# Testimony Of
# The Medical Society of the State of New York
# Before The
# New York State Assembly Committee
# On Ways & Means and Senate Finance Committee
# On the Governor's Proposed Public Health Budget
# For State Fiscal Year 2016-2017

Good morning. My name is Elizabeth Dears, Esq. I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of Joseph Maldonado, M.D., President of the Medical Society of the State of New York and the almost 25,000 physicians, residents and students we represent, let me thank you for providing us with this opportunity to present organized medicine's views on the proposed budget and how it relates to the future of the health care delivery system in New York State.

It must be noted that this proposed budget is being considered simultaneously with a number of market forces which are threatening the very viability of physician practices all across New York State. All the costs of running a medical practice, including the significant cost of medical liability insurance in New York State, and other normal business costs, such as rents, insurance, supplies, utilities, and local property taxes, continue to rise steadily every year, while government-mandated programs demand ever more expensive software and administrative costs. At the same time, medical fees have essentially either been kept at the same level or dropped significantly for the last two decades. Exacerbating these problems are new difficulties brought about by health care reform implementation, including significant financial losses incurred by medical practices across the State as a result of the much publicized demise of Health Republic.

The healthcare delivery system and the system through which it is financed continue to change. Government is shifting from fee-for-service to value based payment through which payers are shifting risk to physicians and hospitals while at the same time imposing huge new cost sharing burdens to the patient. We have an influx of newly insured individuals and an increase in the number of Medicaid beneficiaries. And yet the type of coverage now being offered is far less robust with many plans offering products with much narrower networks – as with the recent example of Emblem, terminating physicians for reasons unrelated to the quality of care they provide- jeopardizing patient access to a physician of their choice and threatening the financial viability of physician practices.

It is through the context of this lens that we view the proposed budget. We urge you to listen to the concerns of New York's physicians – who are the ones predominately providing the care in our medical infrastructure - and to take action to assure that we create and preserve an economically sensible health care delivery system so physicians can continue to deliver the timely and quality care their patients deserve and expect.

**1.) Enact a Guarantee Fund To Assure That All Providers Are Adequately Reimbursed For Care Provided To Consumers Insured By Health Republic**

Physicians throughout the State along with their patients have been severely affected by the consequences of the collapse of Health Republic – a consumer oriented and operated plan

authorized by the Affordable Care Act and licensed to do business in the state of New York. At the time of its collapse, Health Republic had over 200,000 enrollees throughout the state of New York.

We commend NY State's Departments of Financial Services and Health staffs for their extensive efforts to facilitate Health Republic-insured patients in transitioning to other health insurance products. When the closure of Health Republic was announced, MSSNY leaders worked with these officials to address the questions and concerns of both physicians and patients as they sought to address the problems created by the failure as this relates to continuity of care for patients. Now, for physicians, the critical question remains how to move forward with medical practices which have become de-stabilized as a result of the monies they are owed in ranging from thousands to millions of dollars. For many of these physicians, the losses jeopardize flailing practices. For others, it represents a bad business decision to support an entity created as a result of government sponsored healthcare reform. The certain negative impact of a failure to make whole medical practices which have supported health reform by participating in the Health Republic reform offering cannot be overstated.

We have heard from numerous practices which have indicated that they are owed millions of dollars in outstanding claims, including 5 medical practices in the Lower Hudson Valley that together are owed over $12 million. Several months ago, MSSNY, with the input from several specialty societies, developed a survey which made inquiry of physicians regarding the impact of the Health Republic debacle on their practices and care provided to patients. The survey had close to 1,000 respondents. The survey showed 42% have outstanding claims to Health Republic, of which:

- 11% are owed $100,000 or more;
- 20% are owed $25,000 or more; and
- 49% are owed $5,000 or

For these physician groups, the demise of Health Republic could not come at a worse time. Countless physician-owned practices have closed in recent years, with many of these physicians facing no choice but to become employees of large health care systems. For virtually every such practice, the cost of care is now higher for the same services being rendered by the same providers. For those practices that remain in independent private practice, they face an ever-tightening squeeze due to declining payments from other health insurers, while continuing to face extraordinary liability insurance cost burdens and other huge overhead costs associated with implementing new technologies such as electronic medical record systems into their practice workflow.

