New York HPA Health Plan Association

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MEMORANDUM IN OPPOSITION

FOR IMMEDIATE RELEASE: January 25, 2016

Re: S.2303 (Hannon)/A.1193 (Lavine) AN ACT to amend the insurance law, in relation to determination of overpayments to health care providers by extrapolation.

The New York Health Plan Association (HPA) opposes S.2303/A.1193, which would provide physicians with a new additional right of review to contest health plan efforts to recoup amounts overpaid by the health plan to the physician.

This Legislation Runs Counter to Plans' and Physicians' Ability to Agree on Contract Terms

Currently, pursuant to existing statute, health plan physician contracts, provider manuals, bulletins, and policy statements or web postings delineate the policies and procedures by which the physician and plan determine how claim overpayments will be calculated and the process by which the physician can challenge an overpayment recovery. This statutory requirement is monitored by the Department of Financial Services (DFS). Physicians are free to negotiate the specific terms of how overpayments are recovered and appealed with health plans through the contracting process. This legislation would obviate existing contractual agreements and have a chilling effect on the use of extrapolation.

Physicians and plans, by contract agree to various terms and conditions including standards for payment, timeliness for claim submission, prompt pay and recoupment of overpayments. The contracts also include the use of independent dispute resolution through the use of arbitration and mediation. Both parties have the option of also seeking an independent review through the judicial process. This bill seeks to create a new additional independent review for overpayment disputes with the plan paying half the cost on behalf of the physician challenging the plan overpayment determination. As physicians already have a number of independent review options, no need exists for the remedy sought by this legislation.

When a physician has been found to have been overpaid, the extrapolation process allows health plans to start when the overpayment was found and apply it to the period in which the overpayments were made. The bill would have a chilling effect on the use of extrapolation by adding the requirement that there be a mutually agreed upon independent third party auditor, with the plan and physician sharing the cost of the appeal. The process contemplated by this legislation will encourage additional reviews for which health plans now will be responsible for half the cost of, which will make the overpayment reconciliation process more lengthy and expensive.

Health Care Fraud is Not a Victimless Crime

All New Yorkers end up paying for health care fraud and abuse through higher premiums, higher taxes, higher co-pays and, sometimes, fewer benefits. Beyond the financial risk is the potential physical risk posed to patients by subjecting them to unnecessary procedures.

The New York Health Plan Association represents 26 managed care health plans that provide comprehensive health care services to more than 7 million New Yorkers.

State regulations require health plans to comply with the prompt pay law, forcing the insurer to recover overpayments through a "pay and chase" methodology. Unlike property and casualty insurance, where one claim equals one case, it can take a review of hundreds, even thousands, of separate claims to uncover abusive overbilling activity in health care. In recognition of the costs attributable to fraud, waste and abuse, and a desire by the Governor and Legislature to reduce waste and abuse, New York's commercial health plans are mandated by DFS to have a comprehensive fraud detection and prevention plan and a Special Investigation Unit (SIU) in place. It is the health plan's SIUs that protect consumers from abusive billing practices by health care providers. Moreover, health plans are required to make detailed filings of their anti-fraud and abuse efforts and report all cases of potential fraud and abuse.

This legislation would not only impact commercial insurers efforts to recoup overpayments, but would also apply to the contracts of Medicaid managed care plans, and have a direct impact on the recovery efforts of the plan SIUs , Office of the Medicaid Inspector General and Attorney General's Medicaid Fraud Control Unit.

The Work of the Health Plan Special Investigations Unit

Health plans use state of the art anti-fraud computer systems and protocols to expose billing practices that rise to the level of "abuse" and warrant recoupment to protect consumers and small businesses. SIUs work collaboratively with other health plan departments (e.g., claims, utilization review) to identify suspicious activity, run computer programs against provider claims to uncover anomalous patterns of billing, support consumer fraud hotlines and public awareness activities, and participate with the New York State Office of the Medicaid Inspector General (OMIG), Attorney General Medicaid Fraud Control Unit (MFCU) and local law enforcement task forces.

Examples of Overpayment

- Duplicate billing (e.g., billing two payers or a payer and beneficiary).
- Scheduling unnecessary appointments with beneficiary.
- Running unnecessary tests (e.g., x-rays, blood work).
- Upcoding (e.g. coding for a more complex service than was performed).
- Over billing for time spent.
- Adding family members' names to bills.
- Kickbacks (e.g., sharing payments with another provider as a result of patient referral).

HPA urges the legislature to focus on improving quality and affordability of health care, and to reject measures that severely restrict health plans ability to fight fraud, waste and abuse, and say no to S.2303/A.1193.