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February 4, 2011

RE: AN ACT to amend the insurance law and the public health law, in relation to access to health care providers in managed care plans

A.1808 (Dinowitz)

**MEMORANDUM IN OPPOSITION**

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shields Plans oppose enactment of this bill, which would decrease the ability of managed care health plans to control quality and cost issues within their provider networks, and would significantly increase administrative costs associated with both provider and enrollee transitions. Existing law allows patients to continue receiving care from a non-participating provider for a period of 60 or 90 days depending on circumstances. The proposed bill would significantly expand these time periods by allowing patients to receive care for up to a year or an indefinite period of time if the individual is diagnosed with a terminal condition.

**1. THIS BILL WOULD POTENTIALLY REQUIRE HEALTH PLANS TO RETAIN POOR QUALITY PHYSICIANS AT THE WHIM OF ENROLLEES.**

Current law permits continued care by non-participating providers for a reasonable period of time to complete treatment or to transition to a new provider or health plan. A fixed extended transition period is currently provided to pregnant women. This bill would permit an enrollee to continue care for any condition with a specific non-participating provider for a period of up to one year at the enrollee's election. In addition, an enrollee diagnosed with a "terminal" condition, a broad discretionary determination of a patient's condition made solely by the treating physician, would be permitted to continue care with the non-participating provider indefinitely. The

continuation of care provisions in this bill would apply both when a provider leaves a network and when an enrollee changes plan to one in which the enrollee's provider does not participate.

In the case of providers leaving the network, the bill ignores the possibility that the provider may have been terminated for legitimate patient care issues. Although providers who pose an imminent threat to their patients or who have had their licenses revoked would not be eligible for continuing care to enrollees, such limitations are extremely limited and, as a result, many providers whose quality of care is questionable will continue to serve patients. For example, providers who have been disciplined by the health department (but still retain their licenses) or providers that have been terminated for quality issues that do not rise to the level of "imminent harm" would still be eligible to continue care. For providers that are treating "terminal patients" (i.e., those where the illness is "likely to cause or be a major contributing factor in causing such patients death within 3 years"), their participation in the network could last indefinitely. Essentially, this bill forces health plans to accept poor quality providers simply because an enrollee wishes to continue receiving care from that provider.

**2. THIS BILL IGNORES THE ADMINISTRATIVE COSTS ASSOCIATED WITH USE OF NON-NETWORK PROVIDERS.**

Existing law provides for the continuation of care when an enrollee is engaged in an "outgoing course of treatment," is in a mid-to late stage pregnancy, or for enrollees entering a managed care plan, if the enrollee has a life-threatening, disabling or degenerative condition. These transition periods were designed to balance the administrative costs associated with the extended use of non-network providers against the desire of enrollees to continue ongoing care with a certain provider. This bill would upset that balance by offering continuation of care to every enrollee, without any justification for the additional costs. The existing law, which requires an ongoing course of treatment, a pregnancy, or a life-threatening illness makes a meaningful relationship between the provider and the patient far more likely.

In addition to direct costs of patient care, there are administrative costs associated with the use of non-network providers by enrollees that are not addressed in this bill. For example, the payment systems used by most managed care health plans are programmed to accommodate participating providers alone. Payments to non-participating providers are often processed manually, at a significantly higher expense than the cost of processing "in-network" claims. By significantly increasing the administrative costs associated with paying for the care, this bill increases the cost of health care for purchasers of health insurance.

**3. THIS BILL WOULD FURTHER COMPLICATE PROVIDER TRANSITION BY LIMITING THE HEALTH PLAN'S ABILITY TO PLAN FOR CONTINUATION OF CARE.**

Current law provides for continuation of care for enrollees whose provider has left the network for a period of up to ninety days if the enrollee is undergoing a "continuing course of treatment" or, in the case of second trimester pregnancy care is continued throughout the remainder of the pregnancy. Enrollees entering a managed care plan in which their provider does not participate may continue care with their provider for a period of sixty days if the enrollee has a "life-threatening condition" for which the enrollee is receiving ongoing treatment, or throughout the duration of a pregnancy. These rules allow managed care plans to effectively plan for provider transitions by identifying, based on active diagnostic codes and other patient data, those patients that are likely to require continuation of care. Under the current system, health plans are able to focus administrative efforts on those identified patients thus making the transition as smooth as possible for those individuals who need continuation of care. This bill would permit any enrollee to elect continuation of care, making it impossible for health plans to predict which or how many patients will require the administrative services associated with the continuation of care. As a result, transitions would be made more difficult for all enrollees, including those who genuinely benefit by the existing continuation of care options.

For the foregoing reasons, the Blue Cross and Blue Shield Plans urge that this bill not be enacted.

Respectfully submitted,

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