

MEMO IN OPPOSITION

FOR IMMEDIATE RELEASE: JUNE 22, 2005

REISSUED: MARCH 7, 2006

Re: S.4392-A (Spano)/A.7351-A (Bradley)

An act to amend the insurance law, in relation to requiring insurers to adhere to the American Medical Association's Current Procedural Terminology (CPT) for the purposes of processing of all health care claims.

This legislation, S.4392-A/A.7351-A, amends the insurance law to institute a new claims payment system that does not meet industry standards. While the stated purpose of the bill is to bring uniformity to the claims processing system, the bill is in fact designed to enhance provider reimbursements, which will result in increased costs to employers and government programs. This legislation will also accelerate more employers to the self-insured marketplace while doing little to provide consistency in claims processing. Our concerns are outlined below:

- ◆ **HIPAA already requires a level of uniformity, for claims submission, thus obviating the stated intent of this legislation.** HIPAA requires a code set that plans must accept for the submission of claims. The Current Procedural Terminology — CPT — as “updated and distributed by the American Medical Association” is included in the HIPAA code set.
- ◆ **Medicare, the nation's largest payer has its own coding system known as the Health Care Common Procedure Coding System, which does not recognize many CPT codes.** As recently as January 2005, The Centers for Medicare and Medicaid Services (CMS) invalidated several CPT codes in developing its own coding system. Under this legislation, a New York provider who submits appropriate CMS codes could not be reimbursed.
- ◆ **ERISA preemption undermines the claims processing uniformity sought by sponsors.** Nearly 50% of New Yorkers are enrolled in self-insured plans. These plans are not under the aegis of New York's statutes or regulation. Passage of this legislation would not solve the sponsors' concern for uniformity. It would, however, spur more employers to move to the self-insured marketplace.
- ◆ **Terms in the bill suggest it is designed to enhance provider reimbursement:**
 - The requirement that all health care provider claims be “eligible for payment” by merely submitting a CPT code is an unacceptable standard for reimbursement and un masks this legislation as an unabashed effort to enhance provider reimbursements. *For instance, every claim requires a tax ID number and other key data for proper adjudication and processing. Health plans and other stakeholder spent considerable time on establishing the parameters of a clean claim that are now required by Insurance Department regulation.*
 - Provider submission of a CPT code does not necessarily mean the code correctly reflects the services provided or that the service was necessary. *A health plans inability to examine these*

codes and the purported services provided undermines efforts to eliminate health insurance fraud and abuse.

- ◆ **The bill has unrealistic timeframes for implementation.** This legislation would require plans to install new software and systems by January 1, 2007 to address this new system. In addition to the fact that the cost of this transition will be considerable, it would not be possible to implement these changes in such a short timeframe.

S.4392-A/A.7351-A is a proposal that undermines appropriate claims processing, which will lead to inflationary increases to provider reimbursements. Passage of this legislation will raise premiums for commercial payers as well as the State's Medicaid and other government-subsidized insurance programs.

For all these reasons, the Health Plan Association opposes S.4392-A/7351-A.

-30-

The New York Health Plan Association represents 30 managed care health plans that provide comprehensive health care services to more than 6 million New Yorkers.