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**ADMITTED TO THE BAR IN:**

- DISTRICT OF COLUMBIA
- MASSACHUSETTS
- NEW YORK

**LICENSED TO PRACTICE**

**CHIROPRACTIC IN:**

- DISTRICT OF COLUMBIA
- NEW YORK
- VIRGINIA

August 17, 2012

Ms. Danielle Holahan  
Project Director of Health Insurance Exchange  
Planning for the State of New York  
New York State Health Benefit Exchange  
New York State Department of Health



DRAFTED BUT NOT COMPLETELY PROOFREAD  
[Submitted electronically to [exchange@health.state.ny.us](mailto:exchange@health.state.ny.us)]

RE: Benchmark Options for Essential Health Benefits  
File: I-12-2012

Dear Ms. Holahan:

The New York State Chiropractic Association (NYSCA) and the New York Chiropractic Council (Council) submits these comments on New York's selection of an Essential Health Benefits (EHB) benchmark plan for use in the individual and small group insurance markets. The NYSCA and the Council represent the interests of chiropractic patients and doctors of chiropractic state-wide. Both the NYSCA and the Council support efforts attempting to provide quality, affordable health care accessible to all of New York State's citizens. We appreciate this opportunity to provide you our comments concerning the implementation of this aspect of the Patient Protection and Affordable Care Act ("ACA" Public Law 111-148, 124 Stat. 119) in New York State.

The NYSCA and Council appreciate especially, the invitation to attend and listen to the Milliman presentation on August 2 and the informational chart from the Milliman report posted on the Exchange website post-meeting – "Review of State Mandates and Potential Benchmark Plans." We also appreciate the thorough contemplation, diligence, and study that went into the examination of New York's potential EHB plans following the guidance on the issue set out in December 2011 by the Department of Health and Human Services (HHS). The selection of benchmark plan is monumentally important since this could set the bar for essential benefits included in non-grandfathered plans inside and outside of the Exchange, and for the potential for the benchmarking of EHBs that will affect other plans and programs including Medicaid and the potential to affect other plans and programs after the state-based Exchange opens to the participation of larger employers in 2017.

While the NYSCA and Council appreciate the effort that went into the Milliman presentation and chart, the language of the Affordable Care Act raises questions that appear to go to the heart of what is considered an "essential health benefit" and what those parameters entail.

1. At this juncture, it is our understanding that the state is trying to identify the basic benefits and services – that is, the "products" in a benchmark plan selected by the state to meet the September HHS requirement for selection.<sup>1</sup> Further, it is our understanding that the essential benefits from the

selected benchmark will be used to set the standard for inclusion through the Exchange of other Qualified Health Plans.

The ACA indicates that “[t]he Secretary [of HHS] shall ensure that the **scope of the essential benefits**” in the ten general categories of covered items and services, “is equal to the **scope of benefits** provided under a **typical employer plan**, as determined by the Secretary.”<sup>2</sup> (Italics and emphases added.) It is unclear exactly what the “scope of essential benefits” or “scope of benefits” means precisely. Does “scope of benefits” refer to the breadth of benefits and specific services that an Exchange “product” needs to include (inclusion criteria only), or does “scope of benefits” also refer to the cost-sharing values – that is, the deductibles, copayment, coinsurance amounts and treatment limits required in an Exchange plan?<sup>3</sup> It is also unclear what Congress intended by its reference to a “typical employer plan.” The NYSCA and the Council acknowledge the Secretary’s dilemma – that “While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of “typical”<sup>4</sup> and we recognize the efforts the Secretary undertook to address this dilemma.<sup>5</sup> We realize, however, that Congress left this determination in the capable hands of the Secretary and that the Secretary chose to give the states the flexibility of selecting benchmark plans that reflects the scope of services offered by a “typical employer plan” that best meets the needs of the citizens of the respective states.<sup>6</sup> Still, in view of the information in the Milliman report, the question prevails of what constitutes “the scope of essential benefits” in a “typical employer plan?”

For example, insofar as chiropractic is concerned, we appreciate the fact that all ten benchmark plans Milliman examined covered chiropractic in the list of “products” to be included in an Exchange plan. However, for seven of the ten benchmark plans<sup>7</sup> the product appeared to be “unlimited” in theory, recognizing of course that access and care would be governed by such things as medical necessity determinations, evidence-based practice guidelines, comparative effectiveness regimens and utilization review,<sup>8</sup> while the chiropractic product in Federal Employee Health Benefit Plans was limited to one office visit and 12- or 20-manipulation visits per year<sup>9</sup> – whether provided by a doctor of osteopathy or chiropractor<sup>10</sup> – even though the chiropractic product in the Federal plans are managed by the same utilization review criteria and mechanisms as the “unlimited” chiropractic products above.

