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 2017-2018

Good morning. My name is Moe Auster, Esq., and I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of 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, and other business costs, such as rent, insurance, supplies, utilities, and local property taxes, continue to rise steadily every year. Meanwhile, Medicaid, Medicare and other payors are demanding participation in various value-based payment programs which require extensive infrastructure investment including upgraded Electronic Health record systems and other costs.

This includes the new Delivery System Reform Incentive Program (DSRIP) system that, as reported on the DOH website, has resulted in large payments to the large institutions that administer the Performing Provider systems (PPS) in every region, but in most cases has not yet flowed downstream to their community partners such as primary and specialty care physicians. Moreover, new this year physicians will need to comply with the Medicare Merit-Based Incentive Payment System (MIPS) established by Congress which is going to require significant administrative efforts to report quality measures, to report use of electronic medical record systems and other reporting obligations to prevent our Medicare payments from being cut.

Not surprisingly, a recent *Annals of Internal Medicine* study reported that, for every hour a physician spends delivering care, two more hours are spent on paperwork. And a recent study by Milliman noted that health insurers' use of burdensome prior authorization and step therapy requirements for prescription medication basically doubled between 2010 and 2015.

Exacerbating these problems are new difficulties brought about by health care reform implementation, including the ridiculously low payments being offered by insurers to participate in New York Health Insurance Exchange products, and a significant increase in physicians' billing and collection costs due to huge new cost sharing requirements including unaffordable deductibles. Nearly 21% of responding physicians indicated that ¼ - ½ of their patients now face deductibles of $2,500-$5,000.

More and more physicians are being forced to close their practices and join large hospital systems in order to continue to deliver care, which in turn will reduce patient choice, reduce competition, and drive up the cost of health care and health insurance. Worse still, many experienced but frustrated

physicians have indicated they may simply retire and close their practices, further exacerbating the existing access-to-care issues.

It is through the context of this lens that we view the proposed State 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.

1) 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 and to fund it at its historical level of $127.4M. We urge that the Legislature include this funding for the Excess program in the final budget adopted for 2017-2018.

However, we are concerned by the addition of an express condition that physicians otherwise eligible for the Excess coverage must have received tax clearances from the department of tax and finance before they can obtain such coverage. Specifically, for each eligible physician, the pool administrator must receive from the commissioner of tax and finance a tax clearance which demonstrates that the physician has no past due tax liabilities. While the language attempts to frame the tax clearance review in terms of past due tax liabilities which are final, the commissioner is *also* required to, when the tax clearance request so requires, determine whether (i) the subject of the request has complied with applicable tax return filing requirements for each of the past three years; and/or (ii) whether a subject of such request that is an individual or entity that is a person required to register to collect taxes on behalf of the state pursuant to section one thousand one hundred thirty-four of this chapter is registered pursuant to such section. The Commissioner is required to deny the tax clearance if the individual has not complied with applicable return filing and/or registration requirements.

We feel that the implementation of this proposed tax clearance obligation as a condition for Excess coverage is unwieldy and cumbersome and could serve as an impediment to timely issuance of the Excess policy. Not only could it jeopardize the availability of this coverage for a physician, it also could jeopardize the availability of these funds for a potential plaintiff.

We are not certain of the process to assure a physician can receive a tax clearance within the time frames for being certified for Excess coverage. As such, we are very concerned whether a good faith dispute over an alleged tax liability can be resolved in time to assure that coverage will not be jeopardized. Current provisions of the New York Insurance Law require a 30-day advance notice of a non-renewal. Once the policy is effective, cancellation can only be based on specific reasons, which does not include failure to get a tax clearance. If carriers who provide coverage for the Excess program are not able to provide a clearance prior to the 30-day non-renewal period, they may believe they have no choice but to non-renew many physicians who have not had the opportunity to clear their alleged tax liability. Given the possibility of good faith disputes, even mistaken identify (for example, there are 5 physicians in New York State with the name of "Thomas Smith"), the risk of a physician being unfairly dropped from this coverage is too great.

By way of background, 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 and severity of awards continues to grow steadily each year.

