The Medical Society
of the State of New York

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 2012-2013

Good morning. My name is Gerard L. Conway, Esq. I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of the State Medical Society 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.

1. **Addressing Medical Liability Reform in the Context of the State Budget for Fiscal Year 2012-2013 Will Reduce Medicaid Expenditures for Liability Exposure and Defensive Medicine Costs**

We are disappointed that the proposed budget for FY 2012-13 did not include any relief for the perpetual medical liability premium costs shouldered by physicians practicing in the State of New York. As New York State struggles to balance its Budget and reduce the extraordinary tax burden placed upon its citizens, we can no longer afford the costs that arise from a deeply flawed and unsustainably expensive medical liability adjudication system. Moreover, the extremely difficult practice environment physicians face in New York State makes moving to other states an increasingly attractive option, particularly as more and more states enact legislation to reform their medical liability laws. To bring down the costs of health care in New York as well as to preserve access to New York's world-class but financially strained health care system, the State Legislature must enact meaningful medical liability reform.

The Texas Medical Liability Trust, the largest medical liability insurer in Texas, just reduced premiums to physicians for the ninth straight year since the enactment of comprehensive medical liability reform legislation in Texas 2003. 90% of Texas physicians have seen a minimum 30% reduction in their premiums since 2003. In Los Angeles, California, in a state where strong medical liability reforms were enacted in the mid-1970s, Ob-GYNs pay less than 1/3 the premiums that New York physicians pay. As noted below, in both these states, medical liability premiums have gone down significantly since 2003 while the opposite has occurred in New York.

Liability premiums for New York physicians went up 55-80% from 2003 to 2008, and went up an average additional 5% in 2010 (for some physicians it was significantly higher). Even though rates generally held steady for the 2011-12 policy year, the rates are stabilized at extraordinarily high levels. Many New York physicians pay ability premiums that far exceed $100,000 and some even exceed $200,000. For example, for just a single year of coverage, the cost of medical liability coverage for the 2011-12 policy year was:

- $306,393 for a neurosurgeon in Nassau and Suffolk counties;
- $171,275 for an Ob-GYN in Bronx and Richmond counties;
- $116,989 for a general surgeon in Kings and Queens counties; and
- $109,019 for a vascular surgeon or cardiac surgeon in Bronx and Richmond counties

With continuing downward pressure from health insurance companies and government payors to reduce payments for patient care, the costs currently paid by New York physicians for their medical liability premiums are not sustainable. Something has to give. It is imperative that we reduce the direct and indirect costs of medical liability as a way to bring down the costs of New York's extraordinarily expensive Medicaid program. It is important to remember, furthermore, that New York's out of control liability system has created a "defensive medicine" culture which significantly increases health system costs well beyond the impact of direct premium costs. Other states are passing measures to assure patients can continue to access necessary physician care. For example, in just the last year, three more states, North Carolina, Oklahoma and Tennessee, enacted laws to provide meaningful limits on non-economic awards in medical liability actions bringing to over 30 the number of states which have enacted such limitations. The time for change is now!

Medical liability tort reform IS Medicaid redesign and health care reform. To that end, the Medical Society of the State of New York supports meaningful medical liability reform as part of the budget for FY 2012-13 including a $250,000 cap on pain and suffering. Moreover, we support legislation to: (1) require disclosure of the identity and deposition of an expert witness prior to trial; (2) require that a physician consulted for a Certificate of Merit be identified, be of the same specialty as the physician against whom the suit is filed and be required to file a certification statement; (3) protect physicians who express sympathy to a patient for an unanticipated outcome from having such statement used against the physician in any subsequent litigation that may arise; and (4) extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees. The addition of these measures to the $250,000 cap on pain and suffering constitute <u>meaningful</u> medical liability reform which we urge the Legislature to include in the State Budget for FY 2012-2013.

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 and we urge that the Legislature include funding for the Excess program in the final budget adopted for 2012-2013. The Excess Program provides an additional layer of coverage to physicians with hospital privileges who maintain primary coverage at the $1.3 million/$3.9 million level. The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to ease concerns among physicians that their liability exposure far exceeded available coverage limitations. This fear continues even today. The size of verdicts in New York State has increased exponentially. From 1999-

2005, 59% of all verdicts exceeded $1 million, thereby making the continuation of the Excess liability coverage even more essential today than when first authorized. Consequently, approximately 25,000 physicians currently have excess coverage. The cost of the program since its inception in 1985 has been met by utilizing public and quasi-public monies. Beginning January 1, 2002, monies from the Health Care Reform Act's (HCRA's) tobacco control and initiatives pool were allocated to fund the cost of this program. The Excess program was extended until June 30, 2014. Importantly, the proposed state Budget for 2012-13 would appropriate $127.4M for the Excess program.

