

MEDICAL SOCIETY OF THE STATE OF NEW YORK



DIVISION OF GOVERNMENTAL AFFAIRS

Philip Schuh
Interim Executive Vice-President

ELIZABETH DEARS KENT, ESQ.
Senior Vice President
Legislative and Regulatory Affairs

MORRIS M. AUSTER, ESQ.
Vice President
Legislative and Regulatory Affairs

PAT CLANCY
Vice President
Public Health and Education

BARBARA K. ELLMAN
Associate Director for Policy

JOANNE WISE
Manager, Continuing Education

EILEEN A. CLINTON
Program Coordinator

September 24, 2012

Danielle Holahan
Project Director for Health Benefit Exchange Planning
New York State Department of Financial Services
Albany, New York 12257

Dear Danielle,

Thank you for the opportunity to offer comments regarding the development of health insurance exchanges in New York State, including what should be contained within the Essential Health Benefits (EHB) package that must be offered in products offered through the Exchange.

The development of health insurance exchanges is likely to have a profound effect upon the purchase of health insurance in New York State. From our perspective, the purpose of the exchange is to better enable consumers and small businesses to easily compare a wide array of health insurance products and facilitate competition in an environment where currently just a few insurers dominate markets in all regions of the State. A well-designed exchange will promote insurance transparency and accountability, facilitate increased enrollment, and lower the cost of health insurance. At the same time, it is critically important to assure that the Exchanges are not developed in a way that exacerbates the already overwhelming health insurer market domination and over-regulation of medical care delivery that would make the already very difficult practice environment most New York physicians face even more difficult.

Core Principles

To guide our advocacy, last year MSSNY's Committee on Health Care Reform Implementation developed a list of 14 principles (Attached) regarding the development of Exchanges. They have been shared with the Governor's office, State Health Department and State Department of Financial Services, and key members of the Legislature. Among these very important principles include:

- Exchanges must assure that qualified health plans maintain adequate physician networks and not place unreasonable obstacles in the way of enrollees' access to out-of-network physicians
- Exchanges must assure that insurers disclose their methodology for covering-out-of-network care which must be based on the new FAIR HEALTH medical cost reporting system.

- Exchanges should maximize health plan choice for individuals and families purchasing coverage and should allow for the offering of high deductible health insurance plans (HDHP) issued in conjunction with Health Savings Accounts (HSAs),
- Exchanges should maximize affordability by enhancing competition among qualified health plans.
- Exchanges should maximize health plan choice in benefit design and must minimize cost sharing for individuals and families purchasing coverage.
- Exchanges should provide a high level of transparency to enable patients to make an informed choice of insurer. A standardized comparison tool that allows patients to compare plans offered on the exchange is essential to enabling an informed choice of insurer.
- Physicians must not be forced to participate in certain qualified health plans participating in an exchange or in Medicaid.

Essential Health Benefits

As you review which existing health insurance products should form the benchmark for the EHB, it is important for you to be aware of the many types of care that the physician community in New York State has recommended must be contained within health insurance coverage sold in this State. In addition to defining the EHB, the Exchange governance must take steps to assure patients are truly able to access the care that they expect to receive by purchasing this coverage through the Exchange.

First, it is critical to assure that the health insurers offering coverage for these essential health benefits take the steps necessary to establish large enough networks to provide the necessary care patients expect to receive. Critical to this goal is requiring health insurers to address the barriers that currently cause some physicians to choose not to participate with some insurance products, including overly burdensome prior authorization procedures for needed care and prescription medicines, as well as insufficient payments for care. Because it is expected that over 1 million New Yorkers will receive coverage through the Exchange, the Exchange will have the leverage to demand that insurers offering coverage through the Exchange address these long-standing problems.

Moreover, it is critical to assure that patients and employers have meaningful options to purchase coverage that permit a patient to receive care from the physician of their choice outside of the health plan's network, as well as assuring that such coverage will truly provide significant coverage of the costs of this out of network care. Making an out of network option a requirement in all tiers and coverage offered in every region of the state should be a necessary requirement for a qualified health plan offering coverage through the Health Insurance Exchange. As was reported earlier this year in the *New York Times* and *Daily News*, there are several insurers which currently offer policies that theoretically provide coverage for out of network care, but in reality fail to provide such coverage because the payments for such coverage are set at levels abysmally low (such as Medicare) and far below the true cost of care as reported in the FAIR Health database. The coverage is, in effect, a "mirage". Again, the Exchange has the power to correct this insurer abuse and deception, and assure that consumers and employers "get what they pay for" when they purchase coverage with an out of network option.