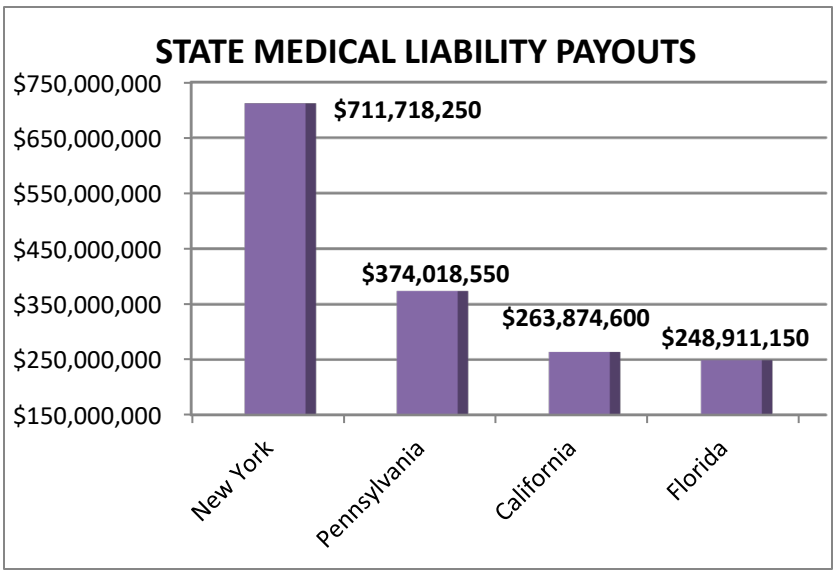
The severity of the liability exposure levels of physicians makes it clear that the protection at this level is essential, especially today. Given the realities of today's declining physician income levels and the downward pressures associated with managed care and government payors, the costs associated 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.

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 a dysfunctional medical liability adjudication system and the real solution is reform of that system.

Physicians in many other states have seen their premiums reduced in the last several years, while the liability premiums for New York physicians continue to rise. Physicians in New York 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 just one year of insurance coverage and an OB/GYN practicing in the Bronx or Staten Island must pay $186,630. By comparison, an Ob-GYN practicing in Los Angeles, CA pays less than $50,000, about 25% of New York's staggering premiums.

This is not surprising, given that a recent report by Diederich Healthcare showed that once again New York State had by far and away the highest number cumulative medical liability payouts ($711,718,250), nearly two times greater than the state with the next highest amounts, Pennsylvania ($374,018,550), and far exceeding states such as California ($263,874,600) and Florida ($248,911,150).

To be clear, this is not just a product of New York's population size. New York again had the dubious distinction of the highest per-capita medical liability payments in the country, far exceeding the second highest state Massachusetts by nearly 20%, the third highest state Pennsylvania by 23%, and the fourth highest state New Jersey by 26%. Remarkably, it was more than 500% more than California, a state with nearly twice the population that has enacted comprehensive medical liability reform.



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.

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 the Excess program to ensure that physicians can remain in practice in New York State.

2) **Funding the "Health Republic Fund" Enacted in the 2016 Budget**

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, as well as efforts to assure an orderly wind-down. 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.

We have heard from numerous practices which have indicated that they are owed huge amounts from Health Republic, including 5 medical practices in the Lower Hudson Valley that together are owed over $12 million. Last year, 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% had outstanding claims to Health Republic, of which:

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

For these physician groups, the demise of Health Republic could not have 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.

Last year the Legislature debated whether to establish a "Guarantee Fund" to recompense health care providers who lost substantial sums as well as to mitigate against any future health insurer

liquidations. As a compromise, the Legislature established a special "Health Republic of New York Insurance Fund" within the State Finance Law to pay outstanding claims after liquidation was completed to be funded with dollars generated from state settlements. However, no specific funding allocation was made.

Documents made available regarding the liquidation shows that Health Republic has over $460 million in outstanding liabilities, with less than $100 million in assets. That means that physicians and other care providers are likely to only be paid pennies on the dollar. In this regard, we urge the Legislature to include funding in this State Budget to address this enormous gap.

3) Oppose rollback of "prescriber prevails" protections

We are concerned with a number of different proposals in the Executive Budget that would eliminate the "prescriber prevails" protection given to prescribers to better assure that their patients covered by Medicaid can obtain the prescription medications without adding on to the extraordinary "hassle factor" most physicians already face in their interactions with insurance companies and government payors. Physicians are already drowning in paperwork and other administrative burdens 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 had increased in the last three years, and nearly 60% indicating it had increased significantly. As noted above, another study from the *Annals of Internal Medicine* reported that, for every hour a physician spends delivering care, two is spent on paperwork. 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. Therefore, we urge you to take all possible steps to assure Medicaid managed care plans follow the law and to address these unnecessary hassles.