The severity of the liability exposure levels of physicians makes it clear that the excess protection is essential. However, given the realities of today's aggressive constraints on physician incomes 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 environment. 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. Absent meaningful reform of the dysfunctional tort system, the continuation of a properly funded Excess program is critically necessary to prevent the liability disaster that was so narrowly averted in the mid-eighties. MSSNY will work to continue an adequately funded Excess program.

1. **Effectuate Greater Transparency and Fairness in Access to Out of Network Physician Services**

MSSNY supports the enactment of legislation as part of the budget for FY-2012-13 which would amend the public health and insurance laws to prevent health insurance companies from selling policies that purport to but, in fact, fail to adequately cover out-of-network health care benefits. The legislation would also require health insurance companies to base their out-of-network reimbursement methodology on true UCR (such as that developed under FAIR Health).

Some consumers and employers choose to have health insurance policies that permit them to receive care from a non-participating physician because it enables them to be treated by the physician who they believe is best able to treat their particular condition or with whom they have a long-established patient-physician relationship. However, the payment system for out-of-network coverage has been fraught with abuse by insurance companies. As a condition of settlements with the Attorney General in 2009, several health insurance companies agreed to discontinue the use of the flawed Ingenix database for determining payments when patients receive care outside of a plan's network of physicians. As detailed in a report by the Attorney General, titled *The Consumer Reimbursement System Is Code Blue* **(**http://www.ag.ny.gov/bureaus/health_care/HIT2/report.html), the database was maintained by a company (Ingenix) that is a wholly owned subsidiary of United HealthCare, and was being manipulated in ways that resulted in patients incurring higher than necessary out-of-pocket costs when they received care from physicians not in their plan's network, because the database significantly understated the true market cost of such health care services. The report noted how conflicts of interest and a lack of transparency created a system of out-of-network reimbursement that is "unfair, unclear, and needs to be reformed."

As a result of the investigation, several health insurers were directed to contribute nearly $100 million toward creating a new database to be maintained by a new unaffiliated non-profit

organization, called FAIR Health, Inc. The purpose of the database is to assure that patients, employers, and health insurers have accurate information concerning the true cost of out-of-network medical services. The new database is operational for reporting medical charge data. This development was applauded by the consumer and provider communities.

Instead of solving this problem, however, a number of insurers have embarked upon an approach which has actually made the problem worse. Some companies have changed their methodology for covering out-of-network care to methodologies that appear at first blush to cover costs adequately, but, in fact, often result in severely inadequate coverage for patients. These include methodologies based upon the Medicare fee schedule, which is widely known to be far below the actual cost of care and subject to political forces unrelated to the actual cost of care. Remarkably, these reimbursement methodologies result in even less coverage—and in many cases, substantially less coverage—than that which was provided when the insurance companies were using the manipulated Ingenix database. This problem is even more acute for patients with chronic medical conditions who frequently need highly specialized medical care.

Patients and employers should get what they pay for. If they paid for the right to see the physician of their choice—who may be out of the plan's network— they should actually be able to avail themselves of this benefit. Patients should be able to easily understand and anticipate their out-of- pocket costs for a particular treatment. Employers choosing health insurance coverage for their employees should be able to easily compare various health insurance products that contain coverage for out of network care so as to be better informed as to whether the coverage they provide for their employees will actually significantly cover the costs of health care.

Consequently, the Medical Society supports the enactment of language as part of the budget which would better assure that health insurance companies are informing their enrollees how their coverage for out-of-network care compares to the actual cost of services and assure that such policies provide adequate coverage for out of network care.

2. Creation of a Health Insurance Exchange

The Governor's proposed Budget contains language which would establish a New York Health Insurance Exchange as required to be created by the federal health care reform law. The exchange, which would be established for the purpose of facilitating the ability of individuals and employers to purchase health insurance coverage, is required to be operational by 2014. While the Medical Society has adopted a series of 14 principles (listed below) that we believe are essential for health insurance policies sold through the exchange, we wish to specifically highlight a few key recommendations that must be addressed with the Exchange proposal.