With regard to specific types of care that should be within the EHB, below please find the items contained within a white paper recently adopted by the MSSNY Council entitled "Screening Programs and Interventions Most Beneficial in Improving the Overall Health of the Public". The paper set forth a series of essential preventive screening tests, as well as essential counseling services, that physicians believe must be covered by a basic health insurance policy offered through the Exchange.

Essential Behavioral Changes

1) *Smoking Cessation and Counseling* – Tobacco cessation counseling on a regular basis is recommended for all persons who use tobacco products. Pregnant women and parents with children living at home also should be counseled on the potentially harmful effects of smoking on fetal and child health. (US Preventive Services Task Force).

2) *Healthy Diet Counseling and Nutritional Intervention* – Counseling adults and children over age 2 to limit dietary intake of fat (especially saturated fat) and cholesterol, maintain caloric balance in their diet, and emphasize foods containing fiber (i.e., fruits, vegetables, grain products) is recommended. A variety of groups have recommended nutritional counseling or dietary advice for patients at average risk for chronic disease, including the American College of Preventive Medicine (ACPM), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), and the American College of Obstetricians and Gynecologists (ACOG). Recommendations on nutritional counseling for patients at risk (e.g., those who have hypertension or hyperlipidemia) have been issued by the American Dietetic Association (ADA) and two panels sponsored by the National Institutes of Health (NIH) National Heart, Lung, and Blood Institute. The ADA recommends that primary care providers screen for nutrition-related illnesses, prescribe diets, provide preliminary counseling on specific nutritional needs, follow up with patients, and refer patients to appropriate dietetic professionals when necessary. (<http://www.ahrq.gov/clinic/3rduspstf/diet/dietr2.htm> - ref52)

3) *Exercise Promotion* – Counseling patients to incorporate regular physical activity into their daily routines is recommended to prevent coronary heart disease, hypertension, obesity, and diabetes. This recommendation is based on the proven benefits of regular physical activity (Department of Health and Human Services (*Healthy People 2010*) Centers for Disease Control and Prevention, National Center for Education in Maternal and Child Health (*Bright Futures*), American Academy of Family Physicians, American Academy of Pediatrics, The American Heart Association, and The American College of Obstetricians and Gynecologists).

Essential Preventive Screening

1) *Hypertension Screening and Treatment* – Screening for hypertension in adults in adults aged 18 and older. (US Preventive Services Task Force).

2) *Diabetes Screening and Treatment* – Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg is recommended. (US Preventive Services Task Force). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for type 2 diabetes in asymptomatic adults with blood pressure of 135/80 mm Hg or lower.

3) *Primary Prevention of CVD in Adult – Frequency of Screening* In general, a comprehensive assessment of risk factors should be performed at least every 5 years starting at 18 years of age, and a global risk score should be calculated at least every 5 years starting at the age of 35 years for men and 45 years for women. Those with increased cardiovascular risk, for example, those with diabetes, cigarette smokers, or those with obesity, should have their risk factors and cardiovascular risk assessed more frequently. (J Am Coll Cardiol, 2009; 54:1364-1405, doi:10.1016/j.jacc.2009.08.005 © 2009 by the American College of Cardiology Foundation).

4) *Primary Prevention of Stroke* – Guidelines include well-known prevention measures such as controlling high blood pressure, not smoking, avoiding exposure to secondhand smoke, being physically active and treating disorders that increase the risk of stroke such as atrial fibrillation (a type of irregular heartbeat), carotid artery disease and heart failure. The guidelines suggest physicians consider using a risk assessment tool such as the Framingham Stroke Profile to assess patients' risk. (American Heart Association/American Stroke Association; US National Institute of Neurological Disorders and Stroke).

5) *Breast Cancer Screening Mammography and Appropriate Treatment* – Women age 40 and older should have a screening mammogram every year and should continue to do so for as long as they are in good health. Breast self exam (BSE) is an option for women starting in their 20s. Women should be told about the benefits and limitations of BSE. Women should report any breast changes to their health professional right away. Women in their 20s and 30s should have a clinical breast exam (CBE) as part of a periodic (regular) health exam by a health professional, at least every 3 years. After age 40, women should have a breast exam by a health professional every year. (Screening Guidelines for the Early Detection of Cancer in Average-risk Asymptomatic People—American Cancer Society). Criteria for the use of breast MRI screening as an adjunct to mammography for high risk women include: having a BRCA 1 or 2 mutation; having a first-degree relative with a BRCA 1 or 2 mutation and are untested; having a lifetime risk of breast cancer of 20-25 percent or more as defined by models that are largely dependent on family history; received radiation treatment to the chest between ages 10-30 such as Hodgkin’s Disease; carry or have a first-degree relative who carries a genetic mutation in the TP53 or PTEN genes. (Saslow D, Boetes C, Burk W, et. al. American Cancer Society Guidelines for BreastScreening with MRI as an Adjunct to Mammography. CA Cancer J Clin 2007;57:75-89).