However, we do note that we support the proposal that would for first time regulate the practices of pharmaceutical benefit managers (PBMs) in New York State. It is our understanding that the cumbersome prior authorization and step therapy requirements for prescription medications imposed by health insurers are often the result of the financial arrangements for pharmaceutical pricing that a PBM has negotiated, and these incentives should be required to be disclosed.

4) Support Inclusion of E-cigarettes Under Clean Indoor Air Act

The Medical Society of the State of New York strongly supports the inclusion of e-cigarettes under the Clean Indoor Air Act (CIAA) as proposed by the 2017-18 New York State budget. MSSNY has for several years called for these products to be treated the same as tobacco products and also called for inclusion under the CIAA.

Electronic cigarettes are electronic devices that deliver nicotine to the user. They heat up liquid nicotine and emit water vapor together with various chemicals, of which there is very little known. E-cigarettes are not currently regulated by the FDA and are not subjected to tobacco laws since they do not contain tobacco. People are being placed at risk because of the lack of information regarding the chemical makeup of liquid nicotine or the risk to individuals from inhaling the water vapor either directly or through secondhand exposure.

Testing done by the FDA shows that electronic cigarettes can be dangerous because users inhale carcinogens and toxic chemicals, such as diethylene glycol, an ingredient found in antifreeze. Recent studies have suggested that e-cigarettes may contain more carcinogens than traditional cigarettes, in some instances ten times the carcinogens of traditional cigarettes.

We urge that this provision remain in the State Budget.

5) Concern with Health Care Modernization Task Force

The Budget contains a provision to establish a "Health Care Regulation Modernization Team" to review ways to restructure health care statutes, policies, and regulations and make recommendations to the governor of its findings by December 31, 2017. The recommendations would include ways to streamline state agency certificate of need and other licensure approval processes and ways to create more flexible rules on licensing and scope of practice for clinicians and caregivers. While we appreciate the goals of such a Work Group, we are very concerned with a provision that would permit the commissioner of health, commissioner of mental health and the commissioner of the office of alcoholism and substance abuse services to have the power to implement demonstration programs to deliver health care services that could override existing laws without legislative approval. There are many good reasons why the Legislature chooses to not pass a particular piece of legislation such as a change to the scope of practice of a particular health care profession. Moreover, we do not understand the rationale for such a new Work Group given the ongoing work of the Medicaid Redesign Team, and other workgroups established pursuant to the Delivery System Reform Incentive Payment (DSRIP) program. We would urge that this provision be rejected. Moreover, this provision is also strongly opposed by several other specialty societies who share our concerns.

6) Concern with Medication Management Programs

We have strong concerns with a provision in the Executive Budget that would permit pharmacists to enter into "comprehensive medication management protocols" with physicians or nurse practitioners to manage, adjust or change the medications of patients with a chronic disease or diseases who have not met clinical goals of therapy, or are at risk for hospitalization. While many physicians believe that these programs, if structured properly, can be helpful to managing the treatment of a patient, the Budget proposal would go much further than the "collaborative drug therapy" programs that are currently permitted within the hospital environment on a demonstration basis.

The current collaborative drug therapy law was originally established with a "sunset date" in 2015, and was extended by the State Legislature to continue until 2018. However, this proposal goes well beyond this demonstration program.

For example, only physicians are currently permitted to enter into such protocols within the hospital. Not only would this proposal expand the existing law to permit NPs to enter into these protocols in a hospital or other article 28 entities, it would permit them to enter into these protocols in any care setting. We are concerned that there has been no demonstration within a specific care setting in New York, such as in a hospital, that nurse practitioners have the sufficient pharmacology background to successfully work with pharmacists on managing patient medications on a large scale basis as is contemplated in this proposal. By contrast, physician-pharmacist CDTM protocols were studied extensively following the enactment of New York's law, which led to the Legislature extending the existing program in 2015. As such, it would be premature to now add Nurse Practitioners.