First and foremost we believe it is critically important that any legislation that is adopted specifically include a physician representative on the Exchange Governing Board. Without such protection, we have serious concerns that the exchange will be dominated by health insurance companies and others whose chief interest is cost control, rather than assurance that patients obtaining coverage through the exchange will be able to obtain the care they need.

The Executive Budget language included a number of criteria for persons to serve on the Board. However, it did not include a requirement that persons serving on the Board have

expertise in the actual delivery of care. In the opinion of New York's physician community, this is a major shortcoming with this legislation.

The chief goal of the federal health care reform law was to assure that patients can obtain the timely quality care health care they need from a physician of their choice. Without such protections, we anticipate that a number of health plan abuses that patients and their physicians already experience will only get worse, including: cumbersome pre-authorization processes that delay our patients from receiving needed care and testing; arbitrary limitations on necessary prescription medications; overly aggressive barriers that limit patients' ability to receive care from the specialist physician of their choice; and claims payment tactics that threaten the viability of physician practices, which in turn jeopardizes patients' access to needed care.

Certainly, we recognize that those who serve on the Board governing the exchange must have sufficient expertise in health care finance as well as in management of health care systems. However, we believe it is vital that there be a place on the Board for those with experience in the actual delivery of care. While we appreciate that the proposed Budget language would include up to two "health care provider representatives" on each of the proposed five regional advisory committees to the Board, this provision does not even specifically require that any one of these "health care provider" representatives must be practicing physicians. Again, this is a major shortcoming in the legislation. Candidly, the situation allowed by this bill is inconceivable because under this bill the vitally important Exchange Governing Board and the five regional advisory committees could be completely devoid of physician representation.

Second, with regard to the information to be disclosed to the public regarding qualified health plans offering coverage through the exchange, in addition to those items that have been articulated in the legislation, we believe it is very important that the following items also be required to be disclosed:

- The medical loss ratios for each insurance product sold through the exchange;
- Data which the Insurance Department currently makes available through its "Consumer Guide to Health Insurance", including general complaint data, prompt payment complaint data, and internal and external appeal data. This information must be disclosed in a format that makes it easier for patients to compare health insurance plans.
- If out of network coverage is offered, the payment methodology should be expressed as a percentage of true out of network costs as detailed in the new FAIR Health database (the successor database to Ingenix that was required to be created as a result of the settlements between the health insurance industry and Governor, then Attorney General, Cuomo).

Third, we believe it is important that the bill specify as one of the requirements for qualified health plans that they provide "real-time" eligibility verification when patients receive care so that patients will have greater assurance that their needed care will be covered. Moreover, employers purchasing coverage through the exchange should be required to update employee eligibility information as expeditiously as possible. Physicians and patients are often left without recourse for coverage when a business fails to timely report or a health plan fails to timely update pertinent eligibility information. It is the health plan or the business that should bear this risk in these circumstances, not the patient or their physician.

Finally, with regard to the portion of the legislation calling for the Exchange Board to study options for funding the exchange in the future, we urge you delete the specific reference to the consideration of "assessments upon providers." We certainly understand that, even if the Board were to recommend that assessments be imposed on providers to help fund the exchange, such a requirement would have to be enacted by the Legislature. However, we believe that it would send entirely the wrong message to the physician community to even suggest in statute that an assessment on their services should be considered to fund the operation of the exchange. Physicians are currently struggling under the weight of the extraordinary administrative costs of running a medical practice, including paying unsustainably large medical liability insurance costs. This problem is exacerbated by the continuing difficulty in receiving fair payment from health insurance companies for the necessary care they provide to patients. Physicians need relief from these extraordinary financial burdens so that they can continue to provide the care that is expected from those purchasing coverage through the exchange, not additional financial burdens that may prevent them from being available to provide this care. Providing vitally important health care services to all Americans is a noble objective. Taxing those who provide such care in order to assure its delivery is neither logical nor fair.

Principles for Creation and Operation of a State Health Insurance Exchange

1. Exchanges must include practicing physicians in their governance structure and not exclude physicians based on conflict of interest.

2. 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), provided that the HSA is not controlled by the insurer issuing the HDHP. Exchanges must assure that HSAs are fully funded by the individual or employer. An HRA must be a protected account for COBRA purposes.

3. Exchanges should maximize affordability by enhancing competition among qualified health plans.

4. Exchanges should maximize health plan choice in benefit design and must minimize cost sharing for individuals and families purchasing coverage.