It is imperative that a safety net is critical for patients enrolled in these plans and the physicians who provide the services be put into place. A guarantee fund is one mechanism which could be used to provide this protection. All insurance companies (with limited exceptions) licensed to write life and health insurance or annuities in a state are required to be members of the state's life and health insurance guaranty association. If a member company becomes insolvent, the state guaranty association obtains money to continue coverage and pay claims from member insurance companies writing the same line or lines of insurance as the insolvent company. Inexplicably, New York State is the only state without a guarantee fund for health insurers. Failing to reassure physicians that their practice revenue will be protected when an insurer fails through the enactment of a guarantee special fund initiative will send the wrong message to physicians as they consider their options going forward with upcoming reform initiatives. We strongly urge that the State of New York enact a Guarantee or other special fund to assure that Health Republic

claims are paid should its assets be determined insufficient to pay outstanding provider claims, and that this legislation be enacted in the opening weeks of the 2016 Legislative Session.

**2.) Continuation of an Adequately Funded Excess Medical Liability Program**

We are grateful that Governor Cuomo has proposed to continue the Excess Medical Liability Insurance Program. However, we are extremely concerned by programmatic changes included in the proposal to significantly limit physician access to Excess coverage and drastically reduce its appropriation by $25M to $102.4M. We urge that the Legislature restore this appropriation to its historical level of $127.4M and reject the programmatic changes recommended in the budget.

Specifically, the proposal would require the Superintendent to, at least once every five years beginning on July 1, 2016, rank from highest to lowest each class and territory combination used for apportionment of premiums to pay for the excess coverage. Ranking, therefore, will be from the highest excess premium to the lowest. The proposal requires the Superintendent to grant priority for purchasing policies based on this ranking. Under this proposal, 55% of physicians who currently receive Excess coverage would be dropped from the program. In upstate communities north and west of Greene county, coverage would continue only for neurosurgeons, general surgeons including bariatric surgeons and OB-GYNs. That means that in the Capital District, in Northern New York, in Central New York, in western New York and in the Southern Tier every family physician, internist, pediatrician, ophthalmologist, emergency room physician, vascular surgeon, cardiologist, radiologist, pathologist, otolaryngologist, dermatologist and allergist would be automatically dropped from the Excess program. Even in some downstate communities including in the Bronx, Kings, Queens, Westchester, Sullivan and Orange counties, many primary care physicians, ophthalmologists, otolaryngologists, pathologists, dermatologists and allergists would be dropped. This means that many of the primary care physicians and ENTs in the five group practices in the Lower Hudson Valley that together are owed over $12 million as a result of the demise of Health Republic (noted earlier) are also going to lose their Excess coverage. In addition, there would be only enough funding under this proposal to cover 527 of the 2108 internists who currently have Excess coverage and practice in New York, Westchester, Sullivan, Orange and Rockland counties. It is unclear how such coverage would be allocated among these internists. At a time when the state is seeking to attract and retain physicians, this proposal deters physicians from wanting to practice in New York State for fear of putting themselves and their families in financial jeopardy for judgements and settlements exceeding the limits of their primary coverage. This result couldn't be further from this State's stated policy goals.

The Excess Medical Liability Insurance Program provides an additional layer of $1M of coverage to physicians with hospital privileges who maintain primary coverage at the $1.3 million/$3.9 million level. The cost of the program since its inception in 1985 has been met by utilizing public and quasi-public monies.

The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had worked for all of their professional lives could be lost as a result of one wildly aberrant jury verdict. This fear continues since absolutely nothing has been done to ameliorate it. The size of verdicts in New York State has increased exponentially.