The question is how will the state chose a “typical employer plan” when the plans examined offered such different choices in product benefits?

The NYSCA and Council feel that plans that only offer specific office and treatment limits – particularly of the sort found in the Federal Employee Health Benefit plans – are artificial, arbitrary and capricious; at variance with most evidence-based, medical treatment and utilization review guidelines, and do not take into account a patient’s presenting condition, attendant comorbidities, whether the patient is acute or chronic, or whether the presentment is an exacerbation of a pre-existing condition and on. While the NYSCA and the Council understand that resources are finite and not unlimited, and we recognize that HHS has indicated that some limits are permissible,<sup>11</sup> and that New York State has weighed in on “benefit limits” in state’s comments to the December 16, 2011 HHS Essential Health Benefit Bulletin,<sup>12</sup> nonetheless, as outlined above, in principle the NYSCA and Council oppose plans that place arbitrary visit limits chiropractic products in favor of plans that are theoretically “unlimited” but still controlled by the utilization review mechanisms of managed care. The chiropractic product in an “unlimited” benefit plan is managed just as well as the benefit in plans that place arbitrary visit limits on care. In a similar manner, the NYSCA and the Council oppose arbitrary limits placed on benefits for a combination of physical therapy, occupational therapy and/or speech therapy products in lieu of the “unlimited” benefit in the state Empire Plan.<sup>13</sup> However, if the State selects a plan that contains visit limits, the NYSCA and Council feel that there should be parity of coverage between the different classes of provider in comportment with the “Non-discrimination in Health Care” clause found at §

2706 of the ACA.<sup>14</sup>

2. Toward the close of the August 2, 2012 Milliman presentation and meeting, a member of the New York State Department of Financial Services indicated that, if New York State fails to select a benchmark plan by the end of September, the Secretary of HHS would select a benchmark plan for New York<sup>15</sup> and that plan would likely be the Oxford EPO plan.

Presumably, the EPO designation stands for “exclusive provider organization” that provides in-network benefits only and proscribes subscribers from being reimbursed for visits to out-of-network providers. Neither the NYSCA nor the Council could find an exact match for the Milliman/State Oxford EPO. We did find reference to an “Oxford Freedom Ease EPO,” an Oxford HSA Exclusive and an Oxford Exclusive Plan Metro. The NYSCA and the Council have several fundamental concerns with regard to EPO plans.

- It is the NYSCA/Council’s understanding that, at this juncture, the State will be selecting a benchmark plan that includes a majority of the products listed in Milliman’s Essential Benefits Study.<sup>16</sup> Thus, if New York State selects the Oxford EPO plan, or the Secretary of HHS selects the Oxford EPO as New York’s default plan, it is our understanding that what is being selected is the basic benefits – the products and services offered in the plan selected that other qualified health plans (QHPs) that participate in the Exchange would have to match or meet. Is this correct?
  - Further, it is the NYSCA/Council’s understanding that selection of the Oxford EPO plan, or any other plan, would not necessarily constitute a per se endorsement of Oxford EPO plan per se or of any other plan respectively selected by New York state. Is this also correct?
  - Further, if New York selected the Oxford EPO (or any other benchmark plan), apart from selecting the basic benefits, products and services in the plan, it is the NYSCA/Council’s understanding that, in the case of the Oxford EPO for example, New York State would not necessarily be selecting a benchmark that required “in-network” participation and reimburses subscribers and/or their authorized representatives (assignees) for “in network” benefits only pursuant to a participating provider contract. Is this correct as well?
    - The NYSCA/Council note that the ACA specifically provides for “out-of-network providers”<sup>17</sup> and does not force qualified health plans to contract with a provider who refuses to participate and accept the applicable payment rates for the plan selected.<sup>18</sup>
3. Benchmark plans may currently provide illusory benefits. Qualified Health Plans providing and essential benefits package through a state-based Exchange should not be permitted to provide an illusory benefit.

This issue may be tangential to the issue at hand – selecting the essential benefits – the products that qualified health plans in an Exchange will be obliged to cover, however, the NYSCA/Council fee it is monumentally important issue to address sooner rather than later.