Moreover, the Budget proposal goes much further than the existing collaborative drug program in a number of respects, including:

- The current law requires the patient to execute a written consent to have their medications managed by a pharmacist pursuant to a protocol. The Budget proposal also indicates that the patient participation "shall be voluntary" without specifying a written requirement to consent to participate in the protocol.
- The current law only permits a participating pharmacist to change a medication prescribed by a physician only if such responsibility is expressly authorized in the protocol. The Budget proposal does not require that important protection be specifically articulated in the protocol, meaning that it would be assumed unless it is expressly prohibited.
- The current law enables participating pharmacists to order or perform routine patient monitoring functions, such as "ordering and checking patient vital signs, including pulse temperature, blood pressure and perspiration". The proposal would go significantly further and permit pharmacists to "Order and perform routine patient monitoring functions *or disease state laboratory tests"*. The proposal does not specify what these laboratory tests are. We are also very concerned that pharmacists do not have the appropriate training to interpret these tests, and make pharmaceutical recommendations as a result.
- The current law requires the participating pharmacist to have special expertise for executing a CDT protocol, including "clinical experience in a health facility, which involves consultation with physicians with respect to drug therapy and may include a residency at a facility involving such consultation". The Budget proposal does not require the pharmacist to have any such specific expertise with regarding to having previously provided such collaboration with a treating provider.

Again, these programs, if carefully structured, can be helpful to managing the treatment of patients suffering from chronic conditions. However, we are concerned that what is proposed in the State Budget is far too broad and therefore urge that it be removed from the Budget.

7) Restoration of "Crossover Payments"

We are concerned that the proposed State Budget fails to include funding to restore funding for "crossover" payments, cut in previous years, for care provided by physicians to patients who are dually eligible for Medicaid and Medicare. For many years, New York State paid most or at least some of the cost-sharing payments for Medicare enrolled patients who are also eligible for Medicaid. However, these payments were completely eliminated in the 2015-16 State Budget. These cuts have had a disproportionately negative impact on health care practices that treat the poorest and sickest of patients. For example, community cancer clinics potentially will lose tens of thousands of dollars as a result of these cuts, exacerbating other economic trends that are forcing many of these practices to close or be acquired by hospitals. As these clinics and physician practices close, patients will have to go to hospitals to receive care that they could be receiving in the community setting.

8) Further Penalties for Opioid Prescribing

We are very concerned with a proposal in the State Budget that would "make it an unacceptable practice" for a practitioner to prescribe an opioid medication in excess of various limitations set forth in law.

Specifically, we are concerned with the possible varying interpretations surrounding the new 7-day limit for opioid medications for "initial treatment or consultation" for "acute pain" that just went into effect last year, and for which physicians and other prescribers are working to be sure they are compliant. As this provision was being negotiated, MSSNY argued that the line between what is "acute" pain, and what is "chronic" pain could be difficult to distinguish. A patient may have a condition that results in periodic episodes of pain. Based on who is reviewing, one might define the pain as "acute" while the other might define it as "chronic". There might also be varying interpretations regarding what exactly is an "initial consultation or treatment" for acute pain, particularly when a patient being prescribed opioid medications has an ongoing treatment relationship with a particular physician. This Budget provision would, at least theoretically, give huge discretion to state officials to punish physicians based upon a physician's good faith belief that the pain a patient is experiencing is "chronic" rather than "acute" and whether a particular treatment was an "initial consultation".

We understand the intent to further discourage inappropriate prescribing, but there are already many other provisions that the State government has to sanction physicians including through the penalty provisions pursuant to Section 12 of the Public Health Law, as well as through the Office of Professional Medical Conduct (OPMC). While we understand that a determination pursuant to these existing statutory mechanisms could become the basis for being dropped by Medicaid, we believe those processes should be completed before action could be taken by Medicaid. In particular, we are very concerned that exclusion from the Medicaid program is a severe consequence that could have enormous implications for the physician's practice – they could be dropped from hospital privileges and health insurer networks as a result – which could further intimidate physicians from treating a patient's pain in the manner they deem most appropriate. In this regard, we urge that this overbroad provision be removed from the proposed Budget.

Conclusion

Thank you for allowing us, 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 2017-2018. To summarize, we support the continuation and dedication of funding for the Excess medical liability program which is important to facilitate the retention and recruitment of needed primary care and specialty physicians in New York until such time as meaningful civil liability reform is enacted. We ask that you remove the language which would allow an outstanding tax obligation to render an otherwise eligible physician ineligible for Excess coverage. We also ask that the Health Care Modernization Work Group be eliminated, or at least be modified to remove language that gives the various agencies authority to implement pilot programs without legislative changes. We also ask that you remove provisions that would repeal existing "prescriber prevails" provisions. We also ask that you assure that funding is allocated to pay the outstanding claims of the collapsed insurer Health Republic, as well as re-instating payment for the care provided to patients dually eligible for Medicare and Medicaid. And we urge you to reject proposals that would create a parallel and greatly expanded comprehensive medication management program, as well as proposals that would discourage appropriate prescribing for pain treatment by threatening physicians with dismissal from the Medicaid program.