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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 pre-authorization of health care services

A.3789 (Weprin)
S.9651 (Rivera)

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 the enactment of this bill, which places a number of onerous and unreasonable burdens on the health plan determination process. Specifically, the bill unnecessarily seeks to reduce the time period that health plans have to review whether proposed health care services are medically necessary – limiting the ability of health plans to effectively apply medical management and utilization review ("UR") to ensure that enrollees are receiving clinically appropriate treatment. Further, this bill would restrict a plan's ability to review preauthorized services at a reasonable interval, essentially meaning that once a patient receives preauthorization for a treatment, it is approved in perpetuity.

The modifications to the existing preauthorization timeframes proposed in this bill will inordinately shorten the timeframes for preauthorization requests and impose significant administrative costs. Plans are currently prohibited from applying preauthorization to emergency services, meaning these new timeframes would apply to care other than emergency services.[1] The bill would establish a 24-hour review process if the request is for a member with a medical condition that places the health of the member in serious jeopardy without the health care services recommended by the member's health care professional. For standard preauthorization requests, this bill would apply a 72-hour timeframe. Under combined federal and New York requirements, health plans must make a determination regarding urgent preauthorization requests within 72 hours of receipt of the request and, for standard preauthorization requests, within three (3) business days from receipt of the necessary information but no later than 15 calendar days from receipt of the

[1] N.Y. Insurance Law § 4905(m) and N.Y. Public Health Law § 4905(13).

request.[2] Effective January 1, 2026, a new federal regulation requires government program plans (e.g., Medicare Advantage, Medicaid managed care plans, Child Health Plus plans) to make preauthorization determinations within 72 hours from receipt of an urgent request and seven (7) calendar days from receipt of a standard request.[3] This new federal timeframe is consistent with current New York law and not the shortened timeframe proposed by this legislation.

Instead of accounting for weekends and holidays, this bill would apply the current urgent timeframe to all preauthorization requests, regardless of the urgency of the request service, while shortening the urgent timeframe to 72 hours. The net impact of this change is that it would require plans to operate their UR review departments on a 24/7 basis, which will significantly increase administrative expenses and, in turn, result in increased premiums. Furthermore, excessively short timeframes, in particular the 72-hour timeframe proposed by this bill, are not always in the patient's best interests, as it does not allow time for the health plan to discuss the case with the treating provider. This change is unnecessary and will only result in increased administrative costs borne by New Yorkers through premium increases, 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 shall be valid for (1) the duration of the prescription, including any authorized refills and (2) the duration of treatment for a specific condition requested for pre-authorization." As a result, preauthorization for treatment of an individual's chronic condition would continue in perpetuity, and health plans would lose the ability to periodically reassess a health care provider's request in light of the enrollee's current medical condition or emerging science and innovative medication technologies. This function is critical as prescription drug treatment protocols are constantly evolving, in particular as new drugs become available.

Health plans are currently permitted to conduct UR at reasonable intervals to assess whether services are medically necessary.[4] In many instances this process is designed to protect the member from unnecessary and perhaps costly treatment. For example, plans typically preauthorize a set number of physical therapy visits. If the insured needs additional care, the provider would then request additional services, subject to review to determine medical necessity. The timeframe for concurrent review (meaning extended services or additional services for an insured undergoing an ongoing course of treatment) is one (1) business day from receipt of the necessary information.[5] This review allows the health plan to monitor an ongoing course of treatment to ensure that the care being provided is appropriate and achieves its goals. This bill would essentially prohibit health plans from concurrently reviewing an ongoing course of treatment, meaning that the care they preauthorized is approved for as long as the patient continues treatment. For chronic conditions, a service could be approved for life.

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[2] 29 C.F.R. § 2560.503-1(f)(2)(i); 45 C.F.R. § 147.136(b); N.Y. Insurance Law § 4903(b)(1); and N.Y. Public Health Law § 4903(2)(a).

[3] Center for Medicare & Medicaid Services, *Fact Sheet: CMS Interoperability and Prior Authorization Final Rule CMS-0057-F*, *available at* https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.

[4] N.Y. Insurance Law § 4905(f) and N.Y. Public Health Law § 4905(6).

[5] N.Y. Insurance Law § 4903(c)(1) and N.Y. Public Health Law § 4903(3)(a).

The ultimate goal of this bill – to reduce the administrative burdens on health care providers submitting preauthorization requests – is a laudable goal. Shortening timeframes will not reduce that burden but would require providers to respond even quicker to requests for additional information. Tools currently exist to reduce burdens on health care providers requesting preauthorization, notably electronic health records ("EHR"). Plans review preauthorization requests and may request information to make a determination if necessary. With EHR, the plan would have immediate access to the necessary information, thus reducing the repeated requests for information, increasing efficiency and reducing delays. Granting plans access to EHR would ease administrative burdens on providers need to submit medical records, particularly by antiquated and inefficient methods like by fax or mail. To truly reduce the administrative burdens and delays regarding preauthorization, providers should be required to permit plans to access EMR to make UR determinations, within appropriate guidelines for security and confidentiality.

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

Respectfully submitted,

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