5. 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.

6. Exchanges must comply with the State's Freedom of Information and Open Meetings laws and Members of the Board of Directors shall comply with ethics rules including disclosure of outside interests and potential conflicts of interest.

7. 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 must assure that insurers in such disclosures include patient cost-sharing amounts.

8. 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. Physicians must not be forced to participate in certain qualified health plans participating in an exchange or in Medicaid.

9. Exchanges must be self-supporting after the federal planning and establishment grants expire. Taxes or fees on physician services should not be applied either directly or indirectly to pay for exchange operations.

10. Exchanges must require qualified health plans to comply with the AMA's Health Insurer Code of Conduct Principles

11. Exchanges must require that qualified health plans adhere to national standards to facilitate administrative simplification for claims processing including standard coding sets and coding edits based on the AMA CPT codes, guidelines and conventions and the National Correct Coding Initiative (NCCI).

12. Exchanges must require that qualified health plans comply with all statutory and regulatory physician and patient protections enacted or implemented by the State of New York.

13. Exchanges must assure that qualified plans, in their process for prior authorization, utilization review and other practices, utilize only medical guidelines developed by medical specialty societies recognized by the American Board of Medical Specialties or American Osteopathic Association.

14. Exchanges must be available to all residents of New York State, including legal immigrants and legal aliens.

3. Monitoring Prescription Drug Use and Preventing Continued Drug Abuse

Since the tragedy on Long Island occurred last year, there has been a renewed focus to combat the abuse of prescription drugs. The Medical Society of the State stands ready to work with the Legislature, the Cuomo Administration and the Attorney General to address this growing problem. However, we must be very careful in addressing this issue to assure that we do not through overly aggressive mandates create barriers to patients obtaining needed pain medications as well as other needed medications to treat or stabilize a health condition.

We have articulated in many forums our suggestions for how we can address this problem. The solutions are multipronged. It must include increased law enforcement efforts to prevent and punish inappropriate diversion of prescription medications. It must include the need for increased accessibility of treatment for patients suffering addictions so as to reduce the likelihood of inappropriate diversion of prescribed medications. It must include better use of the existing database that is currently collected by the New York State Health Department on all controlled substance prescriptions. And it must include the need for additional resources for associations representing prescribers so that they can educate their members about the existence of the database and the circumstances of patients presenting themselves in health care settings that should trigger a prescriber to check the database. In addition, it's imperative that DOH educate the public regarding the dangers of prescription misuse and diversion and the legal requirement to inform all prescribers of any controlled drugs they are taking.

We must note that it is been inaccurately reported in the media that New York lacks a prescription drug tracking database that other states have created. We have a database, and New York State has for many, many years collected this information. The issue is how this information that already exists can be best used and improved to inform physicians and other non-physician prescribers, as well as pharmacists dispensing these medications, so as to prevent or reduce "doctor-shopping," diversion and abuse.

It has only been in the last two years that physicians have been able to access data from the database, and pharmacists currently do not have any access to it. And our expert panel of physicians who have been reviewing this issue have repeatedly highlighted the cumbersome nature of accessing information on the existing database.

First, it requires a physician to have a Health Commerce Account (formerly HPN account), for which many physicians have found the application process and maintenance of access to be

cumbersome. Second, once on the website, it is difficult to navigate to search for the patient information that is needed. Third, physicians cannot delegate their staff to check the website. Fourth the information currently available on the database is itself limited to a short timeframe and no data is available unless a patient has reached too high a threshold of recent prescriptions filled at multiple pharmacies; rather, all data on any controlled prescriptions fill should be available anytime a prescriber checks the database. Finally, the database needs to be promoted more thoroughly to the medical community, an effort for which MSSNY would be happy to partner with DOH. We are also supportive of legislation to permit pharmacists to check the database which would better enable pharmacists to provide relevant information to the prescribing physician.

We believe these shortcomings with the existing database can be remedied however, and have been working with DOH to address these problems.

As we look to identify ways to prevent misuse and inappropriate diversion, we need to be careful that we do not "over correct" this problem. In fact, some have concluded that physicians are not actually prescribing pain medications enough. As such, the medical community has grave concerns with the "I-STOP" proposal (A.8320/S.5720) that would mandate reporting and checking a database anytime a controlled substance prescription is written, and impose serious financial penalties for failure to do so. The mandates and penalties will undoubtedly discourage many physicians from prescribing necessary medications due to the extraordinary administrative burdens they face in their practice as a result of health insurance companies, Medicare and Medicaid.

