PROGRAM BILL #288

GOVERNOR'S PROGRAM BILL

2010

MEMORANDUM

AN ACT to amend the insurance law, in relation to no-fault insurance

Purpose:

This bill would amend the Insurance Law to reform the automobile no-fault insurance system by: (1) allowing insurers to defend or deny a claim if timely payment is not made within thirty days after proof of claim has been submitted; (2) requiring arbitration of no-fault insurance claims under a certain amount; and (3) permitting the Superintendent to prohibit a provider of health services from demanding or requesting payment for health services rendered under Article 51 of the Insurance Law if the Superintendent determines that the provider has engaged in certain activities.

Summary of provisions:

Section 1 of the bill would amend the lead sentence of Insurance Law § 5102 to specify that the definitions set forth in that section apply only to Article 51 and not to the entire Insurance Law and to add new Insurance Law § 5102(n) to specify that the term "provider of health services" means "a person or entity who renders health services."

Section 2 of the bill would amend Insurance Law § 5106(a) to make the payment of interest and reasonable attorney fees to a claimant the exclusive remedy when an insurer fails to make timely payment. The failure of an insurer to make timely payment or issue a denial within thirty days after proof of claim has been submitted to an insurer shall not preclude such insurer from issuing a denial or asserting a defense after the thirty-day period has elapsed.

Section 3 of the bill would amend Insurance Law § 5106(b) to require mandatory arbitration of no-fault claims when the amount in dispute is five thousand dollars or less. The "amount in dispute" is defined as the total amount of disputed first party benefits sought by a claimant for health services rendered to an eligible injured person by a particular health service provider arising out of injuries sustained in a motor vehicle accident. The option of either an arbitration or court action is maintained for disputes in excess of five thousand dollars.

Section 4 of the bill would amend Insurance Law § 5106(c) to allow an insurer or claimant to obtain a de novo court review of a master arbitrator's award from a master arbitrator's award in the amount of three thousand dollars or greater, reduced from the current threshold of five thousand dollars or greater.

Section 5 of the bill would add a new Insurance Law § 5106(e) to require, with respect to an action for serious personal injury pursuant to Insurance Law § 5104, that the award or decision of an arbitrator or master arbitrator rendered pursuant to Insurance Law § 5106(c) shall not constitute collateral estoppel of the issues arbitrated.

Section 6 of the bill would amend Insurance Law § 5109 to permit the Superintendent to prohibit a provider of health services from demanding payment for health services rendered under Article 51 of the Insurance Law, for a period not exceeding three years, if the Superintendent determines, after notice and hearing, that the provider of health services:

(1) has admitted to or been found guilty of professional misconduct in connection with health services rendered under Article 51;

(2) solicited, or employed another person to solicit for the provider or another person or entity, professional treatment, examination or care of a person in connection with any claim under Article 51;

(3) refused to appear before, or answer any question upon request of the Superintendent, or refused to produce any relevant information concerning the provider's conduct in connection with health services rendered under Article 51;

(4) engaged in a pattern of billing for health services alleged to have been rendered under Article 51 which were not rendered, or engaged in a pattern of billing for unnecessary health services;

(5) utilized unlicensed persons to render health services under Article 51;

(6) utilized licensed persons to render health services, when rendering the health services is beyond the authorized scope of the person's license;

(7) ceded ownership, operation or control of a business entity that provides health services to a person not licensed to render the health services for which the entity is legally authorized to provide, unless otherwise permitted by law;

(8) committed a fraudulent insurance act as defined in Penal Law § 176.05;

(9) has been convicted of a crime involving fraudulent or dishonest practices; or

(10) violated any provision of Article 51 or regulations promulgated thereunder.

Section 6 of the bill would amend Insurance Law § 5109(c) to state that a provider of health services shall not demand or request payment for any health services under Article 51 that are rendered during the term of the prohibition ordered by the Superintendent pursuant to Insurance Law § 5109(b).

Section 6 of the bill would also amend Insurance Law § 5109(d) to require the Superintendent to maintain a database containing a list of providers of health services that the Superintendent has prohibited from demanding or requesting payment for health services rendered under Article 51, and to make this information available to the public.

