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RE: AN ACT to amend the public health law and the insurance law, in relation to utilization review program standards, and in relation to pre-authorization of health care services.

A.7129-A (Gottfried)
S.6435-B (Breslin)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shield Plans strongly opposes enactment of this bill, which unnecessarily seeks to reduce the time-period that insurers have to review whether proposed health care services are medically necessary for the individual enrollee – limiting the ability of insurers to effectively apply utilization review ("UR") for proposed medical services and ensure that their enrollees are receiving clinically appropriate treatment. Further, this bill would restrict a plan's ability to provide pre-authorization for prescription medications for established durations, hampering the ability of insurers to periodically confirm that a drug continues to be clinically appropriate – even as new medications and standards of care are developed. Finally, this bill would require insurers to pay claims for services received by a person who was not covered at the time service was provided, even in instances where an employer failed to timely notify the insurer of that such individual's change in employment status rendered him or her ineligible for coverage.

Specifically, modifications to the existing utilization review process proposed in this bill are unnecessary in light of the existing mechanisms available to providers and enrollees; and will impose significant administrative costs by moving the determination period away from the use of business days. The bill proposes to establish a 24-hour review process where the health of the enrollee is in serious jeopardy without the recommended healthcare services. This change is unnecessary in light of the fact that emergency services are not subject to prior authorization requirements, provided such services are medically necessary to treat an emergency condition.[1] Notably, pursuant to the 2020 Enacted Budget, issuers are prohibited from denying payment to a hospital for medically necessary inpatient services, observation services, or emergency department

[1] DFS OGC Op. No. 08-07-07, available at: http://www.dfs.ny.gov/insurance/ogco2008/rg080707.htm

services based solely on the fact that a hospital failed to timely notify such issuers that the services had been provided.[2]

Further, the Department of Financial Services ("DFS") requires utilization review requests for urgent medical conditions to make determinations within one (1) business day of the receipt of a complete request.[3] The most significant change, however, is to require all determinations to be made within 48-hours, rather than the current standard of three (3) business days. The net impact of this change, especially for non-emergency services and treatment, is that it would require insurers to operate their UR review departments on a 24/7 basis, which will significantly increase administrative expenses and, in turn, result in increased premiums. For non-emergency situations, this change is unnecessary and will only result in increased costs borne on New York residents, especially considering that the existing standard is already one of the most stringent in the nation.

Additionally, this bill would require that "[a]n approval for a request for a pre-authorization [] be valid for (1) the duration of the prescription, including any authorized refills and (2) the duration of treatment for a specific condition..." As a result, pre-authorization for treatment of an individual's chronic condition would continue in perpetuity, and insurers would lose the ability to periodically reassess a health care provider's request in light of emerging science and innovative medication technologies. This function is critical as prescription drug treatment protocols are constantly evolving, and because prescription drug costs are the fastest growing component of health care costs.

Finally, this bill would remove provisions of existing law that allow an insurer to deny claims that are provided to an individual who is no longer covered at the time services are rendered if "eligibility [was] confirmed on the day of service." Problematically, employers often fail to inform plans that an employee's coverage should end due to a change in employment status. Therefore, an insurer may confirm eligibility and provide pre-authorization based on the information available, only to later to be informed to retroactively terminate coverage. While existing law contemplates this scenario, the Bill would require insurers to pay such claims – ultimately increasing systemic costs and, therefore, individuals' premiums. Instead, to prevent the pre-authorization of services for an uncovered persons, a more practical solution would be to compel employers to timely notify plans of employee disenrollment.

For the foregoing reasons, the New York State Conference of Blue Cross and Blue Shield Plans urges that this bill not be enacted.

Respectfully submitted,

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Legislative Counsel for the Blue Cross and Blue Shield Plans of New York

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[2] Insurance Law §§ 3217-b(j)(1) and 4325(k)(1) and Public Health Law § 4406-c(8)(a).
[3] NYS DFS, *Attachment A: Minimum Process Requirements for Concurrent Authorization Utilization Review* (September 2017), *available at*: http://www.dfs.ny.gov/insurance/health/ul_min_concur-req.pdf