4. Elimination of the state ACO Demonstration

The budget enacted for FY 2011-12 included language to foster the development of accountable care organizations (ACOs) in New York State, but only on a demonstration basis. The language limited the number of ACOs which could be allowed to seven. MSSNY opposed this limitation as a disincentive to ACO formation. This year legislation has been introduced which would eliminate the limitation on the number of ACOs which can form in NYS. MSSNY is supportive of legislative action to assure the development of horizontally integrated, physician-driven accountable care organizations. Consequently, we would support the elimination of the 'demonstration' which limited the number of ACOs authorized to obtain a Certificate of Authority pursuant to Section 2999-p (3).

Question has arisen as to whether Article 29-E applies to Medicare-only ACOs. This is a thorny issue. There are certainly many community-based ambulatory care providers with a sufficient Medicare patient population to warrant their applying for federal approval. Federal comments note that state law controls. If state law does not formally state that it applies to Medicare-only ACOs, these providers may believe that they need only to apply for federal approval. However, in that instance, if Article 29-E does not apply, the protections contained in Section 2999-r, which are vitally necessary to enable the legal construction of an ACO in New York State, would not apply. We would like to resolve this issue with you this year. While some providers may want to pursue one application process, the federal process does not confer the authority upon the state to provide safe harbors from state fee splitting, anti-kickback, and antitrust protection. Such authority is only derived through section 2999-r. Consequently, we urge the inclusion of language which will confer the protections of 2999-r to Medicare-only ACOs. The purpose of this language is to assure that an organization that solely functions as an ACO under the Medicare Shared Savings program has the protections under 2999-q (5), and 2999-r.

5. Eliminate Inappropriate Scope of Practice Expansion for Non-Physician Providers

We are also very concerned by the opportunistic advocacy attempts by certain non-physician providers to use the budget crisis now facing the state to advance their effort to expand their scope of practice. Their attempt to camouflage this effort under the guise of cost-efficiency is misplaced. Such proposals can only be appropriately considered through the spectrum of quality of care. Although nurses, nurse practitioners, physician assistants, pharmacists and other non-physician providers are competent within their own fields, they should not be allowed to work in areas beyond their competence and training and/or without an appropriate relationship with a physician. Specifically, with regard to nurse practitioners, the proponents of independent practice for NPs argue that such a policy change would result in reduced health spending, presumably because NPs earn less than physicians. The Cochrane review suggests that this differential may be offset by increased utilization of services and referrals by NPs. This assertion was confirmed in a study by the American College of Physicians that compared utilization rates among physicians, residents, and nurse practitioners in the Journal Effective Clinical Practice. "Researchers showed that utilization of medical services was higher for patients assigned to nurse practitioners than for patients assigned to medical residents in 14 of 17 utilization measures, and higher in 10 of 17 measures when compared with patients assigned to attending physicians. The patient group assigned to nurse practitioners in the study experienced 13 more hospitalizations annually for each 100 patients and 108 more specialty visits per year per 100 patients than the patient cohort receiving care from physicians". *The Question of Independent Diagnosis and Prescriptive Authority for Advanced Practice Registered Nurses in Texas: Is the Reward Worth the Risk?* Ramos, 2011.

The purpose of defining scope of practice in statute is to ensure that practitioners are only practicing within the parameters of their education and training and, if required, in a defined relationship with a physician. This provides protection and safety for patients in their care. These proposals would seriously endanger the patients for whom they care. Moreover, expansion of scope of practice for non-physician providers without an adequate educational base will inevitably increase health care costs – not decrease them. Nor will such proposals address our physician workforce shortage. Non-physician practitioners wish to practice in the very same regions of the state in which physicians now practice. Studies show clearly that they do not choose to practice in rural or urban underserved communities.

6. Funding for The Committee for Physicians' Health (CPH)

Public Health Law Section 230 authorizes the state medical and osteopathic societies to create a Committee of Physicians to confront and refer to treatment physicians suffering from alcoholism, chemical dependency or mental illness. MSSNY contracts with the Department of Health' Office of Professional Medical Conduct (OPMC) to provide the services required by law. The program is funded not from a tax but by a $30 surcharge on the physician's license and biennial registration fee, which is specifically dedicated by statute for this purpose. The Education Law provision authorizing the expending of funds for CPH only requires that the amount expended for CPH does not exceed the total surcharges collected. While the surcharge on an annual basis accrues $1,217,000 the proposed budget appropriates only $990,000 for the CPH program.

