

**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 2014-2015**

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 Sam Unterricht, 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 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, unaffordable deductibles and the 90-day "grace period."

As a result, physicians face an ever-tightening financial vise that threatens to shutter many private physician offices, and with them, the 330,000 jobs statewide that the private practice of medicine generates. Undoubtedly, more and more physicians will be 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.

The healthcare delivery system and the system through which it is financed continue to change. Government is shifting from fee-for-service to capitation. Payers are shifting risk to physicians and hospitals while at the same time shifting higher and higher levels of cost sharing to the insured. 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 – 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.

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 2014-2015. We note for your consideration, however, that the Excess program has historically been re-authorized every three years as HCRA is re-authorized. The Governor's proposed budget would only re-authorize the program for one year. While we are very appreciative that the program was re-authorized and is proposed to be funded at historical levels, we are concerned by this seeming disconnection from HCRA. We ask that you re-authorize the program for a full three year term.

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. 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 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. However, 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 the failed civil justice 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 \$331,295 for just one year of insurance coverage and an OB/GYN practicing in the Bronx or Staten Island must pay \$192,412.

There were over \$760 million in medical liability payments in New York State in 2011, nearly 250% higher than the state with the second highest total (Pennsylvania, \$316 million) and nearly 350% higher than California (\$222 million) and Florida (\$203 million).

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 so to assure that physicians can remain in practice in New York State.

2.) Providing Meaningful Access to the Patient’s Choice of Physician, including Access to Out of Network Physicians

There has been much focus recently on “surprise” medical bills received by patients who believed they had insurance coverage for their needed health care. A major contributing factor to this problem is that many health insurers have drastically reduced their levels of coverage in policies for care provided by out-of-network physicians. As a result, the increased financial responsibility for patients seeking out-of-network care is both substantial and unexpected.

The proposed budget contains provisions similar to legislation (S. 2551 and A. 7813) sponsored respectively by Senator Hannon and Assemblyman Gottfried to provide greater transparency of a health insurer’s out of network coverage and to broaden availability of a patient’s right to go out of network if the insurer’s existing network is insufficient. These proposals also seek to assure that out of network benefits are more comprehensive. MSSNY is generally supportive of the enactment of legislation which will assure that our patients have meaningful coverage and access to out of network care. We are hopeful that the inclusion of a proposal in the Governor’s budget will at last lead to a comprehensive solution on this issue.

When he was Attorney General, Governor Andrew Cuomo required health insurers to discontinue the use of the grossly distorted Ingenix database for determining payments for out-of-network care when it was found Ingenix was manipulating the database resulting in lower out-of-network payments. The settlements with the insurers and the creation of the FAIR Health database by then AG, now Governor, Andrew Cuomo should have at last provided fairness in the adjudication of claims for out of network health care coverage. Instead, health insurers have created an even greater problem because they switched to methodologies for covering out-of-network health care services that appear on their face to adequately cover the cost of out-of-network care but, in fact, deceptively result in grossly insufficient payments. They have drastically reduced their coverage for patient care based upon a politically driven woefully inadequate Medicare fee schedule that often only covers out of network care at pennies on the dollar. It’s almost worthless.

The gross inadequacy leaves the patient with staggering out-of-pocket responsibilities. Moreover, businesses which believe they are paying for the right of their employees to have coverage to see the physician of their choice are in fact paying for almost no coverage at all.

MSSNY supports legislation to require health insurers to clearly disclose to patients and employers the scope of their out-of-network coverage, set as a percentage of the likely costs of care as set forth in the FAIR Health database established by then AG, now Governor, Andrew Cuomo. MSSNY also supports legislation to require health insurers offering a policy for out-of-network coverage to assure that there is significant coverage of such costs.

We further note that MSSNY opposes efforts to create an across-the-board dispute resolution mechanism to determine payments for out-of-network emergency care, or other mechanism which permits insurers to grossly underpay for necessary emergency room care. While a dispute-resolution mechanism could be appropriate in circumstances where truly excessive billing is alleged, an across-the-board dispute-resolution process that would capture all bills from out of network physicians would likely further discourage many physician specialists from providing emergency on-call care.

We look forward to working with the Legislature and the Governor to address the out of network access and coverage issues which now confront us in the context of the budget this year.

