provision that allows the insurer to make such adjustments. If the contract does not contain this provision, an EOB must be issued.
5. An EOB is not required where the participating provider bills a larger amount than the amount specified or referenced in the provider contract (or agreement) with the insurer. This would be considered payment in full because the provider was paid the contracted amount.

6. An EOB is not required when an exact duplicate of a claim is resubmitted to the insurer for payment provided that an initial EOB has been issued to the insured.

Please note that it is the Department's position that transfer of risk to a third party, such as an Independent Practice Association (IPA), does not negate the obligation of the insurer to furnish an EOB to the insured or subscriber where required by Law.

Finally, the EOB requirements set forth in 3234 and this Circular Letter do not apply to Family Health Plus, Medicaid or Child Health Plus because member notices are already required for these government programs by Federal regulations. Insurers will be advised by the Department of Health as to the content of the notices of determination that will be issued to members of these plans.

Any questions regarding this Circular Letter may be directed to Janet A. Graham of this Department at (518) 486-7815 or by e-mail to jgraham@ins.state.ny.us.

Very truly yours,

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