On June 30, 2011, MSSNY submitted its voucher for $98,213.36 which represented salaries and equipment purchases made pursuant to its contract with New York State for the 2010-11 fiscal year which had concluded on March 30,2011. Contractors with New York State have ninety days from the last date of a contract to submit vouchers for reimbursement. CPH, however, must present its vouchers within sixty days. MSSNY submitted its voucher after this sixty day window but in a timely fashion had the ninety day timeframe applied. Despite the fact that the MSSNY voucher was tardy, MSSNY was reimbursed. MSSNY was reimbursed, however, not out of monies from the 2010-11 fiscal year but from the appropriation for this program under the 2011-12 fiscal year. In December, MSSNY was informed by OPMC that it must now repay the $98, 213.36 alleging that the voucher had not been filed in a timely manner. Repayment of this money amounts to a denial of payment for prior services appropriately rendered. Repayment will seriously impact MSSNY's ability through the CPH program to deliver the services it is required by contract to provide during the current fiscal year. Given that the surcharge accrues more than what has been allocated to the program, we request your consideration of directing that an amount equal to that of the MSSNY voucher be redirected to the CPH budget line.

During the Conduct of this MSSNY program, CPH has evaluated 3505 physicians, routinely monitors the recovery of 450 physicians, and annually reached out to an additional 190 physicians thought to be suffering from alcoholism, drug abuse or mental illness. We believe that the work of the CPH program is valuable to all physicians and indeed to the state generally and would ask that an appropriate allocation be identified to assure that the fine work of the program is not compromised in any way.

7. Preserving Prescriber Prevails Under the Medicaid Prescription Drug Program

As you know, the Medical Society has long advocated for protection of the physician's clinical decision making authority and the patient's unfettered right to access the medication or treatment prescribed by their physician. This is why we strongly supported the Legislature's efforts in the past to establish and continue the "provider prevails" language as it pertained to the preferred drug program (PDP) and clinical drug program (CDRP). Central to our consideration of these programs was our position that the PDP & CDRP procedures and rules should not interfere with the ability of a physician to assure that his or her patient had the most appropriate medication. We ask for your support for applying a "provider prevails" policy to prior authorization administered by Medicaid managed care plans for prescribed medical services and pharmaceuticals.

Physicians are subject to an absurd number of requirements imposed by managed care plans and health insurers which force them to take more and more time away from their patients but which in many cases provide no commensurate benefit to the problem. This is extremely costly to the provider and very often diminishes rather than enhances care, quality and access. As government seeks to shift risk downward to the health plans, we are concerned that already burdensome prior authorization processes will become more and more intrusive upon the physician. Already, physicians feel that the medication approval processes in New York cost them unnecessary time and money as they seek to assure that their patients have access to the medications they prescribe. As we move more and more of the Medicaid population into Medicaid managed care, this problem will worsen unless you take action to establish appropriate protections for physicians and their patients. Increasing ancillary practice burdens on physicians will not and cannot save money in the long term. Additional time consuming requirements take large amounts of time and time is an expensive commodity.

In support of this request, I would like to draw you attention to the results of a survey of over 650 physicians conducted by MSSNY between December 1st and December 8th which clearly demonstrate the significant concerns of physicians regarding prior authorization for medications. Many of these physicians treat a large number of Medicaid patients in their practice. 96% percent of responding physicians believe that the current PA processes for medications present a burden to physicians and their office staff. 65% of these indicated that they or their staff spent more than fifteen minutes to receive PA from a Medicaid managed care plan for a prescription needed for their patients. 87% of respondents indicated that the Medicaid managed care plan either occasionally denied or frequently denied their request for PA for a prescription for a patient. 47% of physicians appealed the plan's denial of their PA request. Importantly, 72% of physicians who responded to the survey stated that at no time during the PA or appeal process were they afforded an opportunity to speak with a physician or pharmacist concerning the appropriateness of their prescription for their patient. Overall, 74% of respondents believe that the PA process is more difficult than what existed prior to October 1st and 75% find it to be difficult to access information regarding the Medicaid managed care plan formularies or step therapy rules. An overwhelming 94% of respondents believe that the lack of a single state-wide formulary for all Medicaid patients increases the burden on them and their office staff. Some of the most frequently cited Medicaid managed care plans include Fidelis, Blue Cross/Blue Shield, HealthFirst, HIP And MVP.

