COSTS:
Costs for the Implementation of, and Continuing Compliance with this Regulation to Regulated Entity:
We estimate this change will increase Medicaid costs by about 7.4 million dollars gross, annually. Of this amount, about 1.2 million dollars is attributable to allowing FQHCs to bill for limited off-site visits. 6.2 million dollars is attributable to allowing FQHCs to bill for group therapy services. These changes are being made in order to comply with Federal requirements.

Pricing & Volume Data				Cost Estimates
	Downstate	Upstate	Statewide Average	
Offsite Visits				Offsite Visits
Subsequent Hospital Care	$62.73	$55.19	$58.96	$1,117,212
Psychotherapy Services				Group Therapy
Group Psychotherapy	$34.86	$30.81	$32.84	$6,222,733
2004 FQHC Visit Volume	1,894,864			
				Total
Volume Increase Assumptions				$7,339,945
Group Therapy Increase = 10% Increase				
2004 FQHC Volume				
Off-site Visit Increase = 1% Increase				
Over 2004 FQHC Volume				

Cost to the Department of Health:
This represents a permanent filing of regulations already in effect. There will be no additional costs to the Department.
Local Government Mandates:
This amendment will not impose any program service, duty or responsibility upon any county, city, town, village school district, fire district or other special district.
Paperwork:
This amendment will increase the paperwork for providers only to the extent that providers will bill for social work services.
Duplication:
This regulation does not duplicate, overlap or conflict with any other state or federal law or regulations.
Alternatives:
Recent changes to federal law make it clear that states must reimburse FQHCs under Medicaid for off-site primary care services and the services of certified social workers for both individual and group psychotherapy. In light of this federal requirement, no alternatives were considered.
Federal Standards:
This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.
Compliance Schedule:
The proposed amendment will become effective upon filing with the Secretary of State.

Regulatory Flexibility Analysis
Effect on Small Businesses and Local Governments:
No impact on small businesses or local governments is expected.
Compliance Requirements:
This amendment does not impose new reporting, record keeping or other compliance requirements on small businesses or local governments.
Professional Services:
No new professional services are required as a result of this proposed action. These changes will bring our regulations into compliance with the State Education Department's (SED) new standards for social worker licensure.
Compliance Costs:
This amendment does not impose new reporting, recordkeeping or other compliance requirements on small businesses or local governments.
Economic & Technological Feasibility:
DOH staff has had conversations with the National Association of Social Workers (NASW), UCP, and CHCANYS concerning the interpretation of the current regulation as well as proposed changes to the existing regulation. Although some systems changes will be necessary to ensure that payment is made only to FQHCs, the proposed regulation will not change the way providers bill for services, and thus there should be no concern about technical difficulties associated with compliance.
Minimizing Adverse Impact:
There is no adverse impact.
Opportunity for Small Business Participation:
Participation is open to any FQHC that is certified under Article 28 of the Public Health Law, regardless of size, to provide individual psychotherapy services by certified social workers. Any FQHC, regardless of size, may participate in providing off-site primary care services as well as on-site group psychotherapy services by certified social workers, a licensed psychiatrist or psychologist.

Rural Area Flexibility Analysis
Types and Estimated Number of Rural Areas:
This rule will apply to all Article 28 clinic sites in New York that have been designated by the Centers for Medicare and Medicaid Services (CMS) as Federally Qualified Health Centers. These businesses are located in rural, as well as suburban and metropolitan areas of the State.
Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:
No new reporting, recordkeeping or other compliance requirements and professional are needed in a rural area to comply with the proposed rule.
Compliance Costs:
There are no direct costs associated with compliance.
Minimizing Adverse Impact:
There is no adverse impact.
Opportunity for Rural Area Participation:
The Department has had conversations with the National Association of Social Workers Association (NASW), UCP, and CHCANYS to discuss Medicaid reimbursement for social work services and the impact of this new rule on their constituents. These groups and associations represent social workers and clinic providers from across the State, including rural areas.

Job Impact Statement
Nature of Impact:
It is not anticipated that there will be any impact of this rule on jobs or employment opportunities.
Categories and Numbers Affected:
There are almost 1000 Article 28 clinics of which approximately 58 are FQHCs, FQHC look-alikes, and rural health clinics.
Regions of Adverse Impact:
This rule will affect all regions within the State and businesses out of New York State that are enrolled in the Medicaid Program as an Article 28 clinic and that has been designated by the Centers for Medicare and Medicaid Services (CMS) as a Federally Qualified Health Center.
Minimizing Adverse Impact:
The Department is required by federal rules to reimburse FQHCs for the provision of primary care services, including clinical social work services, based upon the Center's reasonable costs for delivering covered services.
Self-Employment Opportunities:
The rule is expected to have no impact on self-employment opportunities since the change affects only services provided in a clinic setting.

