

New York State
Seal

**STATE OF NEW YORK
INSURANCE DEPARTMENT**
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NEW YORK, NEW YORK 10004

George E. Pataki
Governor

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The Office of General Counsel issued the following opinion on August 18, 2004 representing the position of the New York State Insurance Department.

RE: No-Fault, Coordination of Benefits

Question Presented:

Where a health care provider charges more for treating an individual injured as a result of an automobile accident than is allowable under the No-Fault Fee Schedule, is the injured party's health insurer responsible for the difference between the amount reimbursed by the insurer providing "first party benefits" and the amount charged by the health care provider?

Conclusion:

The health care provider was in violation of the New York Insurance Law (McKinney 2000 and 2004 Supplement) and the regulations promulgated thereunder in the amount it charged. The health insurer is not obligated to reimburse for the difference between the amount reimbursed by the insurer providing "first party benefits" and the amount charged by the health care provider.

Facts:

A subscriber under a contract issued by a Health Maintenance Organization with a Certificate of Authority from the Commissioner of Health in accordance with New York Public Health Law § 4403 (McKinney 2002) states that one of the HMO's participating health care providers is a dentist.

Some 10 years ago, the subscriber was treated by that dentist. Earlier this year, the subscriber was struck by an automobile while riding his bicycle and his jaw was injured. Because of the subscriber's satisfaction with the previous work performed and because the dentist was a participating provider with the HMO, the subscriber again went to this dentist.

The dentist informed the subscriber that he did not take assignments under the No-Fault statute, (New York Insurance Law Article 51 (McKinney 2000)) and that the subscriber would have to pay the dentist directly. The

subscriber did so and submitted the bill to the insurer providing "first party benefits." That insurer reimbursed the subscriber an amount less than the subscriber had paid the dentist. The insurer indicated that the amount that it paid was the limit of its obligation.

The subscriber inquired of his HMO if it will reimburse him for the amount he is still "out of pocket" and he has been informed that since the dentist was limited in the amount he could charge, reimbursement by the HMO was unnecessary. The subscriber inquires if the HMO is correct.

Analysis:

New York Insurance Law § 5102 (McKinney 2000) defines "basic economic loss" and "first party benefits" in pertinent part as follows:

(a) "Basic economic loss" means, up to fifty thousand dollars per person of the following combined items, subject to the limitations of section five thousand one hundred eight of this article: (1) All necessary expenses incurred for: (i) medical, hospital . . . surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section five thousand one hundred eight of this article. . . .

(b) 'First party benefits' means payments to reimburse a person for basic economic loss on account of personal injury arising out of the use or operation of a motor vehicle

New York Insurance Law § 5108 (McKinney 2000) provides:

(a) The charges for services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge.

* * * *

(c) No provider of health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article may demand or request any payment in addition to the charges authorized pursuant to this section. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health

provider within thirty days after such insurer has knowledge of such pattern.

In effectuation of New York Insurance Law § 5108(a), the Insurance Department has promulgated N.Y. Comp. Codes R. & Regs tit. 11, Part 68 (Regulation 83) (2002). N.Y. Comp. Codes R. & Regs. tit. 11, § 68.2(a) (2002) provides:

After consultation with the chairman of the Workers' Compensation Board and the Commissioner of Health, the Superintendent of Insurance hereby establishes fee schedules for professional health services referred to in section 5102(a) (1) of the Insurance Law, and for which schedules have not been prepared and established by the chairman of the Workers' Compensation Board. The schedules for such professional health services, hereby adopted by the Superintendent of Insurance, are incorporated herein as Appendix 17-C and charges for services listed therein shall not exceed the charges permissible under such schedules.

Dentistry is one of the professions where the fees for treatment of individuals involved in automobile accidents are limited to amounts set forth in Appendix 17-C of Regulation 83. Accordingly, the subscriber's dentist was limited to charging such amounts.

In addition, N.Y. Comp. Codes R. & Regs. tit. 11, § 68.7(a) (2002) provides:

No provider of health services specified in section 5102(a) (1) of the Insurance Law may demand or request any payment in addition to the charges permitted by the provisions of this Part. If the insured also possesses health insurance coverage and such health insurance contract does not exclude payment for no-fault benefits,

payment by the health insurer for health services under such contract is restricted by the limitations of section 5108 of the Insurance Law, unless such limitation would impair the terms of a provider's contract with the health insurer, in which case payment by the health insurer to the provider may be made in accordance with the provider's contract; however, the provider may not receive duplicate payment.

Although HMOs are primarily regulated by the Health Department, their subscriber contracts are regulated by the Insurance Department as if they were subscriber contracts of not-for-profit health insurers. New York Public Health Law § 4406(1) (McKinney 2002). As part of its regulation of health insurance policies and contracts, the Insurance Department has promulgated N.Y. Comp. Codes R. & Regs. tit. 11, Part 52 (Regulation 62) (2003). As part of that regulation, N.Y. Comp. Codes R. & Regs. tit. 11, § 52.16(c) (2002) provides

No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows: . . . (8)

. . . benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable . . . (9) dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly . . .

Accordingly, even though, if it had not excluded accidents covered under New York Insurance Law Article 51, the HMO would have had to cover treatment to the subscriber's jaw, the limits of its coverage would have been the amount payable pursuant to Appendix 17-C of Regulation 83. The subscriber has already received this amount from the insurer providing "first party benefits." Thus, the HMO was correct in its advisement.

For further information you may contact Principal Attorney Alan Rachlin at the New York City office.