The NYSCA/Council note in the details of many of the benchmark plans that patients pay primary care physicians/practitioners a lesser copayment while the patients of chiropractors and other providers pay a higher specialist/specialty copayment rate. Further, it is the NYSCA/Council’s understanding that the reason for the copayment disparity rests in part on the definition of primary care physician/practitioner found in Public Health Law, acknowledged by the New York State Department of Health and the Department of Financial Services, which defines a “primary care physician” to be “a physician specialist in the field of family practice, general pediatrics, primary care internal medicine or

primary care obstetrics and gynecology; who provides coordinated primary care services<sup>19</sup> and everyone else is categorized as a specialist or a provider or specialty services.

It is our understanding that one reason patients pay higher copayments rates for the specialty services is to offset in part the higher fees specialists – orthopedists, neurologists, cardiologists, surgeons, etc. charge. In addition, the higher specialty copayment fee also has a salutary deterrent effect to counteract the moral hazard of insurance coverage. The end result is that patients are required to pay the higher specialty copayment fees to providers of lower cost complementary and ancillary health care services that is ordinarily reserved for patients to pay for the specialty services of an orthopedist, neurologist, surgeon or other medical specialist. To make matters worse from a providers' perspective, in order to participate in many plans, most insurance carriers and third-party administrators (TPAs) only offer providers "adhesion contracts" – take it or leave it agreements wherein the contracted fee(s) is(are) often less than a patients specialty copayment obligation. This means that the provider cannot even collect the full specialty copayment amount; the provider can only collect the contract fees according the fee schedule in participating provider contracts; patients ends up paying for all of their care out-of-pocket; and the insurer/TPA/payer ends up paying nothing for the benefit provider making the insurance coverage for the service(s) rendered illusory.

At a recent meeting with representatives of the Department of Financial Services, the Department intimated that it frowns upon this practice. In the past, however, one of the Department's predecessors – the New York state Insurance Department – excused this practice rationalizing that the patient ultimately benefits from the participating provider contract by paying a lower fee than they "might have" had to have paid in the absence of the adhesion contract. Further, the Department has held that if the providers did not like the fees schedule contained in provider agreement, the providers should not have agreed to them. Simple to say, but for many providers often presents a Hobson's choice – either sign the agreement and accept the lower fees simple to be in the in-network directory in order to access the payer's subscribers and go out-of-business slowly when the provider cannot make overhead, or decline to sign the agree cutting off access to the payer's subscribers and go out-of-business sooner rather than later. The bottom line, however, is that this practice results in the carrier/TPA/payer providing an illusory benefit that the patient pays for completely; it undermines the deterrent effect of paying a higher copayment and interferes with the moral hazard effect of insurance; the patient ends up paying less than required by their subscriber contracts with payers generating goodwill which inures to the benefit of the payer.

This practice is controversial among the various classes of professional and has spawned legislation to curtail this practice.<sup>20</sup> The NYSCA/Council supports these legislative efforts in principle.

The New York State Department of Health, or whatever other state agency, quasi-public agency or non-profit organization ends up managing the State's Exchange in comportment with the ACA, should insist on provider-payer contract language that would mitigate some of the foregoing concerns.

The NYSCA/Council realize that ACA stipulates that "[n]othing . . . shall be construed to require a qualified health plan to contract with a provider . . . if such provider refuses to accept the generally applicable payment rates or such a plan"<sup>21</sup> which, as pointed out above, are often less than the contracted subscriber copayment. The NYSCA/Council also recognize that the ACA does not require plans to contract with "any willing provider."<sup>22</sup> Nevertheless, much like the state does for managed care contracts,<sup>23</sup> at the very least, the State should insist on participating-provider contract language which allows an in-network provider to accept "the greater of the contracted, participating-provider fee schedule amount for a particular visit or service, or the full patient copayment obligation" for that particular class of provider, or, stating it alternatively, the participating provider contract should allow the provider to accept "the contracted, in-network, participating provider fee schedule amount for that particular service or visit, or the patient copayment amount, whichever is greater." While the benefit to the patient would still be illusory, this provision would relieve some provider angst concerning reimbursement; it would restore the deterrent effect of higher specialty copayments to the moral

hazard of insurance coverage, and would oblige patients to make payments they were legally obligated to make pursuant to their subscriber agreements.

4. Access to medical review criteria – evidence-based, clinical practice guidelines to determine medical necessity.

Providers and patients should be able to access the guidelines, protocols or similar criterion used by qualified health plans (QHPs) to make determinations of medical necessity, not only in situations where adverse determinations have been issued, but in any and all circumstances whenever a determination is made.