The liability exposure level of physicians makes it clear that the protection at this level is essential, especially today. Given the realities of today's declining physician income levels and the downward pressures associated with managed care and government payers, the costs associated with the Excess coverage are simply not assumable by most physicians in today's practice environment. Indeed, as mentioned earlier, the ability of a physician to maintain even the primary medical liability coverage is increasingly compromised as a result of escalating costs and decreasing reimbursement. Without Excess, however, many physicians will be unable to continue to practice. Indeed, those who would be dropped would be personally exposed to financial ruin in the event that a judgment or award exceeded the limits of the primary layer.

It is important to note finally that the Excess program is not a solution to the underlying liability problem in New York State. That problem is caused by the failed civil justice system and the real solution is reform of that system.

**3.) The Need To Enact Meaningful Liability Reform**

While physicians in many other states have seen their premiums reduced in the last several years, liability premiums for a great number of New York physicians remain at very high levels. Physicians in the New York City metropolitan area face far greater liability insurance costs and exposure than their colleagues in other states. By way of example, a neurosurgeon practicing on Long Island must pay an astounding $338,252 for just one year of insurance coverage and an OB/GYN practicing in the Bronx or Staten Island must pay $186,639.

There were over $689 million in medical liability payments in New York State in 2013, nearly two times greater than the state with the second highest total (Pennsylvania, $356 million) and far exceeding states such as California ($274 million) and Florida ($199 million). The same report concluding this data also showed that New York had the highest per-capita medical liability payments in the country, far exceeding the second highest state, Pennsylvania, by 57%, the third highest state New Jersey by 67% and the fourth highest state, Massachusetts, by 74%.

Another recent article in OB-GYN News details that New York State has the greatest number of medical liability awards of greater than $1M (210), 3.5 times higher than Illinois (610), the state with the second highest total and nearly 5 times greater than California (43), a state with a far greater number of physicians.

The problems of the medical liability adjudication system do not just impact physicians – they impact the cost of all health care. Several studies have shown that billions of dollars are unnecessarily spent each year due to the practice of defensive medicine, such as unnecessary MRIs, CT scans and specialty referrals.

Meanwhile, a recent study by the Medical Group Management Association concluded that practice expenses per physician have risen more than 50% in the past decade, nearly twice as much as inflation generally, and compared with a 3% increase in Medicare reimbursement over the same time. As such, New York can no longer sustain such an expensive and flawed medical liability adjudication system if we wish to assure that our healthcare system will be able to accommodate the patient demand that comes as our population ages, as well as the over 2,000,000 newly insured patients who are starting to receive coverage through New York's new Health Insurance Exchange.

We need comprehensive reform of our flawed medical liability adjudication system to reduce these costs. MSSNY supports a number of reforms that have been enacted in many other states whose medical liability insurance costs are far less than New York's. These reforms include: placing reasonable limits on non-economic damages, which 30 other states have enacted; identifying and assuring qualified expert witnesses; eliminating joint and several liability; strengthening our weak Certificate of Merit requirement; and assuring statements of apology are immunized from discovery. Other important measures we support include alternative systems for resolving Medical Liability claims such as Medical Courts or a Neurologically Impaired Infants Fund that applies to physicians.

Given these real threats to our health care system, it is also imperative legislators reject "stand-alone" measures to expand medical liability that would most certainly exacerbate these problems, such as legislation that would establish a broadly construed "date of discovery" statute of limitations rule which is estimated to increase physician premiums by fifteen percent and legislation to eliminate statutory limitations on attorney contingency fees which is estimated on its own to increase physician premiums by over ten percent.

New York must follow the lead of the many, many other states who have passed legislation to bring down the gargantuan cost of medical liability insurance. We stand ready to discuss any number of proposals that will meaningfully reduce medical liability premium costs for our physicians. Until that discussion occurs, however, we must take all steps necessary to protect and continue a fully funded Excess program so to assure that physicians can remain in practice in New York State.

**4.) Prevent the Proliferation of Retail Clinics**

The proposed budget would allow diagnostic and treatment centers owned by for-profit companies to be established to provide health care services within the space of a retail business operation, such as a pharmacy, a store open to the general public, or a shopping mall. They would be referred to as "limited service clinics." The Commissioner is required to promulgate regulations setting forth operational and physical-plant standards, requiring accreditation: designating or limiting the treatments and services that may be provided; prohibiting the provision of services to patients under two years of age; specific immunizations to patients younger than eighteen years of age and advertising guidelines; disclosure of ownership interests; informed consent; record keeping, referral for treatment and continuity of care, case reporting to the patient's primary care or other health care providers, design, construction, fixtures and equipment and requiring a commitment to locate such clinics in medically underserved regions of the state.