Section 6 of the bill would also re-letter Insurance Law § 5109(e) as (f) and add a new subsection (e) to permit the Superintendent to levy a civil penalty not exceeding $50,000 on any provider of health services that the Superintendent prohibits from demanding or requesting payment for health services pursuant to Insurance Law § 5109(b). However, any civil penalty imposed for a fraudulent insurance act must be levied pursuant to Article 4 of the Insurance Law.

Section 7 of the bill provides that the act shall take effect immediately, except that sections three and four shall be effective one hundred and eighty days after enactment.

Existing law:

Arbitration proceedings, which are governed by the procedures set forth in 11 NYCRR §65.17, are subject to limited review by the courts. An arbitration award is binding on all parties to the arbitration, unless vacated or modified by a master arbitrator. The award of a master arbitrator, in turn, is also binding on the parties to the proceeding, unless vacated or modified by a court on any of the grounds set forth in Article 75 of the Civil Practice Law and Rules. Moreover, where the amount of the award of a master arbitrator is $5,000 or more, exclusive of interest or attorney's fees, a claimant may obtain de novo court review of his or her claim.

Insurance Law § 5102 defines, for purposes of the Insurance Law, terms related to no-fault insurance. Insurance Law § 5109 requires the Superintendent, in consultation with the Commissioners of Health and Education, to promulgate a regulation that establishes standards and procedures "for investigating and suspending or removing the authorization for providers of health services to demand or request payment for health services as specified in" Insurance Law § 5102(a)(1).

Insurance Law § 5109 also requires the Commissioners of Health and Education to provide a list of the names of all providers of health services who the Commissioners deem unauthorized to demand or request any payment for medical services because the provider has engaged in certain activities, including soliciting or employing another to solicit for himself or herself or for another, professional treatment, examination or care of an injured person in connection with any claim under Article 51, or engaging in patterns of billing for services that were not provided.

Insurance Law § 5109 also prohibits a provider of health services from subsequently treating, for remuneration, as a private patient, any person seeking medical treatment under Article 51 of the Insurance Law, and requires the Commissioners of Health and Education to maintain a database containing a list of providers of health services prohibited from demanding or requesting payment for health services.

Legislative history:

This is a new bill.

Statement in support:

No-fault insurance fraud is on the rise. The Insurance Department's Frauds Bureau has seen an increase in the number of referrals alleging no-fault insurance fraud of approximately ten percent each year since 2006. In 2009 alone, the number of no-fault referrals accounted for 54 percent of all referrals received by the Frauds Bureau.

Furthermore, the Insurance Department received more than 90 filings for increased automobile insurance premiums in 2009, the majority of these flex-rating. Roughly 85% of the market changed rates, for an average increase of 6.3% for these companies. Much of this increase was due to personal injury protection (i.e. no-fault insurance). According to current statistics, there is little doubt that this trend will continue well into 2010.

This bill will assist in the fight against no-fault fraud in three ways. It will:

i. amend the Insurance Law with respect to preclusion of insurance company defenses;

ii. provide the Superintendent with the authority to terminate no-fault payments to unscrupulous providers of medical care; and

iii. provide for mandatory arbitration of all no-fault disputes.

i. Preclusion of Defenses

Currently, an insurer that does not deny a claim within 30 days is precluded from asserting a defense to payment based on lack of medical necessity and other grounds, including fraud, and must pay that claim. This encourages unscrupulous individuals and providers to flood the system with multiple claims, knowing claims not denied within 30 days will have to be paid. This is in direct contravention to the original legislative intent in enacting the no-fault law.

This bill addresses the problem by making the exclusive penalty for an overdue payment interest and reasonable attorney fees. Additionally, the legislation permits the insurer to issue a denial and assert a defense after the thirty-day period. Often in cases of fraud, an investigation takes longer than thirty days and requires additional time to determine the appropriate course of action.

ii. Provider Payments

For years, certain owners and operators of professional service corporations have abused the no-fault insurance system. Through such activities as intentionally staging accidents and billing no-fault insurers for health services that were unnecessary or never in fact rendered. This fraud costs no-fault insurers tens if not hundreds of millions of dollars, which insurers ultimately pass on to New York consumers in the form of higher automobile premiums.