Presently, under Articles 49 of New York state Insurance law and Public Health law respectively, utilization review agents<sup>24</sup> making medical necessity determinations,<sup>25</sup> are not required to disclose the “clinical review criteria and standards contained within the utilization review plan,”<sup>26</sup> even in an instance of an adverse determination,<sup>27</sup> and even though the agent is required to report the plan to the state.<sup>28</sup>

Under Federal law, rule and regulation, plan administrators in the case of employee group health benefit plans, are required to provide claimants (patients and/or beneficiaries) or their authorized representative<sup>29</sup> with a copy of any “internal rule, guideline, protocol, or other similar criterion . . . relied upon,”<sup>30</sup> but only in an instance of an adverse determination.<sup>31</sup>

Further, the NYSCA/Council note that, according to the National Association of Insurance Commissioners and pursuant to § 2719 of the ACA,<sup>32</sup> for “internal appeals,” “group plans must incorporate the Department of Labor’s claims and appeals procedures and update them to reflect standards established by the Secretary of Labor.”<sup>33</sup> Specifically, the NAIC notes “[p]lans must comply with the DOL Claims regulation, as published in the Federal Register on Nov 21, 2000, as current modified.<sup>34</sup> Although the Employee Retirement Income Security Act of 1974 (ERISA) usually preserved state regulation of insurance, banking and securities laws from ERISA preemption,<sup>35</sup> it is the NYSCA/Council’s understanding that pursuant to the incorporation of the U.S. Department of claims regulation above, the provisions of the DOL regulation will apply to non-grandfathered, small group, qualified health plans in the benefit Exchange.<sup>36</sup> Is this correct?

The NYSCA/Council feel that all payers should be obliged to disclose all internal rules, clinical practice and other guidelines, protocols, and other criterion relied upon in advance of the making of a medical necessity determinations of any nature and not just in an instance of an adverse benefit determination. In lieu of any statutory or administrative law to this effect, the NYSCA/Council could not help but notice the apparent conflict in state and federal law concerning the disclosure of the “internal rules, clinical practice and other guidelines, protocols, and other criterion relied upon” by claims administrators and utilization review agents in any utilization review plan. For the reasons, set forth above, the NYSCA/Council presume that the U.S. Department of Labor regulations cited above, incorporated into the ACA by reference, trump Articles 49, § 4901 of New York state Insurance Law and Public Health Law respectively, in the administration of a qualified health plan offered through New York’s Health Benefit Exchange. Is the correct?

5. Finally, if the NYSCA and the Council had to select a benchmark plan, the NYSCA prefers the plans not affiliated with the Federal Employee Health Benefit plans; the Council, in contrast, noting that none of the current benchmark plans Milliman examined is optimal as listed, nonetheless, preferred the Direct Access plan to the other plans overall.

The NYSCA also feels that all of the plans should cover all of the services doctors of chiropractic are currently allowed to provide by state law. The NYSCA also believes that the services chiropractors provide should be covered similarly and with the same requirements, fees and medical necessity

guidelines as the same or similar services that pertain to other classes of licensed provider.

The NYSCA/Council feel that, appropriately managed, chiropractors can provide patient-safe, patient-centered, evidence-based, efficacious and cost-effect quality chiropractic care and clinical excellence which will inure to the benefit of the patients chiropractors serve, the citizens of New York state.

In closing, the NYSCA and the Council have been impressed thus far with the amount of planning, organization, communication and dissemination of information and the level of transparency. The selection of essential health benefits provided by qualified health plans through New York's anticipated Health Benefit Exchange is critically important to New York's citizens – especially those individuals and small employers who currently do not have or provide care coverage – and to the providers who will care for them. The EHB package that New York state selects must be sufficient to to address the various needs of a wide segment of the state's population.

The NYSCA and Council appreciate that chiropractic coverage is included in all 10 benchmark plans at some level. We look forward to continuing our dialogue with the State as we work to determine the details of the coverage and how the coverage limits will be determined.

Sincerely,

Karl C. Kranz, DC, Esq.  
Executive Director/Staff Counsel  
on behalf of the  
New York State Chiropractic Association  
and the  
New York Chiropractic Council

cc: Officers, Directors, Delegates  
Legislative Counsel

### References

1.DHHS. Essential Health Benefits: HHS Informational Bulletin. Accessed Aug 16, 2012 at:  
<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

“states would have the flexibility to select a benchmark plan that reflects the scope of services offered by a “typical employer plan.” This approach would give states the flexibility to select a plan that would best meet the needs of their citizens.” (Underlining added.)