Insurance Department

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Guidelines for the Processing of Coordination of Benefit (COB) Claims

I.D. No. INS-52-08-00006-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Amendment of Parts 52 and 217 of Title 11 NYCRR.

Statutory authority: Insurance Law, sections 201, 301, 1109, 2403, 3216, 3221, 3224-a, 3224-b, 4304 and 4305

Subject: Guidelines for the processing of Coordination of Benefit (COB) claims.

Purpose: To establish guidelines for the processing of healthcare claims for persons covered by more than one health insurance policy.

Text of proposed rule: Section 52.23(r) is amended to read as follows:
(r) Right of recovery. *Subject to the provisions of Section 217-2.2(c) of this Title (Regulation No. 178)*
(1) If the amount of the payments made by an insurer is more than it

should have paid under its COB provision, it may recover the excess from one or more of:

(i) the persons it has paid or for whom it has paid;

(ii) insurance companies; or

(iii) other organizations.

(2) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this subdivision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

Part 217 is hereby retitled: ''Processing Of Health Insurance Claims.''

Part 217 (Regulation No. 178) is hereby renumbered Subpart 217-1, in sequence. Subpart 217-1 shall be entitled: ''Prompt Payment of Health Insurance Claims.''

New section 217-1.1 is amended to read as follows:

Section 217-1.1 Definitions and applicability.

(a) For the purposes of this [Part] *Subpart*:

(b) This [Part] *Subpart* shall apply to all health care claims submitted under contracts or agreements issued or entered into pursuant to Articles 32, 42 or 43 of the Insurance Law or Article 44 of the Public Health Law.

New section 217-1.2(d) is amended to read as follows:

(d) Nothing in this [Part] *Subpart* shall prohibit a payer from electing to accept some or all claims with less information than that specified in the lists set forth in subdivisions (b) and (c) of this section.

A new Subpart 217-2, entitled ''Coordination of Benefit Claims,'' is added to read as follows:

Section 217-2.1 Definitions and Applicability.

(a) For purposes of this Subpart:

(1) Coordination of benefits or COB means a procedure that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more health insurers providing benefits or services for medical, dental or other care or treatment by: establishing an order in which plans pay their claims, providing the authority for the orderly transfer of information needed to pay claims properly and permitting a reduction of the benefits of a health insurer when, by the rules established by Section 52.23 of this Title (Regulation No. 62), it does not have to pay its benefits first.

(2) Health care claim means a request for payment for services rendered to an insured pursuant to the benefits provided in a health insurance policy.

(3) Health care provider means an entity licensed or certified pursuant to Article 28, 36 or 40 of the Public Health Law; a facility licensed pursuant to Article 19, 23 or 31 of the Mental Hygiene Law; a health care professional licensed, registered or certified pursuant to Title 8 of the Education Law; or a health care provider comparably licensed, registered or certified by another state; or a dispenser or provider of pharmaceutical products, services or durable medical equipment.

(4) Health insurance policy means a contract that provides benefits or services for medical, dental or other health care or treatment.

(5) Health insurer means an insurer that issues a health insurance policy.

(6) Remittance advice means a form on which a health insurer indicates to a health care provider the details of the health insurer's processing of a particular claim.

(7) Primary health insurer means a health insurer whose benefits for a person's health care coverage must be determined without taking the existence of coverage issued by any other health insurer into consideration, pursuant to the COB rules in Section 52.23 of this Title and the provisions of the health insurer's policy or contract.

(8) Secondary health insurer means a health insurer that is not a primary health insurer that may take into consideration the benefits of the primary health insurer or insurers and the benefits of any other accident and health coverage.

(b) This Subpart shall apply to a health insurer authorized to write accident and health insurance pursuant to Article 42 of the New York Insurance Law, a corporation licensed pursuant to Article 43 of the Insurance Law, or an entity certified pursuant to Article 44 of the Public Health Law, with respect to a health care claim submitted under a health insurance policy.. This Subpart shall not apply to coordination of benefits involving no-fault auto insurance policies, workers compensation polices or the Medicare program.

(c) The requirements of this section shall apply when an individual is covered, or where there is a reasonable basis supported by specific information to believe that the individual is covered, under more than one health insurance policy that provides benefits or services for medical, dental or other care or treatment.