6) *Colon Cancer Screening and Appropriate Treatment* – Annual, starting at age 50 for all asymptomatic persons at average risk--Fecal occult blood test (FOBT) with at least 50% test sensitivity for cancer or fecal immunochemical test (FIT) with at least 50%test sensitivity for cancer or stool DNA test. Flexible sigmoidoscopy every 5 years starting at 50 years of age or colonoscopy starting at age 50 every 10 years. High risks patients should be screened based on their individual medical or family history. (Screening Guidelines for the Early Detection of Cancer in Average-risk Asymptomatic People—American Cancer Society).

7) *Cervical Cancer Screening and Appropriate Treatment* – Cervical cytology screening is recommended every two years for women aged 21-29 with either conventional or liquid based cytology. Women aged 30 years of age and older who have had three consecutive negative cervical cytology screening test results and who have no history of CIN 2 or CIN 3, are not HIV infected, are not immunocompromised, and were not exposed to diethylstilbestrol in utero may extend the interval between cervical cytology examinations to every three years. Co-testing using the combination of cytology plus HPV DNA testing is an appropriate screening test for women older than 30 years. Any low-risk woman aged 30 years or older who receives negative test results on both cervical cytology screening and HPV DNA testing should be rescreened no sooner than three years subsequently. American College of Obstetricians and Gynecologists Clinical Management Guidelines for Obstetrician-Gynecologists, Number 109, December 2009).

8) *Prostate Cancer Screening and Treatment in high risk individuals and populations (African-Americans and Men with a first degree affected relative)* – For men, age 50+, digital rectal examination [(DRE and prostate-specific antigen test (PSA)]. Health care providers should discuss the potential benefits and limitations of prostate cancer early detection testing with men and offer the PSA blood test and the digital rectal examination annually, beginning at age 50, to men who are of average risk of prostate cancer, and who have a life expectancy of at least 10 years. (Screening Guidelines for the Early Detection of Cancer in Average-risk Asymptomatic People—American Cancer Society).

9) *Immunizations* – The best way to reduce vaccine preventable diseases is to have a highly immune population. Appropriate vaccinations should be available for all adults including the following: Seasonal influenza, pneumococcal polysaccharide, Zoster (shingles), Hepatitis B and A, Tetanus, diphtheria, pertussis, polio (for adults who never received or completed the primary series of polio vaccine), varicella for adults who are without evidence of immunity, meningococcal, MMR (measles, mumps and rubella for persons born in 1957 or later or born outside the US), HPV for women through age 26 years of age. (From the recommendations of the Advisory Committee on Immunization Practices).

In addition, MSSNY has also concluded that the following services must also be covered in a basic health insurance policy offered through the Exchange, and has adopted policy in support of mandatory insurance coverage for:

- Infertility treatments
- Prescription contraceptives
- Parity in coverage for mental illness and substance abuse on a parity level with all other medical services
- All therapy services needed by autistic individuals
- Bone Density tests for prevention, diagnosis and treatment of osteoporosis
- Surgical management, including bariatric surgery and reconstructive surgery, related to weight loss and management, as well as nutritional visits, bariatric programs and necessary medications.
- Permitting a patient suffering from a chronic condition to continue to have coverage for medically necessary prescription drugs subsequently removed from a health plan drug formulary where the patient is stabilized on such medications.

Thank you for your consideration of our comments. We re-state that assuring appropriate choice and transparency in the availability of health insurance products sold through the Exchange, as well as assuring appropriate protections for consumers and health care providers against insurer abuses, is crucial if we are to assure patients ability to receive the healthcare that that they are expecting to receive by purchasing coverage through the Exchange.

Thank you for your attention to our comments.

Sincerely,

A handwritten signature in black ink that reads "Robert Hughes MD". The signature is written in a cursive, flowing style.

ROBERT HUGHES, MD