Chief among our concern regarding this proposal is that this is the first time that the state would allow publicly traded corporations to establish health clinics without need for certificate of need review. As discussed below we respectfully submit that the so called dialysis precedent is not appropriately applied to this retail clinic proposal.

Specifically, the budget language would permit publicly traded corporations to operate diagnostic or treatment centers through which health care services may be provided within a retail business including but not limited to a pharmacy, a store open to the general public or a shopping mall. Currently, while there are some physician offices which have co-located with pharmacies in New York, there is no overlapping ownership thereby protecting the sanctity of the doctor-patient

relationship. This proposal would disrupt the independence of medical decision-making and the integrity of the doctor-patient relationship.

'Convenience care clinics' or 'retail clinics' operate in states outside New York in big box stores such as Walgreens or retail pharmacies such as CVS. They are a growing phenomenon across the nation, particularly among upper class young adults who live within a one mile radius of the clinic. These clinics are usually staffed by nurse practitioners or physician assistants and focus on providing episodic treatment for uncomplicated illnesses such as sore throat, skin infections, bladder infections and flu. Physicians feel strongly that retail based clinics pose a threat to the quality of patient care and to the ability of physician practices to sustain financially and should not be allowed to propagate in New York.

Another significant concern is the potential conflict of interest posed by pharmacy chain ownership of retail clinics which provides implicit incentives for the nurse practitioner or physicians' assistant in these settings to write more prescriptions or recommend greater use of over-the-counter products than would otherwise occur. The same self-referral prohibitions and anti-kickback protections which apply to physicians are not applicable to retail clinics, raising the concern for significant additional cost to the health care system. Rather than bend the cost continuum, this proposal will increase costs and negatively impact on quality of care.

As indicated above, we believe that the policy direction taken with this proposal—to obviate the need for certificate of need review—is inappropriate. In New York State, section 2801-a(4)(e) provides as follows: "No hospital shall be approved for establishment which would be operated by a corporation any of the stock of which is owned by another corporation or a limited liability company if any of its corporate members' stock is owned by another corporation." The definition of a hospital in New York State would include a diagnostic and treatment center such as the limited service clinic proposed by this initiative. The only for-profit corporations/limited liability companies that are currently permitted to operate hospitals are corporations/companies owned by individuals. A very limited exception was enacted in 2007 to enable publicly traded companies to participate in the operation of dialysis facilities. This was advanced, however, only after significant study over several years by the NYS Department of Health and the State Hospital Review and Planning Council and Public Health Council. This recommendation was expressly limited to dialysis facilities based on the unique characteristics of the service including:
Chronic renal dialysis is a discrete, definable outpatient service, which varies little in how and when it is prescribed and administered;

- Virtually all those who receive chronic dialysis suffer from a common diagnosis (end stage renal disease);
- Chronic renal dialysis is the only service supported by a federally-guaranteed insurance program of coverage based on dialysis; and
- The continued decline in real terms of Federal payment for dialysis required an alternative to the State's prohibition on publicly traded corporations in this area if access to care is to be ensured over the longer term.

We submit that none of the indicia, which existed to support the limited exception to prohibitions against ownership of hospitals as that term has been defined or would be defined under this proposal, exist to support similar treatment for retail clinics operated by publicly traded corporations.

We must also be mindful that this proposal may threaten the financial viability of primary care physician practices in the community at a time when we have been working hard to expand primary care and medical home capacity. This will likely cause physician practices in certain areas to close or to be sold to large hospital systems, displacing their patients, their employees and further destabilizing the health care delivery system in that community. We strongly urge that the Legislature reject this proposal.