Section 217-2.2 Coordination of benefit requirements.

(a) When a health care provider submits a claim to a health insurer, that submission shall suspend the time period for submission of the claim to a second health insurer until such time as the provider has received a remittance advice or other evidence of a benefit determination, including an appeal determination, from the first health insurer. After the health care provider receives a remittance advice, appeal determination, or other evidence of a benefit determination from the first health insurer, the health care provider shall have at least 60 days from receipt of the remittance, appeal determination or other evidence of a benefit determination to bill any other health insurer that has a potential payment obligation. A claim submitted to the second health insurer after the 60-day period shall be subject to the claims submission rules of the second health insurer. Unless the health care provider is otherwise able to demonstrate, it shall be presumed that the remittance advice, appeal determination, or other evidence of a benefit determination was received within eight calendar days of the date on the document.

(b)(1) If a health care provider submits a claim to a secondary health insurer prior to submitting the claim to the primary health insurer, the secondary health insurer shall deny the claim, notify the health care provider that it is secondary and notify the health care provider of the identity of the primary health insurer, or, if the identity of the primary health insurer is not known, provide whatever information was used to make the determination that it is a secondary health insurer. The secondary health insurer may provide the information by referring the health care provider to the specific page of the secondary health insurer's website and shall include a toll free telephone number through which the information will be provided. The health care provider's submission of the claim to the primary health insurer shall suspend the time period for resubmission of such claim to the secondary health insurer as set forth above in subdivision (a) of this section.

(2) If the information provided by the secondary health insurer is not sufficient to determine the identity of the primary health insurer, the health care provider shall have 60 days from the notice that other coverage may exist to make a reasonable effort to confirm if other coverage does exist. A ''reasonable effort'' shall include at least an attempt by the health care provider to contact the patient.

(3) If the health care provider is unable to confirm other coverage within 60 days as provided in paragraph (2) of this subdivision, the secondary health insurer shall process the claim in accordance with the provisions in the health insurance policy, provided that the health care provider resubmits the claim to the secondary health insurer, with copies of the documents to support the health care provider's efforts to confirm other coverage, within 30 days of the determination that other coverage could not be confirmed despite reasonable efforts.

(c)(1) If a secondary health insurer makes a payment to a health care provider prior to determining the secondary health insurer's actual obligation to pay the claim, the secondary health insurer shall delay any action to recover the payment, pending a determination by the primary health insurer as to the primary health insurer's obligation and a determination by the secondary health insurer of its actual obligation to pay the claim. Subject to all provisions of this subdivision, the secondary health insurer may recover the payment if the health care provider does not submit a remittance advice, appeal determination, or other evidence of a benefit determination from the primary health insurer to the secondary health insurer within 120 days of the secondary health insurer's notification that other coverage exists. Nothing herein shall prevent the secondary health insurer from allowing more than 120 days to submit the documents.

(2) If the information provided by the secondary health insurer is not sufficient to determine the identity of the primary health insurer, the health care provider shall have 60 days from the notice that other coverage may exist to make a reasonable effort to confirm if other coverage does exist. A ''reasonable effort'' shall include at least an attempt by the health care provider to contact the patient.

(3) If the health care provider is unable to confirm other coverage within 60 days as provided in paragraph (2) of this subdivision, the secondary health insurer shall process the claim in accordance with the provisions in the member's health insurance policy, provided that the health care provider notifies the secondary health insurer and forwards copies of the documents to support the health care provider's efforts to confirm other coverage, within 30 days of the determination that other coverage could not be confirmed despite reasonable efforts.

(d) If a health care provider receives approval from a health insurer to provide services to the health insurer's insured, prior to the rendering of those services to the insured, a second health insurer shall not subsequently deny a claim for the services on the basis that no prior approval from that health insurer was received. The fact that one health insurer has given a health care provider prior approval does not, however, preclude another health insurer from determining that the services that were provided were not medically necessary or otherwise not covered under the policy.

(e) Every determination of the primary health insurer and secondary health insurer shall comply with Section 3224-a of the Insurance Law.

Section 217-2.3 Effective Date.

This Subpart shall apply to all claims initially submitted on or after January 1, 2008.

Text of proposed rule and any required statements and analyses may be obtained from: Andrew Mais, NYS Insurance Department, 25 Beaver Street, New York, NY 10004, (212) 480-2285, email: Amais@ins.state.ny.us

Data, views or arguments may be submitted to: Laura Dillon, Consumer Services Bureau, NYS Insurance Department, One Commerce Plaza, Albany, NY 12257, (518) 486-9105, email: Ldillon@ins.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Consolidated Regulatory Impact Statement

1. Statutory authority: Sections 201 and 301 authorize the Superintendent to effectuate any power granted to the Superintendent under the Insurance Law, and to prescribe forms or otherwise make regulations.