2.Patient Protection and Affordable Care Act (PL 111-148), Subtitle D – Available Coverage Choices of All Americans, Part 1 – Establishment of Qualified Health Plans, § 1302 – Essential Health Benefits Requirements, (b) – Essential Health Benefits, (2) – Limitation, (A) – In General.

3.DHHS. Essential Health Benefits Bulletin. Center for Consumer Information and Insurance Oversight December 16, 2011. Accessed Aug 16, 2012 at:  
[http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf). See Footnote 5.

“5 Nomenclature used in HealthCare.gov describes “products” as **the services covered as a package by an issuer**, which *may* have several cost-sharing options and riders as options. A “plan” refers to the specific benefits and cost-sharing provisions available to an enrolled consumer.” (Italics, emphases and underlining added.)

4.DHHS. Essential Health Benefits Bulletin. Center for Consumer Information and Insurance Oversight December 16, 2011. Accessed Aug 16, 2012 at:  
[http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf)

5.DHHS. Essential Health Benefits Bulletin. Center for Consumer Information and Insurance Oversight December 16, 2011. Accessed Aug 16, 2012 at:  
[http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf)

“HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives, in both Washington, D.C. and around the nation to gather public input. Several key themes emerged. Consumer groups and some provider groups expressed concern at the IOM’s emphasis on cost over the comprehensiveness of benefits. Some consumer groups expressed a belief that small group plans may not represent the typical employer plan envisioned by the statute, while employers and health insurance issuers generally supported the IOM conclusion that EHB should be based on small employer plans. Consumer and provider groups commented that specific benefits should be spelled out by the Secretary, while health insurance issuers and employers commented that they prefer more general guidance, allowing for greater flexibility. Both provider and consumer groups expressed concern about discrimination against individuals with particular conditions. Employers and health insurance issuers stressed concern about resources and urged the Secretary to adopt a more moderate benefit package. Consumers generally favored a uniform benefits package, and many consumers requested that State mandates be included in the benefits package. Some requested a uniform benefit package so that consumer choice of plan could focus on other plan features such as premium, provider network, and quality improvement. Some employer, health insurance issuer, and State representatives focused on the need for flexibility across the country to reflect local preferences and

practices.”

6.DHHS. Essential Health Benefits: HHS Informational Bulletin. Accessed Aug 16, 2012 at: <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

“HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the department’s intended approach announced today, states would have the flexibility to select a benchmark plan that reflects the scope of services offered by a “typical employer plan.” This approach would give states the flexibility to select a plan that would best meet the needs of their citizens.”

7.Milliman. Appendix A. New York State Essential Benefit Study. Summary of Covered Services for Potential Benchmark Plans, page 2. Accessed August 16, 2012 at: [http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02\\_milliman\\_exhibit1\\_app\\_a.pdf](http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02_milliman_exhibit1_app_a.pdf)

Specifically, the seven plans that provided a theoretical “unlimited” chiropractic benefit product were the three largest New York state Employee Plans – the Empire Plan, Capital District Physicians Health Plan and Independent Health; the largest commercial, non-Medicaid HMO – HIP Prime, and the three largest small group plans – Oxford HMO, Oxford EPO and Oxford Direct.

8.Milliman. Appendix A. New York State Essential Benefit Study. Summary of Covered Services for Potential Benchmark Plans, page 2. Accessed August 16, 2012 at: [http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02\\_milliman\\_exhibit1\\_app\\_a.pdf](http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02_milliman_exhibit1_app_a.pdf)

9.Milliman. Appendix A. New York State Essential Benefit Study. Summary of Covered Services for Potential Benchmark Plans, page 2. Accessed August 16, 2012 at: [http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02\\_milliman\\_exhibit1\\_app\\_a.pdf](http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02_milliman_exhibit1_app_a.pdf)

10.For example, the 2012 Government Employees Health Association, Inc., Benefit Plan limits chiropractic services to twelve (12) visits per person per calendar year for manipulation of the spine. (See: <http://www.opm.gov/insure/health/planinfo/2012/brochures/71-006.pdf>). The 2012 federal Blue Cross and Blue Shield Service Benefit Plan limits “benefits for osteopathic and chiropractic manipulative treatment to a combined total of 12 visits per person, per year for the Standard Option plan, and a combined total of twenty (20) visits per person, per year for osteopathic and chiropractic manipulation under the Basic Option. (See: <http://www.opm.gov/insure/health/planinfo/2012/brochures/71-005.pdf>)

11.Department of Health & Human Services, Centers for Medicare & Medicaid Services. Frequently Asked Questions on Essential Health Benefits Bulletin, February 17, 2012. Accessed Aug 16 at: <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>

“7. What is the minimum set of benefits a plan must offer in a statutory category to be considered to offer coverage within the category consistent with the benchmark plan?

