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MANAGED CARE REFORM

The Immediate Problem

Exacerbating the excessive liability burden facing New York physicians is the continuing effort by health plans to impose unnecessary obstacles to providing patient care and to unfairly constrain the reimbursement for such services. Fundamental reform is needed to counter the immense power wielded by these companies. In fact, an astounding 75% of the state's managed care enrollees are insured by only five health plans.

NYS MANAGED CARE ENROLLMENT
(As of March 2008)

COMPANY	ENROLLMENT	% OF TOTAL NY HMO ENROLLMENT	CUMULATIVE ENROLLMENT %
HIP-GHI	947,404	24.1%	24.1%
Oxford-United-Americhoice	573,160	14.6%	38.7%
Empire	543,669	13.8%	52.5%
MVP-Preferred Care	459,513	11.7%	64.2%
Excellus	379,490	9.6%	73.8%

Source: New York State Department of Health website

This market dominance has created a situation where most physicians are regularly presented “take it or leave it” contracts that impose one-sided terms. MSSNY supports a series of reforms to protect against abusive practices by health plans. “First steps” legislation has been enacted in each of the last two sessions that begins to address some of these abuses. However, there are many other difficulties encountered by physicians and hospitals in their dealings with health plans that must be addressed.

The Solution

Prohibiting Unfair Contract Provisions

- MSSNY supports legislation to prohibit unilateral adverse contract amendments and/or adverse contract policy changes. (~~A.6508, Bradley/S.5383, Leibell, S.4481-A, Seward/A.1737, Morelle~~)
- MSSNY supports legislation to assure that a physician's contract with a health plan may not be assigned to another network except where the physician has provided express authorization for each specific proposed assignment (~~A.7591-A, Bradley/S.3804-A, Leibell~~). We must outlaw “silent PPO's”.
- MSSNY supports legislation that preserves physician choice regarding which plan products a physician chooses in which to participate (~~S.4934, Hannon~~). We must outlaw “All Products Contract Clauses”.
- MSSNY supports legislation to require health plans to uniformly process and reimburse claims following the rules set forth in the Common Procedure Terminology (CPT) developed by the American Medical Association.. Physicians continue to have significant problems with health plans “downcoding” and “bundling” claims to arbitrarily reduce reimbursement. (~~A.7591-A, Bradley/S.3804-A, Leibell~~)
- MSSNY supports legislation that would permit physicians to collectively negotiate contract terms with health plans (~~A.2177, Canestrari/S.4153, Hannon~~).

Preserving Choice to Participate in a Health Plan

Often a physician's only leverage against onerous health plan participation agreements is to simply decline to participate. However, health plans are employing tactics to limit even this right.

- MSSNY supports legislation to protect the ability of patients to assign their benefits to their treating provider, regardless of such physician's participation status. (**S.5183, Morahan/A.4468-B, Bradley, S.5231, Hannon/A.8335, Gottfried**)
- MSSNY opposes legislation (**S.672, Hannon**) to require non-par physicians to accept a default rate as full compensation for emergency room (ER) care provided to plan enrollees. Often the only leverage a physician has is to simply decline to participate in such plan. Imposition of a requirement that non-participating physicians must accept a rate dictated by the insurer would have a huge negative impact not only on out of network physicians, but participating ones as well. The plans would have no incentive whatsoever to negotiate in good faith. More important, such legislation would cause a mass exodus of physicians from the ER thereby severely compromising patient access to critically necessary emergency care. .

Easing Burdens to Obtaining Necessary Care

MSSNY supports legislation to reduce the hassles imposed by health plans to obtaining necessary care, including:

- • MSSNY supports legislation to establish a list of health care services that will not require pre-authorization,
- • MSSNY supports legislation to reduce the time needed to obtain pre-authorization,
- • MSSNY supports legislation to requiring health plans to complete pre-authorization review within 24 hours of a request for non-emergent care,
- • MSSNY supports legislation to assure that health plans properly follow the 2007 law which provided greater assurance to physicians that care pre-authorized by a plan will be paid for by the plan.
- MSSNY supports legislation to assure that patients are not forced to change a prescription or make a greater co-payment due to a health plan's formulary change (**A.4075, Ramos and A.6739, Rivera**).

Facilitating Timely Payment

- MSSNY supports legislation to assure physicians have the option whether to be reimbursed electronically (**S.4643, Hannon**);
- MSSNY supports legislation to require that claims which are electronically submitted be paid within 14 days, as well as hastening the period for denying the claims or requesting more information (**A.10098, Bradley/S.7043, Leibell, A.4324, Magnarelli. Also A.11680, Morelle/S.8354-B, Seward, which requires payment for electronic claims within 21 days**)

Uniform and Expedited Credentialing

- • MSSNY supports legislation to require health plans to act upon an application for participation within 30 days, and require plans to reimburse for care rendered by such physician after he or she applied for participation, as is the case in Medicare.
- MSSNY supports legislation to require the use of a uniform credentialing form (**A.8163, Gottfried/S.4759, Hannon**).

Limiting Refund Demands

New York law requires insurers to pay claims within 45 days of submission. However, even if payment is made timely, health plans often seek repayment months or even years later. In some instances, health plans use the grossly unfair practice of extrapolation to demand refunds based upon the actual review of only a few claims. Because of the continuing abuses by some health plans, MSSNY:

- Supports legislation to limit the time within which a health plan may demand a refund from a physician, in the absence of fraud, to the same time that a physician has to submit a claim to the health plan (**S.109, Maziarz/A.6058, Sweeney, which limits such refund demands to 6 months**).
- Supports legislation to prohibit a health plan from determining a demanded refund amount through extrapolation (**A.7591-A, Bradley/S.3804-A, Leibell**).