Section 1109 authorizes the Superintendent to promulgate regulations affecting health maintenance organizations (HMOs) and effectuating the purposes and provisions of the Insurance Law and Article 44 of the Public Health Law.

Section 2403 prohibits unfair and deceptive acts or practices.

Section 3216 describes the policy provisions required for individual accident and health insurance forms.

Section 3221 describes the policy provisions required for group accident and health insurance forms.

Section 3224-a requires insurers, HMOs and prepaid health services plans (PHSPs) to process claims within specified time frames, except in those instances where the obligation of the insurer is not reasonably clear.

Section 3224-b establishes rules relating to the processing of health claims and overpayments to physicians.

Section 4304 describes the policy provisions required for individual contracts issued by non-profit medical and dental indemnity or health and hospital services corporations.

Section 4305 describes the policy provisions required for group contracts issued by non-profit medical and dental indemnity or health and hospital services corporations.

2. Legislative objectives: The rulemaking is intended to facilitate the timely processing and payment of health insurance claims in those circumstances where the patient is covered by more than one policy issued by different insurers. Insurers, HMOs, and PHSPs do not always provide all available information, such as the name of the other insurer, to the health care provider when it is determined that other coverage exists. If the claim has already been paid, many times the insurer, HMO or PHSP will recoup the payment from current claims, leaving the provider with an unpaid claim and insufficient information to seek payment from the other carrier. This recoupment is done through accounting transactions on the remittance advice in which the insurer or HMO makes a payment for patient ''A'' and then deducts a payment for patient ''B'' that was originally paid on a previous remittance advice. This results in the appearance of an underpayment by the insurer or HMO for patient A. This practice is permitted if the agreement between the provider and insurer or HMO contains language that allows for the recovery of overpayments in this manner. In addition, if the name of the other insurer is known and the claim is submitted for payment, many times the claim will be denied for late filing, again leaving the provider with an unpaid claim after services had been rendered.

3. Needs and benefits: 11 NYCRR 53.23 (Regulation 62) currently requires insurers, HMOs, and PHSPs to coordinate benefits when a member is covered by more than one accident and health policy. The proposed Subpart 217-2 to Regulation 178 would establish procedures that an insurer, HMO or PHSP must follow when it is determined that other coverage may exist. In addition, the proposed Subpart establishes requirements for the provider if the provider wishes to seek payment from the other insurer, and the time in which the provider must act. These procedures include guidelines for those cases when the claim has already been paid before the existence of other coverage is established, as well as when the existence of other coverage is established before any claim payment is made. The guidelines also change the timely filing requirements for those cases where other coverage exists. The time begins to run from the date of notification of other coverage, not from the date of service. Ultimately, these procedures prevent providers from being stuck with unpaid claims when an insurer recoups payment and the other plan denies the claim for late filing. The amendment to Regulation 62 cross-references the two regulations.

4. Costs: This rule imposes no compliance costs on state or local governments. The Insurance Department does not anticipate any additional costs to this Department.

The costs to regulated parties would be negligible once the process is implemented. The only initial costs are the time and expense required for the insurer, HMO or PHSP to reprogram their internal processing procedures to conform to the new regulation. These regulations are the results of many meetings with representatives of health care providers (Medical Society of the State of New York, Greater New York Hospital Association and Healthcare Association of New York), insurers, HMOs and PHSPs (Health Plan Association and Conference of the Blue Cross Blue Shield) and the New York State Departments of Health and Insurance. These discussions took place over several years from 2004 until a consensus on the Regulation was reached in 2007. Therefore the industry was included in the negotiations of this regulation and is in agreement with the new procedures.

The costs to health care providers include the cost of producing correspondence to their patients regarding additional coverage, the postage to mail such correspondence and the administrative cost of producing the letter. However these negligible costs are offset by the income retained by the provider when the insurer or HMO does not recoup the payment on these claims.

5. Local government mandates: This rule does not impose any program, service, duty or responsibility upon a city, town, village, school district or fire district.

6. Paperwork: There is no additional paperwork required as a result of this amendment.

7. Duplication: This amendment will not duplicate any existing state or federal rule for insurers that write accident and health insurance.