A: Under the approach described in the Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431, and provided that substitutions would not violate other statutory provisions. For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20



covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met. The benchmark plan would provide States and issuers with a frame of reference for the EHB categories.”

“8. Can scope and duration limitations be included in the EHB?

A: Yes. Under the intended approach, a plan must be substantially equal to the benchmark plan, in both the scope of benefits offered and any limitations on those benefits such as visit limits. However, any scope and duration limitations in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. In addition, the Public Health Service Act (PHS Act) section 2711, as added by the Affordable Care Act, prohibits imposing annual and lifetime dollar limits on EHB. Note that for annual dollar limits, the prohibition generally applies in full starting in 2014, with certain restricted annual limits permitted until that time. The prohibition on annual dollar limits does not apply to grandfathered individual market policies.

12. New York State Comments on [the] December 16, 2011 Essential Health Benefits Bulletin.

“4) Benefit Limits

“Because HHS is giving the option to choose a benchmark plan, it follows that states should be permitted to create their own standards (e.g., setting quantitative limits on benefits). HHS should allow states to modify any current quantitative limits associated with a benefit in the benchmark plan (e.g., if further analysis determines that modification is needed to reflect a balance among the categories and/or to balance affordability with comprehensiveness). It seems the Bulletin may only allow issuers, and not states, to vary the scope of services and limits of the State benchmark.

“The Bulletin is clear that if one of the 10 categories of essential benefits is not included in the benchmark plan, it is possible for the state to look to another one of the benchmark options to define the benefit. However, we urge HHS to also allow states the same flexibility with respect to benefits in one of the 10 categories that is included in the state’s chosen benchmark, if the state feels the benefit is inadequate. For example, physical therapy is not standardized in NY, but is included in the rehabilitative category under the ACA. If New York determines that the physical therapy benefit in the chosen benchmark is not sufficient, the state should be allowed to substitute the physical therapy benefit from another benchmark plan. The state needs the flexibility to ensure that the benefits provided meet the needs of its consumers and the ACA’s goal of providing meaningful coverage (particularly in the 10 designated benefit categories).

13. Milliman. Appendix A. New York State Essential Benefit Study. Summary of Covered Services for Potential Benchmark Plans, page 3. Accessed August 16, 2012 at:  
[http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02\\_milliman\\_exhibit1\\_app\\_a.pdf](http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02_milliman_exhibit1_app_a.pdf)

14. PPACA (PL 111-148), Subtitle C—Quality Health Insurance Coverage for All Americans, Part I—Health Insurance Market Reforms, § 1201. Amendment to the Public Health Service Act, adding and inserting inter alia,

“SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is

acting within the scope of that provider's license or certification under applicable State law.

15.DHHS. Essential Health Benefits: HHS Informational Bulletin. Accessed Aug 16, 2012 at: <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

"If states choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state."

See also: See: Essential Health Benefits: HHS Informational Bulletin, accessed Jul 26, 2012 at: <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

16.Milliman. Exhibit 1. New York State Essential Benefit Study. Summary of Covered Services for Potential Benchmark Plans. Accessed August 16, 2012 at: [http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02\\_milliman\\_exhibit1\\_app\\_a.pdf](http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02_milliman_exhibit1_app_a.pdf)

17.For example, PPACA (PL 111-148). Subtitle D – Available Coverage Choices for All Americans, Part 2 – Consumer Choices and Insurance Competition Through Health Benefit Exchanges, § 1311 – Affordable Choices of Health Benefit Plans, (c) – Responsibilities of the Secretary, (1) – In General, paragraph (B) requires that:

- (c) (1) The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum –
  - (B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of ***in-network*** and ***out-of-network providers***; (Italics, emphases and underlining added.)

Further, § 1311 (c)(2) – "Rule of Construction" stipulates that

- (c) (2) Rule of Construction. – Nothing in paragraph (1)(c) shall be construed to require that a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

18.For example, PPACA (PL 111-148). Subtitle D – Available Coverage Choices for All Americans, Part 2 – Consumer Choices and Insurance Competition Through Health Benefit Exchanges, § 1311 – Affordable Choices of Health Benefit Plans, (c) – Responsibilities of the Secretary, (1) – In General, paragraph (B) stipulates that:

- (c) (2) Rule of Construction. – Nothing in paragraph (1)(c) shall be construed to require that a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

19.New York State Public Health Law, Article 9 – Primary care education and training, § 901 definitions.