**5.) Reject Language Which Seeks To Marginalize Physician Participation in the Workers Compensation Program**

The budget contains sweeping changes to long standing Workers' Compensation laws to, according to the supporting memo: ensure the system provides more timely and appropriate medical and wage replacement benefits to workers; provide broader and more accessible options for medical care; make hearings more accessible through flexible scheduling and use of virtual hearings; and streamline Workers' Compensation Board processes and administration to expedite decision making.

While these goals are obviously shared by the physician community, the proposal includes a number of seriously problematic proposals that could further discourage physician participation in the Workers' Compensation program.

The proposal would remove the authority of county medical societies to recommend physicians to serve as treating providers or independent medical examiners under Workers Compensation, which is currently an important community function performed by county medical societies. While several credentialing organizations can and do provide helpful information concerning a physician's educational, practice background and liability history, the role that county medical societies play in the review of the physician is vital. They make sure the inclusion of all necessary information before the application is presented to their committee or Workers Compensation Chair's review thereby assuring that the application is complete and the information contained therein is reliable. There are often instances where incomplete applications are presented. The county medical society staff and physician reviewers work with the physician to assure that their residency, licensure and credentialing information is attached. Should the state do away with this county medical society function, they will first need to assign staff needed to timely review and contend with processing "bottlenecks" caused by incomplete applications. Additionally, the county medical society staff is in the best position to know when the physician applicant has provided inaccurate information in their application such as when their hospital privilege status may be under review but the disposition is not yet final. In our opinion, it is not necessary to replicate the county medical society framework on the state level. Moreover, we have been offered no rationale as to why the Board believes this change is necessary. The county medical societies' processes already assure timely, efficient and complete approval and submission of physician applications to the workers compensation board.

The proposal would also enable treatment of injured workers and direct payment for care by nurse practitioners and physician assistants, without clarity as to how these non-physicians treating patients with serious health conditions will coordinate patient care delivery with the patient's primary care provider. Importantly, the proposal does not address whether new funds will be allocated or whether existing fees will need to be cut to cover this expanded list of care provider.

The budget would also expand the authority of the Board to remove a physician or other healthcare provider from being allowed to provide care to injured workers or perform an IME and provide a new power to fine such physicians or other health care provider.

Moreover, under this proposal an injured worker not subject to a collective bargaining agreement would be prohibited from seeking medical treatment from outside a Workers Compensation PPO before 120 days after his or her first visit to a preferred provider organization provider.

Of further concern, the proposal does not appear to address any of the many excessive administrative hassles identified by physicians that have caused many physicians to drop out of or choose to not participate in the Workers Compensation program. We have worked proactively with the Board in recent years to address these issues, which has resulted in some modestly positive actions taken by the WCB and the Legislature to encourage physician participation in the WC program through removal of arbitration fees and development of an electronic portal for facilitating authorizations from carriers. However, these proposals have only recently begun to be implemented. We are very concerned that the Budget proposals could undermine these other efforts chasing away rather than entice their participation with the program.

**6.) Oppose rollback of "prescriber prevails" protections**

We are concerned with a number of different proposals in the Executive Budget that would eliminate most of the "prescriber prevails" protection given to prescribers to better assure that their fee for service and managed Medicaid patients can obtain the prescription medications they need. In addition to endangering patient health, it would add to the extraordinary "hassle factor" most physicians already face in their interactions with insurance companies and government payers. Physicians are already drowning in paperwork and other administrative burden in seeking to assure their patients can get the care they need. In a recent MSSNY survey, nearly 83% of physicians indicated that the time they spend obtaining authorizations from health insurers for needed patient care has increased in the last three years, and nearly 60% indicated it has increased significantly. Please do not add to this burden by forcing physicians to go through yet another time-consuming hassle.

At the same time, we have heard from numerous physicians who have described the hassles Medicaid managed care plan impose on physicians in order to assure their patient receiving needed medications, even within the drug classes where the Legislature has required "prescriber prevails" protections. We were disappointed that the Governor vetoed legislation passed last year by the Senate and Assembly that would have reduced some of these hassles. Therefore, we urge you to not only reject the elimination of these "prescriber prevails" protections, but also to assure that "prescriber prevails" protections are extended across all drug classes in Medicaid managed care to reduce these unnecessary hassles.