8. Alternatives: No viable alternatives. This amendment was the result of many meetings with representatives of health care providers (Medical Society of the State of New York, Greater New York Hospital Association and Healthcare Association of New York), insurers, HMOs and PHSPs (Health Plan Association and Conference of the Blue Cross Blue Shield) and the New York State Departments of Health and Insurance. These discussions took place over several years from 2004 until consensus was reached in 2007. During these discussions various other options were discussed, such as not making any changes to the current process and also extending or reducing the time frames in this Regulation.

Taking no action was not an option for the healthcare providers who were looking for a way to retain payment for the services they had provided. Reducing the timeframes in this Regulation did not permit the healthcare providers enough time to appeal timely filing denials that will undoubtedly result from the automatic claim processing systems. The health insurance industry was not agreeable to extending the time frames because they want to ensure that the process is concluded in a reasonable amount of time.

After much discussion the proposal as submitted was agreed upon since it provides time for the healthcare providers to investigate whether or not other coverage exists while holding them to a reasonable timeframe, thus permitting the insurers or HMOs to ultimately close their books. The healthcare providers have incentive to work within the timeframes if they wish to preserve the income.

9. Federal standards: There are no minimum federal standards for the processing of claims involving the coordination of benefits. The regulation is not inconsistent with any federal standards or requirements.

10. Compliance schedule: The guidelines shall take effect 90 days after the notice of adoption is published in the State Register and shall apply to all claims initially submitted on or after that date.

Consolidated Regulatory Flexibility Analysis

1. Effect of rule: These regulations will affect insurers paying claims under contracts written pursuant to Articles 32, 42 and 43 of the Insurance Law and health maintenance organizations (HMOs) and prepaid health service plans (PHSPs) authorized pursuant to Article 44 of the Public Health Law. The Insurance Department has reviewed the filed Reports on Examination and Annual Statements of insurers authorized to do business in New York and HMOs, and has concluded that the insurers and HMOs do not fall within the definition of small business found in Section 102(8) of the State Administrative Procedure Act, because there are none which are both independently owned and have under 100 employees.

There are less than 20 PHSPs in New York, some of which are small businesses. PHSPs are entities certified pursuant to Article 44 of the Public Health Law that provide Medicaid services in a managed care environment. However, they will not be negatively impacted by this regulation. These regulations establish minimum requirements for the processing of Coordination of Benefit (COB) claims. These minimum guidelines will assist insurers, including PHSPs, by defining the requirements for processing these claims.

These regulations will also affect health care providers, many of which are small businesses. These regulations set forth guidelines for the processing of these claims, and reduce the administrative burden on the providers by requiring that insurers provide the name of the other insurer when a patient is covered by more than one health insurance policy. In addition,

the guidelines prohibit the automatic recoupment of claims already paid while giving the provider time to seek payment from the other insurer.

These regulations would affect health care facilities that are owned or operated by state or local governments as they would any other healthcare provider. While there will be a small administrative burden to determine if other coverage existed, the income preserved would offset any negative impact. For state and local governments that do not own or operate health care facilities, the regulations do not impose any impacts, including any adverse impacts, or reporting, recordkeeping, or other compliance requirements.

These regulations are the result of meetings with representatives of health care providers, insurers, HMOs and PHSPs, and represent a consensus between the Department and various interested parties as to the appropriate handling of claims.

2. Compliance requirements: Coordination of benefits is already required by 11 NYCRR 52.23 (Regulation 62). Insurers, HMOs and PHSPs are already required to coordinate payments with the benefits of other insurers. There are no compliance requirements for local governments unless they own or operate a healthcare facility. In that case the compliance requirements would be the same as other healthcare providers who, if they choose to take advantage of the process in this regulation, will be required to attempt to verify the existence of other coverage if the name of the primary carrier is not provided by the secondary health plan. In those cases the provider would have 60 days from the notice of other potential coverage to verify whether or not the coverage existed. If the coverage is verified the healthcare provider must submit the claim to the primary carrier. If other coverage is not confirmed the healthcare provider must notify the secondary carrier and provide documents to support their efforts to confirm the existence of other coverage. There are no compliance requirements for small businesses except for health care providers and they are not negatively impacted since the ability to retain the income for services already provided far exceeds the cost of attempting to verify other coverage. These regulations were negotiated with the purpose of helping health care providers by leveling the playing field with regard to COB claims.

3. Professional services: Insurers, HMOs and PHSPs should not need to obtain professional services to comply with these regulations. Health care providers do not need to obtain professional services as a result of this regulation.