- 7. "Primary care practitioner" means a midwife, nurse practitioner, or physician assistant who is licensed or certified to practice in New York state and who provides or arranges for coordinated primary care services.

8. "Primary care physician" means a physician specialist in the field of family practice, general pediatrics, primary care internal medicine or primary care obstetrics and gynecology; who provides coordinated primary care services.

20. For example, during the current legislative session, a bill was introduced, A187 / S4870, at the behest of the New York state Physical Therapy Association which "[p]rovides that no policy of group accident, group health or group accident and health shall impose co-payments in excess of twenty percent of total reimbursement to the provider of care." In justification, the bill's sponsors write:

"This bill will protect consumers by prohibiting plans from inappropriately shifting the cost of physical therapy care to consumers by limiting co-payments to no more than 20 percent of the total reimbursement to the provider of care. Under existing law, health plans must cover physical therapy services. Despite that requirement, health plans have shifted the vast majority of the cost of physical therapy services by imposing increasingly high co-payments on consumers. Under certain health plans, co-payments for physical therapy services have exceeded the reimbursement paid by the plan to the provider of care.

"This cost shift has imposed a financial burden on consumers, and it has restricted access to physical therapy services. Consumers frequently cannot afford the cost imposed by these copayments for medically necessary physical therapy care. Physical therapy services generally require multiple visits over the healing process. A co-payment of \$50 for a physical therapy plan of care of 3 times a week for a month will cost the consumer \$600 in out-of-pocket expenses which is beyond the means of many consumers. As a result, New Yorkers are forgoing medically necessary care running the risk of worsening the underlying condition or risking re-injury.

"This bill would reestablish the obligation of health plans to cover the expense of physical therapy services by limiting co-payments to no more than twenty percent of the total reimbursement to the provider of care. The 20 percent limitation will allow plans to require co-payments that discourage inappropriate care but will prohibit plans from inappropriately shifting the cost of physical therapy care to consumers."

The NYSCA supports the NYPTA effort in principle. If the NYPTA effort was successful, it would open the floodgates of similar legislative efforts on the part of other classes of provider.

21. PPACA (PL 111-148). Subtitle D – Available Coverage Choices for All Americans, Part 2 – Consumer Choices and Insurance Competition Through Health Benefit Exchanges, § 1311 – Affordable Choices of Health Benefit Plans, (c) – Responsibilities of the Secretary, (2) Rule of Construction.

- (c) (2) Rule of Construction.– Nothing in paragraph (1)(c) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

22. PPACA (PL 111-148), Subtitle C—Quality Health Insurance Coverage for All Americans, Part I—Health Insurance Market Reforms, § 1201. Amendment to the Public Health Service Act, adding and inserting inter alia,

"SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

- (a) PROVIDERS.—A group health plan and a health insurance issuer offering group or

individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

23. See: New York State Department of Health "Provider Contract Guidelines for MCOs and IPAs." Accessed August 16, 2012 at: [http://www.health.ny.gov/health\\_care/managed\\_care/hmoipa/hmo\\_ipa.htm](http://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm).

24. New York state Public Health Law, Article 49 – Utilization Review and External Appeal, Title I – Registration of Agents, § 4900 – Definitions,

9. "Utilization review agent" means any company, organization or other entity performing utilization review, except:
- (a) an agency of the federal government;
  - (b) an agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government;
  - (c) an agent acting on behalf of the state and local government for services provided pursuant to title XIX of the federal social security act;
  - (d) a hospital's internal quality assurance program except if associated with a health care financing mechanism; or
  - (e) any insurer subject to article thirty-two or forty-three of the insurance law and any independent utilization review agent performing utilization review under a contract with such insurer, which shall be subject to article forty-nine of the insurance law.

25. New York state Public Health Law, Article 49 – Utilization Review and External Appeal, Title I – Registration of Agents, § 4900 – Definitions,

8. "Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. For the purposes of this article none of the following shall be considered utilization review:
- (a) Denials based on failure to obtain health care services from a designated or approved health care provider as required under a subscriber's contract;
  - (b) Where any determination is rendered pursuant to subdivision three-a of section twenty-eight hundred seven-c of this chapter;
  - (c) The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure;
  - (d) Any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination; and
  - (e) Any determination of any coverage issues other than whether health care services are or were medically necessary.

