Q1. Why do physicians need this legislation?

New York State's Health Insurance Market is highly concentrated with domination by just one or two large health insurers in most regions of the State.

Over the last several years we have seen the takeover of Oxford and HealthNet by United Healthcare; the merger of HIP and GHI; the merger of MVP and Preferred Care; the takeover of Univera by Excellus; as well as Empire's converting to for profit status.

With this market domination, health insurer profits have grown substantially and rapidly because neither health care providers nor consumers/patients have adequate market leverage to meaningfully negotiate either the financial or the clinical terms and conditions of most health insurance contracts. Consequently, fees, covered benefits and access are rigorously limited.

Health insurance company profits effectively extract huge dollars from our health care system which is already becoming prohibitively expensive.

As disproportionately large amounts of the financial resources committed to health care are extracted in the form of corporate profits from the sums available to purchase health care services, quality and access must inevitably suffer.

Federal antitrust laws generally prohibit individual health care providers from collectively negotiating any provisions of contracts presented to them by managed care entities. States are able to authorize conduct that might otherwise trigger antitrust review if they affirmatively displace competition with regulation. This bill would allow physicians -- especially in solo or small group practices -- to communicate with each other and jointly negotiate with health maintenance organizations (HMOs).

Q2. Can you provide examples of unfair practices/terms which could be addressed by more favorable contract terms?

- Plans impose burdensome processes which result in inappropriately long wait times for physicians and their staffs when they request pre-authorization for patient care and needed prescription medications.

- Plans use their own, closed processes to define medical necessity and to determine which drugs to put on formulary.

- Plans establish their own internal review processes for internal review of adverse decisions which processes do not use physicians in the same or similar specialty in the course of that review.

- Plans limit the ability of physicians to refer their patients to ancillary service providers necessary for making correct diagnoses, including imaging facilities and laboratories.

- Plans have the unprecedented ability to change the terms of a contract with a physician unilaterally, with little notice to the physician and only an illusory ability to "opt out" of the contract if the physician disagrees with the amendment.

- Plans make exorbitant refund demands long after the time that payment was initially made, sometimes by making specious allegations of "abusive billing" and using the extremely unfair practice of extrapolation to grossly inflate refund demands.

- Plans constrain reimbursement to the same level year after year, or in some instances impose cuts, despite the fact that the cost of running a practice keeps going up significantly each year.

Q3. How would negotiations proceed?

Negotiations between providers and a health plan are to be conducted through a health care provider's representative.

The New York State Attorney General (with advice from the Commissioner of Health and the Superintendent of Insurance) must approve the subject matter to be negotiated before negotiations can go forward.

The Attorney General will closely monitor the collective negotiations, facilitate resolution of negotiation impasses (through appointment where necessary of a mediator and fact finding board), and actively monitor implementation of agreements.

The negotiated agreement to become effective must be approved by the Attorney General.

Also, the Attorney General must continuously monitor the agreement as it is implemented by the parties.

Q4. What terms can be negotiated?

The bill divides the matters subject to being collectively negotiated into <u>two major areas</u>.

The first issue area involves <u>non-fee related matters</u> such as utilization review, coverage provisions, benefits and exclusions definition of medical necessity, risk transfer, referral provisions, burdensome pre-authorization procedures, limited drug formularies and access where necessary to out-of-network specialists.

The second issue area which can be negotiated involves <u>fee-related matters</u>. These can be negotiated, however, only if the health care plan has <u>substantial market share</u> in the service area in which the physicians are practicing. ("Substantial market share" is defined in the bill.)

<u>Strikes are expressly prohibited.</u>

Q5. Will the negotiation process add cost to the State?

No. The bill requires the Attorney General to set the fees to cover the cost of administration to be paid by the health care provider's representative.

Q6. Will allowing healthcare providers negotiate fees increase costs?

No. The new dynamic created by this legislation will not increase monies committed to health care but will re-distribute existing dollars which will be re-directed away from insurance company excessive profits and to the provision of enhanced clinical care. For example, the patient who needs a currently uncovered service but must forego it because he or she cannot afford it, will now have his or her premium dollars used to buy such service rather than to disappear into shareholder profit.

The Attorney General is actively and intensively involved in every aspect of these negotiations and implied in that review is the responsibility to assure that the state and the citizens of New York would not be adversely affected from a financial perspective.

Also, costs will quite possibly be reduced through improved efficiencies negotiated by providers which will eliminate costs of administrative burdens unrelated to quality.