4. Compliance costs: Insurers, HMOs and PSHPs are already subject to the COB requirements in Regulation 62. Regulation 62 permits insurers and HMOs to coordinate coverage and establishes uniformity in the processing of health care claims when consumers are covered by more than one health plan. This new regulation has been requested by interested parties in order to establish the framework for handling COB claims, both pre-payment and post-payment. The costs to regulated parties would be negligible once the process is implemented. The only initial costs are the time and expense required for the insurer, HMO or PHSP to reprogram their internal processing procedures to conform to the new regulation. However, the industry (The Health Plan Association and Conference of Blue Cross Blue Shield) was included in the negotiations of this regulation and is in agreement on the new procedures.

Costs to health care providers are difficult to measure. In most cases it is anticipated that the secondary insurer will identify the name of the other insurer, in which case the health care provider must simply submit the claim to the other insurer or HMO. If the claim is denied for timely filing by the primary carrier, the healthcare provider will need to appeal the denial and provide a copy of the notice from the secondary carrier. This is an administrative procedure and the costs associated with it involve the generation of correspondence, postage and labor costs. The total cost cannot be estimated because it is not known how many providers will actually take advantage of this process. That being said, the income retained through this process will far outweigh any administrative cost incurred by the health care provider.

5. Economic and technological feasibility: Compliance with these regulations should be economically and technologically feasible for small businesses since the purpose of the regulations is to streamline the processing of COB claims. Adherence on the part of the health care provider will result in less administrative cost because insurers' responsibilities are more clearly defined.

6. Minimizing adverse impact: These regulations are intended to help health care providers, many of which are small businesses, by leveling the playing field. They prevent insurers from recouping money before providers have an opportunity to seek payment from another carrier. If the other coverage cannot be verified, the insurer that paid the claim is prohibited from recouping the payment. Thus, providers will retain the income for the services they have provided.

Other options were discussed at the Healthcare Roundtable including making no changes to the current process, increasing or decreasing the time frames in this regulation and permitting the secondary insurer to recoup the money even if the primary insurer could not be identified. The health insurance industry acknowledged the current process was unfair to health care providers and agreed to accept the liability for the services if the other insurer could not be identified. At the same time the industry asked that the providers be required to make an effort to determine if there was other coverage and also requested time frames in which the provider must act.

7. Small business and local government participation: Notification of the Department's intent to propose the regulations was included in the Department's regulatory agenda for June, 2008 and was accessible to small businesses and local governments. Interested parties representing insurers, HMOs, PHSPs, (The Health Plan Association and the Conference of Blue Cross Blue Shield) and healthcare providers (Medical Society of the State of New York, Greater New York Hospital Association and the Healthcare Association of New York) developed the regulation with representatives of New York State Departments of Health and Insurance during numerous meetings convened by the Department of Insurance. As a result the interested parties had an opportunity to participate in the rule-making process. During these meetings which occurred over several years, the various affected parties discussed many options and alternatives. These include making no changes to the current process, increasing or decreasing the time frames in this regulation and permitting the secondary insurer to recoup the money if the primary insurer could not be identified. The industry recognized that the healthcare providers had served their members in good faith and should be paid for their services. After much discussion we agreed to a regulation that was acceptable to all parties.

Consolidated Rural Area Flexibility Analysis

1. Types and estimated number of rural areas: Insurers to which these regulations are applicable, health maintenance organizations (HMOs) and prepaid health service plans (PHSPs), do business in every county of the state, including rural areas as defined under Section 102(13) of the State Administrative Procedure Act. Health care providers in New York State are comprised of mostly physicians, but include other health care providers in individual practices or small groups throughout the state, including rural areas.

2. Reporting, recordkeeping and other compliance requirements; and professional services: In addition to the requirements currently in contained in 11 NYCRR 52 (Regulation 62), this Regulation will require insurers, HMOs and PHSPs to provide the name of the primary insurer, if known. These regulations will also require health care providers to document their efforts to verify other coverage. If the primary insurer initially denies the claim for late filing the health care providers may also have to appeal the denial and provide a copy of the notice of other coverage from the secondary insurer. These requirements are ministerial in nature and the benefit of retaining the payment for services provided far outweighs the costs.

3. Costs: The costs to regulated parties will be negligible once the process is implemented. The only initial costs are the time and expense required for the insurer, HMO or PHSP to reprogram their internal processing procedures to conform to the new regulations. Any other costs associated with processing COB claims have already been incurred by insurers, HMOs and PHSPs with the implementation of Regulation 62. These proposed regulations do not require insurers, HMOs or PHSPs to provide additional or new benefits, but simply establish the procedures to follow when processing a Coordination of Benefits (COB) claim. The health insurance industry was included in the negotiations of this regulation and is in agreement about the new procedures and thus have accepted the costs associated with this regulation.