26. New York state Public Health Law, Article 49 – Utilization Review and External Appeal, Title I – Registration of Agents, § 4900 – Definitions,

10. "Utilization review plan" means:

- (a) a description of the process for developing the written clinical review criteria;
- (b) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to, a set of specific written clinical review criteria;
- (c) a description of practice guidelines and standards used by a utilization review agent in carrying out a determination of medical necessity;
- (d) the procedures for scheduled review and evaluation of the written clinical review criteria; and
- (e) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of utilization review.

27. New York state Public Health Law, Article 49 – Utilization Review and External Appeal, Title I – Registration of Agents, § 4900 – Definitions,

- 1. "Adverse determination" means a determination by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.

28. New York state Public Health Law, Article 49 – Utilization Review and External Appeal, Title I – Registration of Agents, § 4901 – Registration of Utilization Review Agents,

- 1. Every utilization review agent who conducts the practice of utilization review shall biennially register with the commissioner and report, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subdivision two of this section.
- 2. Such report shall contain a description of the following:
  - (a) The utilization review plan;

29. Department of Labor, Pension and Welfare Benefits Administration. Part VIII. 29 CFR Part 2560 – Employee Retirement Income Security Act of 1974; Rules and Regulations for the Administration and Enforcement; Claims Procedure; Final Rule. Federal Register 2000 Nov 21; 65(225): 70266.

Part 2560 – Rules and Regulations for Administration and Enforcement, § 2560.503-1 – Claims procedures, (b) – Obligation to establish and maintain reasonable claims procedures,

- (4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant . . .

30. Department of Labor, Pension and Welfare Benefits Administration. Part VIII. 29 CFR Part 2560 – Employee Retirement Income Security Act of 1974; Rules and Regulations for the Administration and Enforcement; Claims Procedure; Final Rule. Federal Register 2000 Nov 21; 65(225): 70268.

Part 2560 – Rules and Regulations for Administration and Enforcement, § 2560.503-1 – Claims procedures, (g) – Manner and content of notification of benefit determinations

- (g) Manner and content of notification of benefit determination.

- (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant —
  - (i) The specific reason or reasons for the adverse determination;
  - (ii) Reference to the specific plan provisions on which the determination is based;
  - (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
  - (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;
  - (v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,
    - (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
    - (B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
  - (vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

31. Department of Labor, Pension and Welfare Benefits Administration. Part VIII. 29 CFR Part 2560 – Employee Retirement Income Security Act of 1974; Rules and Regulations for the Administration and Enforcement; Claims Procedure; Final Rule. Federal Register 2000 Nov 21; 65(225): 70268.

Part 2560 – Rules and Regulations for Administration and Enforcement, § 2560.503-1 – Claims procedures, (m) – Definitions

- (4) The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

32. PPACA (PL 111-148), Subtitle C—Quality Health Insurance Coverage for All Americans, Part I—Health Insurance Market Reforms, § 1201. Amendment to the Public Health Service Act, adding and inserting inter alia,

- (g) Section 2719 of the Public Health Service Act, as added by section 1001(4) of this Act, is amended to read as follows:

“SEC. 2719. APPEALS PROCESS.

“(a) INTERNAL CLAIMS APPEALS.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

“(A) have in effect an internal claims appeal process;

“(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

“(c) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

“(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

“(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

“(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

33. See: National Association of Insurance Commissioners (NAIC). Patient Protection and Affordable Care Act Section-by-Section Analysis, May 5, 2011, p. 8. Accessed August 16, 2012 at: [http://www.naic.org/documents/index\\_health\\_reform\\_general\\_ppaca\\_section\\_by\\_section\\_chart.pdf](http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf)

34. See: National Association of Insurance Commissioners (NAIC). Patient Protection and Affordable Care Act Section-by-Section Analysis, May 5, 2011, p. 8. Accessed August 16, 2012 at: [http://www.naic.org/documents/index\\_health\\_reform\\_general\\_ppaca\\_section\\_by\\_section\\_chart.pdf](http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf)

35. See: ERISA § 514(b)(2)(A); 29 USC 1144:

(a) Supersedure; effective date.

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now

or hereafter relate to any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003 (b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

- (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.
- (2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

36. Department of Labor, Pension and Welfare Benefits Administration. Part VIII. 29 CFR Part 2560 – Employee Retirement Income Security Act of 1974; Rules and Regulations for the Administration and Enforcement; Claims Procedure; Final Rule. Federal Register 2000 Nov 21; 65(225): 70268.

Part 2560 – Rules and Regulations for Administration and Enforcement, § 2560.503-1 – Claims procedures,

(k) Preemption of State law.

- (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.
- (2) (i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.
- (ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.