3.) Allowing Physicians Practicing “Urgent Care” To Remain in Practice

The Proposed budget includes provisions which may adversely impact the ability of physicians to remain in practice as “urgent care” practices. Specifically, the budget would define “urgent care” to mean “the provision of treatment on an unscheduled basis to patients for acute episodic illness or minor traumas that are not life threatening or potentially disabling for monitoring or treatment over prolonged periods”. The proposal prohibits anyone from operating as an urgent care practice unless they are accredited pursuant to regulations to be promulgated. The PHHPC is specifically authorized to adopt and amend rules and regulations, subject to the approval of the Commissioner, to effectuate the purposes of this section. On January 7th, PHHPC approved a report with many recommendations including recommendations regarding the scope of services to be provided by urgent care practices as they would be defined by this proposal. Also the PHHPC report would establish standards for referral and continuity of care, staffing, equipment and maintenance and transmission of patient records.

Urgent care providers are engaged in the practice of medicine and possess a professional license as do other practicing physicians. Physicians who practice urgent care provide a valuable service to the communities in which they practice. They are open virtually every day of the year and require no prior scheduled appointments. Consequently, when patients are unable to obtain care from their physician, they know that they can turn to urgent care practices to address their immediate health care needs. Many patients prefer to access the services of an urgent care physician than waiting for hours in a hospital emergency room setting.

Unfortunately, the imposition of the requirements envisioned by this proposal including especially the requirement for accreditation may threaten their very viability through imposition of huge new costs and for this reason, we oppose this provision. Accreditation is an exceptionally costly process. The Joint Commission has an accreditation process for all ambulatory care providers, including urgent care practices. The accreditation fees for one urgent care practice range from a low of \$9,930 for a practice with up to 10,000 annual patient visits to a high of \$28,240 for one urgent care practice with as many as 120,000 and more

patient visits in a year. If the practice had more than one practice site, then additional fees are applied which will add between \$1335 (for 1-2 additional sites) to \$6,625 (9-10 additional sites) to the cost of a three year accreditation. And the cost of the accrediting survey and annual maintenance of accreditation are only two aspects. Staffing costs associated with preparation and maintenance of preparedness for accreditation typically runs into the tens of thousands of dollars. Many urgent care practices are small physician businesses which simply cannot absorb the costs necessary to secure and maintain accreditation. In our opinion, market forces should be the deciding factor in whether a physician owned urgent care practice should seek accreditation.

Other costs would be imposed on these sites as well by virtue of additional recommendations made by the PHHPC. The PHHPC recommended that each urgent care site must have an x-ray machine and crash cart supplies and medications and that its staff must be ACLS and PALS certified. There are some physicians whose urgent care practices are located on a campus which houses an x-ray machine owned by another entity unaffiliated with the physician's practice so that any patient who needs an x-ray is immediately wheeled from the physician practice through a door where the x-ray machine is located in space owned by the other entity which subsequently bills the patient independently of the urgent care physician for the x-ray taken. The patient is made aware of this ahead of time. This urgent care practice will not be able to continue to be an urgent care practice if this recommendation is incorporated in the regulations. Moreover, ACLS and PALS certification is unnecessary since the urgent care practice is not an emergency room. We agree that a patient experiencing chest pain should go to the emergency room and not an urgent care for treatment. Should such a patient arrive in the urgent care practice, an ambulance would be called for proper transport to the closest ED. ACLS and PALS certification is, therefore, an additional and unnecessary cost on an urgent care practice.

Physician urgent care practices are among the small businesses which our communities and the state should protect. As noted above, physicians are the second largest industry in terms of business creation. Across New York, physicians employ more than 330,000 clinicians and non-clinical support staff. Physician urgent care practices are well known to their communities, particularly in the underserved rural and urban communities and are relied upon by patients who need acute episodic care when their own physician is not available. If they are unable to sustain financially, they will transform their business model and patients will be relegated to the most costly and inefficient of all care settings—the hospital owned emergency room.

4.) Amendment to the Office-Based Surgery Requirements of Public Health Law Section 230-d

The proposed budget also contains requirements which would impact upon physicians who perform certain surgery in their offices and who are already required by Public Health law Section 230-d to be accredited by one of three national accrediting agencies recognized by the commissioner of health. Significantly, the proposal would establish a registration requirement for such OBS facilities and would require such practice to submit certain procedure and quality data through their accreditation agency to the Department of Health.