Health care providers will also incur ministerial costs associated with documenting their reasonable effort to identify other coverage, the cost of filing an appeal, related postage and labor costs. However, the benefits of retaining the income for services provided outweigh these costs. In addition, similar costs are currently incurred by health care providers who appeal the recoupments under the current process. This regulation will allow health care providers to retain their income for services provided that otherwise would have been recovered by insurers and HMOs.

4. Minimizing adverse impact: The regulations have the potential to decrease expenses to insurers, HMOs and PHSPs in rural areas by reducing the number of claims that need to be reprocessed. The regulations also will maximize the accounts receivable of health care providers, because insurers will be unable to recoup the payment on a COB claim without first giving the healthcare provider the opportunity to verify other coverage and seek payment from the other insurer. If other coverage cannot be verified and the healthcare provider notifies the secondary insurer in a timely manner the payment cannot be recovered. This should assist in keeping local providers in family practice in their respective communities, and foster consumers' continued access to rurally located providers.

5. Rural area participation: Notification of the Department's intent to propose these regulations were included in the Department's Regulatory Agenda for June, 2008. In addition, interested parties representing insur-

ers, HMOs, PHSPs and providers, including those actually or potentially located in rural areas, discussed the regulation during numerous meetings convened by the Department, and therefore had an opportunity to participate in the rule-making process. The proposed regulation also provides flexibility for providers located in rural areas. First, the healthcare provider has an option to obtain the name of the other insurer either by calling a toll-free telephone number or use of the internet. There is also flexibility in how healthcare providers attempt to verify the existence of other coverage. For instance, there are no requirements that attempts be made via notarized documents or certified mail, thus permitting healthcare providers in rural areas the flexibility to handle these functions in a manner that best meets their abilities.

Consolidated Job Impact Statement

These regulations will not adversely affect jobs or employment opportunities in New York State. The regulations are intended to improve the relationship between payers and providers, ultimately assisting providers in collecting payment for services provided, and keeping providers in their communities. As result of these regulations, providers will spend less time tracking down other coverage and attempting to collect on claims where payment has been made and then recouped by the payers.

There is no anticipated adverse impact on job opportunities in this state.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Credit for Reinsurance from Unauthorized Insurers

I.D. No. INS-52-08-00008-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Amendment of Part 125 (Regulation 20) of Title 11 NYCRR.

Statutory authority: Insurance Law, sections 201, 301, 307(a), 308, 1301(a)(14), 1301(c) and 1308

Subject: Credit for Reinsurance from Unauthorized Insurers.

Purpose: Reinsurance companies that are not authorized or accredited will now post collateral based on their credit ratings.

Substance of proposed rule (Full text is posted at the following State website:http://www. ins.state.ny.us): Sections 125.1, 125.2 and 125.3 are repealed to delete redundant and dated insolvency clause requirements and a new Section 125.1 is proposed to apply principle-based credit risk management standards to all licensed ceded insurers.

Section 125.4 is renumbered Section 125.2 and amended to include a new Section 125.2(h) to provide alternative credit for cessions to unauthorized reinsurers. This alternative credit to unauthorized reinsurers adjusts the credit that the ceding insurer may take in its financial statement based upon the financial strength of the unauthorized assuming reinsurer. In order to qualify for the reduced credit, the unauthorized assuming reinsurer in the transaction must:

- maintain a minimum net worth of $250 million;
- be authorized and meet the standards of solvency and capital adequacy in its domiciliary jurisdiction; and
- have a credit rating from at least two rating agencies.

Moreover, to qualify for the reduced credit with respect to cessions to an unauthorized non-U.S. assuming insurer, the superintendent and the domiciliary regulator of the unauthorized non-U.S. assuming reinsurer must have in place an executed memorandum of understanding pursuant to this part. Further, the domiciliary jurisdiction of an unauthorized non-U.S. assuming reinsurer shall allow U.S. reinsurers access to the market of that jurisdiction on terms and conditions that are at least as favorable as those provided in New York laws and regulations for unauthorized non-U.S. assuming insurers.

Ceding insurers seeking alternative credit for cessions to unauthorized reinsurers must maintain audited financial statements for the unauthorized assuming reinsurers for the last three years, and maintain satisfactory evidence that an unauthorized reinsurer meets the requirements mentioned above.