**7.) Enact Reasonable Changes To The E-Prescribing Mandate**

Effective March 27, 2016, all prescriptions for non-controlled and controlled substances must be electronically transmitted from prescriber to pharmacy before they can be dispensed. Last year we informed you that the e-prescribing vendor community was ill prepared for the implementation of this law. The products sold by these vendors had not yet been certified for e-prescribing of controlled substances. As a result, prescribers would not have been able to comply with the original effective date of this mandate because their electronic health records could not electronically transmit prescriptions for controlled substances. For the most part, this issue has been resolved either because more vendors have been certified or because the prescribers or their institutions have expended significant monies to install compliant stand-alone software.

There remain some modest changes to the e-prescribing mandate which we urge you consider enacting. The original statute sets forth certain limited exceptions to the requirement for electronic transmission of prescriptions. Prescribers may issue a paper prescription when prescribing is not available due to temporary technological or electrical failure; when the prescription is issued by a practitioner under circumstances where, notwithstanding the practitioner's present ability to make an electronic prescription such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition, provided that if such prescription is for a controlled substance, the quantity that does not exceed a five day supply; the prescription is issued by a prescriber to be dispensed by a pharmacy located outside the state. In the event that a prescriber invokes any of these exceptions, he or she is required to file information about the issuance of such prescription with the department of health as soon as practicable. In our view, a prescriber experiencing an electrical failure during the middle of the day when many prescriptions may be written simply does not have the time to contact the department of health each time he or she issues a prescription; nor does a prescriber who writes a prescription for a snowbird or for a patient who resides in a contiguous state. Over 811 million prescriptions were filled in states contiguous to New York in 2014 a sizeable number of which were most likely issued by New York state prescribers. In addition, twenty-five percent of the 250 million prescriptions filled in retail pharmacies located in Florida were filled for persons over the age of 65; a number of whom reside in New York State but live in Florida during the winter. Each time a prescription is written to be dispensed in a pharmacy outside the state the physician is required by statute to call the department of health. The statute doesn't require the physician to make a note in the patient's medical record. It asks the physician to contact the department of health. Why? What possible positive health outcome could result? In our opinion, we believe that the statute should be modified to eliminate and replace the requirement to contact the department of health with a requirement for the prescriber to make a notation in the patient's medical record.

Moreover, we believe that prescribers who issue less than twenty-five prescriptions a year should be exempted from the e-prescribing mandate. While e-prescribing software is not in and of itself extremely costly, EHR upgrades to assure that e-prescribing data is uploaded to the electronic patient medical record and the annual subscription costs do add up, particularly when a physician prescribes on only a limited basis. While the commissioner could issue a waiver for such an individual, pursuant to the statute a waiver is only good for one year which would therefore necessitate that such physician apply annually for a waiver.

**Conclusion**

Thank you for allowing me, on behalf of the State Medical Society, to identify our concerns and suggestions for your consideration as you deliberate on the proposed budget for state fiscal year 2016-2017. To summarize, we urge the enactment of a guarantee or other special fund to assure that physicians and other providers owed money as a result of the demise of Health Republic are adequately reimbursed. Also, while we support the continuation of the Excess medical liability program we urge that you reject the proposed programmatic changes and restore funding for the program to its historic level of $127.4M. Importantly, meaningful reform of the civil justice system must be enacted to control physician premium costs. Also, we believe that it is critically important that the Legislature prevent the proliferation of for profit retail clinics in New York State and urge the rejection of language in the budget that would enable their establishment. We also urge your rejection of language which would eliminate the role currently played by county medical societies in recommending physicians to provide treatment through the workers compensation program to

injured workers. Moreover, we encourage that you do not impose additional prior authorization requirements on generic drugs used for off-label purposes. Lastly, we encourage that you make reasonable and minor changes to the e-prescribing mandate to exempt prescriber who issue less than twenty-five prescriptions a year and to eliminate the requirement for a prescriber to call the department each time he or she invokes an exception to the e-prescribing mandate.