We are concerned by the imposition of a registration process. We are unclear as to what is to be gained by such a process. Is it the intention to by virtue of the registration enable the Department of Health to conduct site surveys or subject the practices to other requirements

imposed on other entities currently regulated by the Department of Health? Would such practices by virtue of being registered with the Department now be entitled to bill a facility fee in addition to a fee for the procedure performed? We need more information before we articulate a position on a registration requirement.

The proposal would also require accrediting bodies to “utilize American Board of Medical Specialties (ABMS) certification, hospital privileging or *other equivalent methods* to determine competency of practitioners to perform office-based surgery and office-based anesthesia.” We believe that this requirement is redundant of what accreditation agencies are already doing and therefore is unnecessary.

Moreover, we are concerned by the requirement imposed on the accreditation bodies to “carry out surveys or complain/investigations upon department request”. The language here does not specify the purpose for which such surveys or investigations will be conducted. We believe this creates a basically unlimited right of the Department of Health to investigate a doctor’s office for reasons that may go far beyond the type of procedures performed or the quality of care delivered. We believe that at a minimum the language should be modified to enumerate the focus of such survey(s) and/or investigations. Additionally, the proposal requires the accreditation bodies to report “findings of surveys and complaint/incident investigations and data for all office-based surgical and office-based anesthesia practices”. Again, the proposal fails to specify what information should be reported. Should patient and physician identifiable information be reportable? We submit that the information reported should be reported on an aggregate and de-identifiable basis. Also, in addition to surveys and compliant/incident investigations, what other data is to be collected? The language fails to specify. We encourage more specificity as to the type of data sought and the format by which such data should be communicated. Moreover, we recommend that specific language be inserted to prohibit public access to this data. MSSNY has long advocated for the ability of physicians to perform quality improvement activities in their offices. This is an approach first identified in the IOM’s *Crossing the Chasm* report. However, such data is not protected from disclosure to forces who would like to use the data in furtherance of litigation. We request that if the state should want this data, it should prevent access to it – whether it collects it or physicians develop the data through ongoing QI activities of their own.

5.) Preventing Inappropriate Expansion of Nurse Practitioner Scope of Practice

The proposed budget would allow Nurse Practitioners to practice for six months in collaboration with an NP who has been in practice for more than three thousand six hundred hours if: (a) the collaborating physician retires, moves, dies, or becomes unqualified to practice and (b) the NP has demonstrated to the Department that she has made a good faith effort to find another collaborating physician but cannot. In addition, the proposal would allow NPs with more than 3600 hours of practice to collaborate with either a physician or a hospital.

We are concerned by this proposal.

The existing Nurse Practice Act, which establishes the scope of practice of nurse practitioners, does not require that a nurse practitioner and his/her collaborating physician be in the same geographic location. Consequently, it would be extremely unusual for a nurse practitioner not to be able to find a collaborating physician within a reasonable distance to provide guidance, advice, and support, as well as review of the nurse practitioner’s patient charts on a regular

basis. In the unlikely event that a nurse practitioner is having difficulty, given the important work be provided by NPs, MSSNY would be very much willing to assist with locating a collaborating physician.

MSSNY strongly opposes the independent practice of a nurse practitioner without a collaborative agreement with a physician. In our opinion, the language in the budget which would allow a NP to collaborate with a hospital in effect would enable independent practice by nurse practitioners in almost any venue. 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).

We can fathom no instance where the quality of patient care can reasonably require the elimination of the written practice agreement and protocols.

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.) 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 fro treatment and continuity of care, case reporting to the patient's primary care or other health care providers, design, construction, fixtures and equipment. To a large extent the recommendations of the Public Health and Health Planning Council (PHHPC) approved in early January would form the substance of these regulations. And while PHHPC did attempt to address many of the

concerns MSSNY raised last year when this issue was first advanced, MSSNY continues to have strong concerns regarding this proposal. Chief among these concerns 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 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, we 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.

7.) Elimination of the Requirement for Written Consent When Offering an HIV Test

The proposed budget includes a provision which MSSNY supports to remove the requirement for separate, written consent when offering an HIV test. The provisions continue the requirement for informed consent and require that the person ordering the test shall at a minimum advise the individuals that an HIV-related test is being performed. Under the bill's provisions, the physician must note the notification in the patient chart and must provide the patient with information that HIV causes AIDS; that there is treatment for HIV that can help an individual stay healthy; that individuals with HIV or AIDS can adopt safe practices to protect people in their lives from becoming infected; that testing is voluntary and that it can be done anonymously at a public testing center; that the law protects the confidentiality of HIV-related test results and prohibits discrimination based on an individual's HIV state; and that the law allows an individual's informed consent for HIV-related testing to be valid for such testing until such time it is revoked by the patient. Should the provisions of the bill pass the New York State Legislature, there would be protocols put in place to ensure compliance with this section. The change amends the Public Health Law, Section 2781 and Chapter 308, Laws of 2010.