In our opinion, a provider prevails policy is an important protection which will assure access to medically necessary care and treatment. Additionally, another needed protection which would become operative upon the making of an adverse determination would be a requirement for the review of a physician in the same or similar specialty as the physician who has prescribed the medication. Currently, Article forty nine of the public health law does not require a physician in the same or similar specialty to be involved in the internal appeal of an adverse determination. We also support legislation (A. 662) sponsored by Assemblyman Gottfried which would require a clinical peer reviewer to be a physician in the same or similar specialty as the physician who ordered the treatment or service or prescribed the medication.

Moreover, we believe it essential for stakeholders to work together to develop and utilize an effective and timely standard prior authorization form and transaction process. MSSNY and the AMA support policies which would simplify and standardize the preauthorization process for physicians and patients. To a large degree, administrative standardization of the PA process will introduce predictability and thereby reduce the overall burden to physicians and their staffs. The State of California recently enacted legislation which would require the use of a standard PA form. In the event that a plan chose not to use the form, the PA request would be deemed approved unless the plan responded to the prescriber within two business days. MSSNY would support the enactment of similar requirements. MSSNY also supports the adoption of a standardized paper preauthorization form by health plans for those physicians who choose to submit paper preauthorization forms. We need to simplify and standardize the prior authorization process among all participating plans in New York State for both medical services and pharmacy. In our opinion, it may be best to identify areas related to the pharmaceutical prior authorization process can be streamlined and develop standard transaction strategies for PA for pharmacy first and then separately develop the standard transaction requirements for medical services.

As you know, step therapy is a practice which requires the least expensive drug in any class to be prescribed to a patient first, even if the required therapy is a different therapeutic agent than

what the patient's physician believes is medically in the best interest of the patient. If the treatment is ineffective, insurers will then cover the more expensive treatment options. Patients, including those with serious medical conditions, can be required to fail for an indefinite period of time before the agent preferred by the physician can be prescribed. This practice has the potential to result in serious negative consequences for our patients. Consequently, we believe that it is appropriate to require Medicaid managed care plans to provide physicians with access to a clear and convenient process to override plan step therapy restrictions where (a) the physician believes in his/her professional judgment that the preferred treatment is expected to be ineffective based on the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, and is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or (b) the physician believes in his/her professional judgment
the preferred treatment has caused or is likely to cause an adverse reaction or other harm to the covered person. This language is contained in legislation (A. 8609, Titone/S.5110, Young) currently pending before the Senate and Assembly Insurance Committees.

Lastly, we would note that the physicians who responded to our survey by a ratio of 3:1 felt that the PA process for medications is now more difficult. 76% found it difficult to access information regarding the Medicaid managed care plan formularies or step therapy rules. We believe that these responses are interrelated. To the extent that physicians cannot access important information regarding whether a drug is on formulary, the more time is devoted to the process and the impression that it is more difficult is made. Moreover, respondents almost uniformly (94%) believe that the lack of a single state-wide formulary for all Medicaid patients increases the burden on them and their office staff. Development of a single formulary is complicated, but we would be willing to continue to discuss this possibility with you in the future.

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 2012-2013. To summarize, we believe that the state can achieve significant savings through the enactment of meaningful medical liability reform. The continuation and dedication of funding for the Excess medical liability program is important to facilitate the retention and recruitment of needed primary care and specialty physicians in certain rural and underserved urban communities in New York State. Additionally, we believe that it is critically important that the language creating and Insurance Exchange in New York must specifically include a physician representative on the Exchange Governing Board. Further, we must very carefully address the issue of monitoring prescription drug use and preventing drug abuse to assure that we do not through overly aggressive mandates create barriers to patients obtaining needed pain medications as well as other needed medications to treat or stabilize a health condition. We support language to foster the growth of accountable care organization in New York State. We caution against and oppose the inappropriate expansion of scope of practice for nurse practitioners and other non-physician practitioners. We also ask your support for applying a "provider prevails" policy to prior authorization administered by Medicaid managed care plans for prescribed medical services and pharmaceuticals. Finally, we ask that MSSNY's Committee on Physicians' Health receive the level of reimbursement deserving for the services it has provided over the course of its contract with New York State.