The reinsurance contract itself must contain an insolvency clause, a designation of a person in New York or the ceding insurer's domestic state for service of process, a requirement that any disputes will be subject to United States courts and laws, and a requirement that the unauthorized assuming reinsurer will notify the ceding insurer of any changes in its license status or any change in its rating from a credit rating agency.

While this alternative credit for cessions to unauthorized reinsurers will reduce the collateral requirement in a manner that corresponds to the financial strength of the reinsurer, where an order of rehabilitation, liquidation or conservation is entered against the ceding insurer, the unauthorized assuming reinsurer must, as a general matter, post full collateral for all outstanding liabilities owed to the ceding insurer.

Section 125.5 is renumbered Section 125.3 and various references to other sections are corrected.

Section 125.6 is renumbered Section 125.4 and various references to other sections are corrected.

Section 125.7 is renumbered Section 125.5 and a reference to another section is corrected.

Section 125.8 is renumbered Section 125.6.

Text of proposed rule and any required statements and analyses may be obtained from: Andrew Mais, New York Insurance Department, 25 Beaver Street, New York, NY 10004, (212) 480-2285, email: amais@ins.state.ny.us

Data, views or arguments may be submitted to: James Davis, New York Insurance Department, 25 Beaver Street, New York, NY 10004, (212) 480-5124, email: jdavis@ins.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Summary of Regulatory Impact Statement

1. Statutory authority: Sections 110, 201, 301, 307(a), 308, 1301(a)(14), 1301(c) and 1308 of the Insurance Law.

These sections establish the Superintendent's authority to promulgate regulations governing when an authorized ceding insurer (i.e., an insurer authorized or licensed to do business in New York) may take credit on its balance sheet for a reinsurance recoverable from an assuming insurer not authorized in this state.

Section 110 authorizes the Superintendent to share documents, materials and other information with other state, federal and international regulatory agencies and the National Association of Insurance Commissioners (NAIC).

Sections 201 and 301 of the Insurance Law authorize the Superintendent to effectuate any power accorded to him by the Insurance Law, and prescribe regulations interpreting the Insurance Law.

Section 307(a) requires insurers doing business in the state to file an annual statement, in a form and containing such matters as shall be prescribed by the Superintendent, in the office of the Superintendent.

Section 308 vests the Superintendent with the authority to require authorized insurers to file reports relating to the insurer's transactions, financial condition or any matter connected therewith.

Sections 1301(a)(14) and (c) and 1308 give the Superintendent the authority to prescribe, by regulation, the conditions under which an authorized ceding insurer may be allowed credit, as an asset or a deduction from loss and unearned premium reserves, for a reinsurance recoverable from an assuming insurer not authorized to do an insurance business in this state.

2. Legislative objectives: Article 13 of the Insurance Law establishes minimum standards for the assets of insurers, including when an authorized ceding insurer may take credit on its balance sheet for reinsurance recoverable from an assuming insurer not authorized to do an insurance business in this state.

3. Needs and benefits: Reinsurance is insurance for insurance companies. It is a means of redistributing risk throughout the global insurance industry. Often, an insurance company will transfer (or ''cede'') part or all of that risk to another party (the assuming insurer or reinsurer). The reinsurer then is ultimately responsible for paying its part of those ceded claims. The primary insurer, or ''cedent'', is given credit on its balance sheet for the business ceded to a reinsurer recognized by New York. This allows the cedent to reduce its reserves and increase the number of policies it can write. However, the ability to take a credit for ceded claims only applies on a very limited basis when the reinsurer, irrespective of its financial strength, is not authorized to do business in New York.

Under the current regulation, the cedent generally may take credit on its balance sheet only if the reinsurer posts collateral equal to 100 percent of the transferred policyholder claims. There is a seldom utilized section of the regulation that allows the cedent to take credit of up to 85% on its balance sheet for cessions to unauthorized companies, provided the cedent maintains documentation demonstrating that the unauthorized insurer meets financial requirements similar to those of New York authorized insurers.

Non-U.S. reinsurers posted an estimated $120 billion in collateral in the U.S. in 2005, the latest year for which there is available data, on which they pay about $500 million a year in transaction costs. The Insurance Department has seen no negative fiscal impacts on US ceding insurers in instances where the collateral levels have been reduced. It therefore makes sense, with appropriate safeguards in place, to build on this precedent and allow the most highly rated non-US reinsurers to reduce their collateral postings further.

Adoption of this amended regulation will reduce this transactional cost and increase reinsurance capacity. It also will bring New York in line with