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April 20, 2009

RE: AN ACT to amend the public health law and the insurance law, in relation to approvals by a utilization review agent.

A.792 (Gottfried)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the
Blue Cross and Blue Shield Plans

The Conference of Blue Cross and Blue Shield Plans of New York oppose enactment of this bill which would impose an arbitrary utilization review standard, allow providers, at the expense of their patients, to appeal concurrent adverse determinations, deem medical necessity determinations outside the utilization review time period approved and create unnecessary preauthorization notification requirements given existing law.

1. THE PROPOSED LEGISLATION WOULD CREATE A CONFUSING AND INCONSISTENT STANDARD FOR UTILIZATION REVIEW AGENTS TO USE FOR MEDICAL NECESSITY REVIEW.

This bill seeks to require a utilization review agent to take into consideration the time and day of the week care was provided and the presenting symptoms, including but not limited to, severe pain, in reviewing a denial for coverage of emergency services. This additional standard is simply unnecessary and would only add an additional ambiguous and arbitrary standard to the review process. Under current law, utilization review is conducted by qualified health care providers in which determinations are made as to whether a course of treatment is medically necessary based on "sound medical judgement" and in the best interest of the enrollee. It is an expensive, time consuming process, yet it affords individuals the right to have medical decisions reviewed by medical professionals. Forcing medical professionals to adhere to these additional standards would not only delay the utilization review process and increase administrative costs, but require determinations to be made based on arbitrary subjective non-medical standards.

2. THIS BILL WOULD ALLOW PROVIDERS TO SEEK POTENTIALLY UNJUSTIFIED REIMBURSEMENT AT THE EXPENSE OF THE INSURED AND DEEM MEDICAL NECESSITY DETERMINATIONS MADE OUTSIDE THE UTILIZATION REVIEW TIME FRAME APPROVED IN COMPLETE DISREGARD OF NEW YORK'S CAREFULLY CRAFTED EXTERNAL APPEAL LAW.

Contrary to the sponsor's belief that New York's External Appeal program is "ineffectual and underused," by any measure the program is a success. According to recent studies by the Kaiser Family Foundation and the State Insurance Department (SID), New York had the highest number of external appeal requests nationwide. Specifically, between 1999 and 2005 SID reported that the External Appeal program processed nearly 7,000 appeal requests. In fact, according to SID, appeals are being disposed of in a timely and efficient manner with more than half (nearly 55%) of the cases supporting the plan's determination. Given the highly accessible nature of the External Appeal program to insureds, allowing providers to appeal concurrent denials on behalf of their patients would result in a substantial increase in frivolous appeals. This proposal would only benefit providers as they would be authorized to seek unjustified reimbursement without any threat of personal expense.

Furthermore, as evidenced by the continued success of the External Appeal program, it is unnecessary for determinations made outside the utilization review time frame to be deemed approved. For instance, the most recent External Appeal Annual Report issued by the NYS Insurance Department showed that since inception of the External Appeal Program in 2000, external appeal applications have increased from 205 in 1999 to 2,475 in 2005. Therefore, given the substantial growth of the program, it is clear that insureds that experience an adverse determination have an efficient, accessible and independent path to appeal their claims.

3. GIVEN EXISTING LAW, THE ADDITIONAL UNCLEAR PREAUTHORIZATION NOTIFICATION REQUIREMENTS PROPOSED BY THIS BILL ARE UNNECESSARY AND WOULD ONLY SERVE TO INCREASE ADMINISTRATIVE HEALTH CARE COSTS.

This bill would require a utilization review agent that has made a verbal preauthorization or approval to "immediately" thereafter supply the provider with a written confirmation of the approval by either: 1) email; 2) fax; or 3) by posting a copy of the approval on the insurer's website and directing the provider to such website in order to print and retain a hard copy. Aside from this bill's technical failure to define "immediately," the proposed provisions are unnecessary in light of existing law. For example, in 2007 the Governor signed Chapter 451 into law which among other provisions included significant consumer protections with regard to preauthorization of health care services. Specifically, Chapter 451 required that where a health plan grants preauthorization for a health care service or services, plans must pay claims for the service or services preauthorized except under a few limited circumstances.

Moreover, under current law, a utilization review agent is already required to notify the enrollee, the enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information for preauthorization. Concomitantly, utilization review agents are required to operate a toll-free telephone line not less than 40 hours per week to respond to provider requests. Furthermore, emergency requests are not subject to preauthorization making "immediate" transmission simply unnecessary. These requirements would only increase the administrative cost of health care services through the creation of additional forms and technological website upgrades; which would in turn increase premiums.

For the reasons stated above, the New York Conference of Blue Cross and Blue Shield Plans opposes the enactment of this bill.

Respectfully submitted,

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