In addition, of great concern to the public is the ownership, control and daily operation of professional service corporations or other similar business entities by individuals who are not licensed to practice medicine. Ownership of professional service corporations by unlicensed persons works as follows: unlicensed persons pay licensed physicians to use the physicians' names, signatures and licenses for the purpose of fraudulently billing no-fault insurers for services that were never rendered, are of no diagnostic value or are medically unnecessary. These physicians essentially sell their licenses, for a fee, and become "paper owners" of the professional service corporation, which in turn permits unlicensed and unqualified persons to own, operate and control a professional service corporation, although they are prohibited from having any financial interest in such a corporation pursuant to Article 15 of the Business Corporation Law.

Schemes such as this, which could involve professional business entities other than professional service corporations and health care professionals other than physicians, severely compromise the safety and integrity of the health care system in New York. As a result, certain professional business entities have become unjustly enriched through the ill-gotten proceeds of illegal activity, increasing the cost of insurance premiums for the driving public. More importantly, these abuses threaten the affordability of health care and the public's health, safety and welfare.

The current version of Insurance Law § 5109 attempted to curb abuses in the no-fault insurance system by requiring the Department of Health and the State Education Department to investigate providers of health services who engage in certain misconduct, and suspend or remove their authorization to seek payment for medical services pursuant to standards and procedures developed by the Insurance Department. However, responsibility for implementation of section § 5109 is too diffuse for the current law to be effective. Section 5109 requires the Insurance Department to essentially set forth the procedures that the Department of Health and State Education Department must follow. Accordingly, this bill consolidates within the Insurance Department responsibility for investigating such providers and prohibiting them from seeking payment.

Specifically, this bill authorizes the Superintendent to prohibit a provider of health services from demanding or requesting payment for health services rendered under Article 51 for a period not exceeding three years, if the Superintendent determines that the provider has

engaged in certain activities. Under the bill, a provider may not circumvent the prohibition by billing a patient or the patient's health insurer directly for health services otherwise eligible for compensation by a no-fault insurer.

Moreover, while the Insurance Department currently interprets "provider" to include an individual and an entity, such as a professional service corporation, this bill makes explicit that the term applies to both in a new definition of "provider of health services" in Insurance Law § 5102.

Furthermore, this bill requires the Superintendent to maintain a data-base containing a list of providers of health services that the Superintendent has prohibited from demanding or requesting payment from no-fault insurers, and to make this information publicly available. In addition, the bill permits the Superintendent to levy a civil penalty not exceeding $50,000 on any provider of health services that the Superintendent prohibits from demanding or requesting payment for health services. Making the information publicly available and permitting the Superintendent to levy a civil penalty will deter abusive no-fault insurance practices.

Finally, the revision of Insurance Law § 5109(f) makes clear that the Commissioners of Health and Education and the Superintendent are not precluded from taking appropriate action under any other provision of law, such as bringing a disciplinary proceeding under the Education Law, merely because the Superintendent prohibits a provider of health services from demanding or requesting payment under Article 51 of the Insurance Law.

iii. Arbitration

Courts, particularly downstate, have been inundated with lawsuits filed by health service providers seeking reimbursement for no-fault services, resulting in long delays in the resolution of disputes. The case dockets of courts where these claims have been filed have experienced a dramatic increase in size. For example, no-fault cases have been primarily responsible for the rise of the caseload of the New York City Civil Court from 212,000 filings in 2000 to 414,000 filings in 2004. The rise in the number of case filings has placed a significant administrative burden on the courts.

By amending the Insurance Law to provide for mandatory arbitration of overdue insurance claims, this bill will assure the competent disposition of claims by arbitrators, qualified to review issues pertaining to no-fault insurance disputes, while achieving the important objective of reducing the administrative burden that these claims place on the courts. The courts will continue to have the authority to review the award of master arbitrators, in accordance with Article 75 of the Civil Practice Law and Rules, and conduct a de novo review of such awards in excess of $5,000.

Further, this bill defines the "amount in dispute" for the purposes of Insurance Law § 5106(b) to mean the total amount of disputed first party benefits sought by a claimant for health services rendered to an eligible injured person by a particular health service provider arising out of injuries sustained in a motor vehicle accident. Pursuant to this language, multiple

claimants may not "bundle" first party benefits sought for health services rendered by one health service provider in order to exceed the $5,000 threshold. Nor may one claimant "bundle" first party benefits sought for health services rendered by multiple health service providers for the purpose of exceeding such threshold.

Budget implications:

This bill will have no fiscal impact on the State.

Effective date:

This bill will take effect immediately, except that sections three and four shall be effective in one hundred and eighty days.