

MEMO IN OPPOSITION

FOR IMMEDIATE RELEASE: June 6, 2006

Re: S.7293 (Spano)/ A.10636 (Bradley)

An act to amend the insurance law, in relation to insurance companies providing written confirmation of verbal approvals.

This legislation, S.7293/A.10636, would require health plans to submit a written prior approval to a provider immediately upon issuing a verbal approval for services. The legislation further establishes the written approval as “prima facie evidence” that the services provided were covered under the insured’s policy. The New York Health Plan Association (HPA) opposes this legislation because its requirements are burdensome, vague, misconstrue the nature of plan prior approvals and will open health plans to unwarranted liability.

MISREPRESENTATION OF PRIOR APPROVAL

This legislation is based on a false presumption that a prior approval confirms that the insured is covered for the requested service. In fact this is not the case. When a plan issues a prior approval for services or products, it certifies that the medical management unit has determined that the requested services are medically necessary and are a covered benefit under the enrollee’s health plan. This should not be interpreted to mean the claim would be automatically paid. Separate from medical management is member eligibility status, which is a critical component to determining if any claim will be paid. This is a significant distinction – especially since there are often time lags between receipt of a prior approval and the actual service being rendered. For example, if a provider asked for a prior approval for a medical procedure at the end of a particular month and the procedure is performed at the start of the following month, it is very possible that the enrollee’s coverage from that plan could have been dropped or their policy altered in the intervening period. Under this legislation an individual who knew they were going to lose their insurance could gain prior approvals for numerous services to be carried out long after they are no longer affiliated with a plan – and the plan would be liable to reimburse providers for these services.

LEGISLATION IS BURDENSOME AND VAGUE

The legislation would require health plans to submit in writing all prior approvals “immediately” after a verbal communication is provided – however, the term “immediately” is not defined. As entities that are closely watched by numerous regulators, this vagueness is very problematic to the operations of a plan. Additionally, the administrative requirements necessitated by the bill will engender new processes demanding personnel to write, process and deliver approvals “immediately.” Furthermore, issuing prior approvals in writing will

likely trigger health plans to demand greater documentation in writing – before offering a written approval. This will place additional burdens on providers – significantly slowing the approval process to the detriment of providers and patients alike.

UNWELCOME LIABILITY ON HEALTH PLANS

This proposal elevates written prior approvals to prima facie evidence “that the services performed by the provider were services covered under the insured’s policy.” Establishing this legal status for prior approvals, especially when the products or services may not be covered because of member eligibility status is an unwarranted standard of liability on health plans. This provision will add costs to premiums as plans will be forced to cover treatments for non-enrollees and for the purchase of additional liability insurance to shield future legal actions.

S.7293/A.10636 is a vague and burdensome proposal that will place plans under an unnecessary level of liability without improving patient care. For all these reasons the New York Health Plan Association opposes its passage.

-30-

The New York Health Plan Association represents 31 managed care health plans that provide comprehensive health care services to nearly 6 million New Yorkers.