



# ***News From MSSNY***

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## **PHYSICIANS CALL FOR COMPREHENSIVE HMO REFORM LEGISLATION TO BETTER PROTECT PATIENTS**

The state's emergency care safety net would be devastated by proposals sought by the state's billion-dollar profit-generating HMO industry to set default reimbursement rates for patient care provided by non-contracted physicians, according to physicians representing several specialties who came to Albany today to testify at a hearing convened by the New York State Insurance and Health Departments. Instead, the physicians argued, comprehensive legislation to reform abusive HMO practices is needed to assure patients can obtain timely needed care, as well as to protect patients from unforeseen medical expenses.

These physicians came to Albany today to testify at a hearing examining the issue of unexpected medical bills received by patients who are enrolled in managed care plans. Dr. Andrew Kleinman, MD, a plastic surgeon in Westchester County, testified today on behalf of the Medical Society of the State of New York (MSSNY). Dr. Dan Murphy, an emergency care physician at Mercy Medical Center in Rockville Centre, testified on behalf of the New York Chapter of the American College of Emergency Physicians. Dr. Scott Groudine, an anesthesiologist at Albany Medical Center, testified on behalf of the New York State Society of Anesthesiologists.

The physicians testified that the problem examined in the hearing is caused by the ongoing efforts of the managed care industry to extract huge profits from the healthcare system at the expense of patients, health care providers and businesses. While the HMOs have generated over \$1 billion in profits in New York State in each of the last six years, employers and patients are shouldering much higher costs. Studies show that the premiums paid by employers have doubled over the last decade. According to the 2008 annual survey conducted by Kaiser Family Foundation and the Health Research & Education Trust, the average annual family premium in 2008 is 27% higher than the average family premium four years ago and 119% higher than the average family premium in 1999.

Even with employers paying so much more, employees get less and less health coverage. Patients must pay more out of pocket. They are forced to switch medications upon which they have been stabilized due to formulary changes. Their needed care and medication is unnecessarily delayed as a result of burdensome pre-approval procedures. And frequently they (with their treating providers) are forced to challenge arbitrary denials of medically necessary care. These problems must be addressed, stated the physicians.

Dr. Kleinman noted that patients are the ones who are ultimately hurt by the aggressive HMO cost-cutting efforts that have prompted at least some physicians to decline to participate with some health plans. "The fact that some physicians remain non-participating is often the fault of health plans dictating unfavorable terms that impose burdensome hassles that interfere with the ability to provide needed care to patients or unfairly restrict payment for such care" stated Dr. Kleinman. "Moreover, the HMO industry has exacerbated this problem through the use of the grossly manipulated Ingenix database to determine payments for patient care to physicians not in the plan's network". Ingenix has been accused by Attorney General Andrew Cuomo of operating "a defective and manipulated database that most major health insurance companies use to set reimbursement rates for out-of-network medical expenses" which

ultimately results in much higher bills that must be paid by patients. A recent federal court case (McCoy v. HealthNet) set forth in great detail the manner by which the database was manipulated to produce higher out of pocket expenses for patients.

Dr. Murphy noted that the proposals sought by the HMO industry to cap reimbursement for non-contracted providers would seriously exacerbate the already significant shortage facing hospital emergency departments for on-call specialty care. According to ACEP, the Northeastern region of the country, including New York State, has the highest rate of inadequate on-call coverage - 74% of hospitals surveyed reported this as a problem. "If specialists are not available to emergency departments to provide complicated care, some patients will be transferred to distant facilities which delays time-sensitive treatments and increases overall costs" stated Dr. Murphy.

Dr. Groudine noted that "in New York State, as well as the rest of the U.S., healthcare plans are charging more for their products and providing less. Companies that sell health insurance products are reaping huge profits while placing the blame for the healthcare crisis on physicians."

The enormous market power wielded by the health insurance industry makes the ability to negotiate needed changes difficult for physicians and patients, if not impossible. Five health plans insure 75% of New York's managed care market. At the same time, as noted above, these companies are generating astronomical profits. According to a recent report by the HealthLeaders InterStudy, HMO net income in New York State is more than twice that generated in New Jersey and more than three times that generated in Connecticut when compared on a per member, per month basis.

The groups urged action by the Legislature and the Departments of Insurance and Health to better protect patients, providers and business by reining in the rapidly growing power of the health insurance industry. To address these problems, the groups urged the Legislature to enact into law measures such as **S.3677 (Seward)**, which would require the Superintendent of Insurance to approve the premium rates charged by health insurance companies, and **A.2177 (Canestrari)/S.4153 (Hannon)**, which would permit physicians the ability to jointly negotiate participating provider agreements with health plans under close state supervision. The physician groups also urged the enactment of a significant number of other targeted measures to provide necessary protections to consumers and health care providers in their dealings with health plans. These include:

- **S.5383 (Leibell)/A.6508 (Bradley)** – Would prohibit health insurance companies from unilaterally imposing materially adverse policies and procedures during the term of a contract;
- **S.3804-A (Leibell)/A.7591-A (Bradley)** – Would enact numerous contracting reforms, including limiting the ability of carriers to unilaterally change contract terms, limiting their ability to bundle and arbitrarily "down code" provider claims; prohibiting health insurers from assigning a physician contract without authorization from the physician; expediting the timeframe for payment; and creating an independent dispute resolution system;
- **S.4481-A(Seward)/A.11737 (Morelle)** – Would enact several targeted consumer and provider protections in their dealings with health plans.
- **S.8354-B (Seward)/A.11680-A (Morelle)** – Would reduce the circumstances when health plans may set premiums without approval from the Superintendent; and reduce from 45 to 21 days the time within which a health plan must reimburse a claim submitted electronically.

*Founded in 1807, the Medical Society of the State of New York represents over 25,000 physicians, residents and medical students.*

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