



## What We Did in 2009: Brief Summary of Stakeholder Gains from NYS Legislative Bill S5472-A/A8402-A

Key Beneficiary	Benefit Gained
All Healthcare Providers*	Prompt Pay: Reduces timeframe for prompt pay of reimbursement from plans, from current 45 day maximum to 30 days maximum for electronic/internet claims submission, and to 45 days for claims submitted via fax & paper (mail). If a plan needs more information to adjudicate the claim, it must notify the provider within 30 days for all claims (electronic and paper).
Hospitals	Unless fraud is suspected, plans now limited to a 2 year look back on claims paid to hospitals.
MD's & Healthcare Professionals	90 days notice to MDs from plans before "adverse reimbursement change"; MDs may terminate contract within 30 days of receiving notice.
Patients	<ul style="list-style-type: none"> <li>• Grievance process must exist &amp; be communicated;</li> <li>• Plans must provide access to specialty care; network of providers must exist</li> <li>• Plans must provide access to transitional care</li> <li>• Extends deadline from 90 to 120 days for submitting documentation of loss of time for disability</li> </ul>
Patient & All Healthcare Providers	Coordination of Benefits: Claims Can No Longer Be Pended or Denied: Prohibits an insurer from denying a claim on the basis that it is coordinating benefits and another insurer is liable for payment, unless the plan has a reasonable basis to believe that the consumer has other primary health coverage or if the insurer does not have current information from the insured. However, if the insurer does not have current information, the plan has only 45 days to request and receive the needed information from the insured. If no information is received by the end of the 45-day timeframe, the claim must be adjudicated.
Insurers	Submission of Claims: <ul style="list-style-type: none"> <li>• Providers must submit claims to insurer within 120 days after date of service, unless contractually negotiated otherwise.</li> <li>• 25% reduction in reimbursement for untimely filing of claims, unless contractually negotiated otherwise by the hospital, or there is an unusual circumstance preventing submission within the timeframe by the hospital.</li> <li>• Plan may deny claim in full if 365 days after date of service.</li> <li>• Provider gets more time (a) if unusual circumstances exist and are documented, and (b) providers have demonstrated pattern of timely filings.</li> </ul>

\* All Healthcare Providers means hospitals and physicians.

\*\* MLR = Medical Loss Ratio = the percentage of premium dollars collected for a specific health insurance product, that are then expended on healthcare services.

Key Beneficiary	Benefit Gained
Businesses & Consumers	Medical Loss Ratio** remains 75% for small group, and 85% for large employer plans. However, new provision requires plans that do not meet those MLRs to either (a) issue refunds to policy holder or subscriber who had a policy at <i>any point</i> during the contract period, or, (b) with approval of the Superintendent of Insurance, issue credits toward the current premiums.
All Providers	Credentialing of Physicians: Failure of health plan to provide timely notice of application status means automatic credentialing in network
Health Plan	<ul style="list-style-type: none"> <li>• Credentialing of Physicians: Refund \$ received if MD denied credentials.</li> <li>• Submission of Claims: Decreased window. Unless contracts stipulate otherwise, claims must now be submitted within 12 months to qualify for reimbursement (previously 15 months.)</li> </ul>
All Healthcare Providers	No penalties for one provider (e.g. hospital or MD) if the other provider is out-of-network during an episode of patient care requiring multiple providers
All Healthcare Providers & Patients	Transitional care must be covered by the Plans while provider awaits authorization of such care.
Patients & All Healthcare Providers	<p>External Appeals: Providers would have an explicit right to both a retrospective and concurrent external appeal in the event of an adverse determination. The legislation also requires the external appeal agent to notify a provider of the determination when necessary.</p> <ul style="list-style-type: none"> <li>• Loser Pays: An external appeal initiated by a provider that is rendered in favor of the provider must be paid for by the plan; when rendered in favor of the plan, the appeal must be paid for by the provider (except when the provider is acting as the insured's designee, in which case the appeal is paid for by the plan); when rendered partially in favor of either party, payment would be equally divided between the plan and provider.</li> <li>• Hold Harmless: A provider requesting an appeal cannot pursue reimbursement from the consumer for services determined by the agent to be not medically necessary, except for copayment, coinsurance, or deductible.</li> </ul>

\* All Healthcare Providers means hospitals and physicians.

\*\* MLR = Medical Loss Ratio = the percentage of premium dollars collected for a specific health insurance product, that are then expended on healthcare services.