In 2010, the New York State Legislature changed its HIV law to comply with some of the 2006 Centers for Disease Control and Prevention "Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings" that expanded requirements to offer an HIV test to persons between the ages 13-64. The 2010 New York State law which changed requirements for pre-and post- test counseling and allowed for the use of rapid HIV testing maintained the requirement for a separate written consent from the patient. For over 25 years, the Medical Society of the State of New York has advocated that HIV testing be part of routine medical care and believes that separate, written informed consent remained the biggest barrier for patients to get tested for HIV.

8.) Oppose One-Sided No-Fault Reform

We are very concerned with the No-Fault reform component of the Executive Budget proposal that would enable the Superintendent of Financial Services to investigate a health care

provider's office when the "Superintendent deems it expedient for the protection of the interests of this State". We believe this creates a basically unlimited right of DFS to investigate a doctor's office for reasons that may go far beyond reasonable suspicion of fraud.

This proposal will undoubtedly have a huge chilling effect on physicians treating injured auto accident victims. We do not need to re-create in the No-Fault system the crisis we already seeing in Workers' Compensation where physicians are fleeing from the program due to huge new administration burdens imposed on them just to deliver the care their patients need and to be fairly paid for providing this care.

MSSNY has long sought to partner with agencies and the Legislature to address No-Fault fraud. Staged automobile accidents leading to fake injuries, billing for testing or treatment which was not required or never occurred, and the criminal networks which may include various healthcare providers, insurance adjustors, attorneys, automobile repair shops, and others who promulgate such illegal behavior should and must be eradicated, with the need for legislation which will lead to effective prosecution.

But as we approach this, it is critically important that any solutions are narrowly tailored to address true fraud and abuse, yet without exacerbating the already existing difficulties physicians experience in being paid both fairly and in a timely manner for the necessary medical care we provide to our patients.

For example, in the past when the insurance industry has been pressed to define which "healthcare providers" were allegedly committing supposed fraudulent acts, the insurance industry admitted that there was a higher total volume of alleged fraud associated with chiropractors, acupuncturists, massage therapists, and non-physician owned imaging centers than there were with physicians in individual or group medical practices.

Unfortunately, many of the proposals advanced to date would provide the carriers with even greater discretion to delay and deny claims submitted by the vast majority of physicians and other health care providers who have not done anything wrong, effectively penalizing the many for the inappropriate behavior of the few. This provision would effectively treat all physicians as potential criminals.

This is simply unfair. We urge that this provision be dropped from the Budget.

Moreover, it is also our position that any reform of the No Fault system must also include balance to identify and punish those employed within the insurance industry, whether at the level of adjustors or branch managers, who believe that Regulation 68 and the laws affecting No-Fault claims allows them to treat honest providers and truly injured claimants as if they too are criminals, issuing denials in an arbitrary and capricious manner, while providing those who are harmed by these inappropriate actions with little recourse. In this regard, we urge that this proposal include provisions that would require auto insurers to be prohibited from denying claims unless they are reviewed by physicians in the same or similar specialty as the physician providing the patient care.

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 2014-2015. 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 also ask for your support to work to address the out of network access and coverage issues which now confront us but to be careful that in doing so we do nothing to further discourage many physician specialists from providing emergency on-call care. We urge your opposition to proposals which would threaten the viability of physician owned urgent care practices including any requirement for such practices to be accredited. We urge your consideration of the addition of language to assure that the data sought to be collected from OBS practices by the Department of Health is related to quality of care and that such information is protected from public access. We caution against and oppose the inappropriate expansion of scope of practice for nurse practitioners and other non-physician practitioners. Also, we believe that it is critically important that the Legislature prevent the proliferation of retail clinics in New York State. We urge the elimination of the written informed consent requirement which we believe to be the biggest barrier for patients to get tested for HIV. Finally, we urge the defeat of the conveyance of unbridled authority on the Superintendent of Financial Services to investigate a health care provider's office with regard to potential No-Fault fraud.