

MEDICAL SOCIETY OF THE STATE OF NEW YORK 2017 HOUSE OF DELEGATES

Report of the Reference Committee on Governmental Affairs and Legal Matters (B)

Presented by: Raymond Lanzafame, MD, Chair

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Madam Speaker and Members of the House of Delegates:

Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Reference Committee on Governmental Affairs and Legal Matters Sunset Review Report
2. Resolution 108 - Board Certification Participation in Insurance Plans
3. Resolution 112 - Oppose Medicaid Eligibility Lockout

**RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

4. Resolution 114 - Regulation of Hospital Advertising
5. Resolution 101 - Preserving the Anesthesia Care Team Model
6. Resolution 102 & 105 - Protecting Patients from High Drug Prices and Maintenance Medications and Pharmacy Parity
7. Resolution 103 - Pharmaceutical Shortages of IV Bags
8. Resolution 104 - Covered Drugs during Insurance Enrollment Year
9. Resolution 106 - Restricting Faxes from Pharmacy Benefit Managers
10. Resolution 107 - Workforce Development for Addiction Treatment by Physicians
11. Resolution 109 - Comprehensive Minimal Facility Security Standards
12. Resolution 110 - NYS DOH Employment of Immediate Jeopardy For Surgical Attire
13. Resolution 111 - Opposition to Medicaid Work Requirements

**REFERRED TO COUNCIL**

14. Resolution 115 - Chiropractor (D.C.) Scope of Practice

**RECOMMENDED NOT FOR ADOPTION**

15. Resolution 100 - Saving Lives and Money

## 1. SUNSET REPORT

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUNSET REPORT FOR GOVERNMENTAL AFFAIRS AND LEGAL MATTERS B FOR 2018 BE ADOPTED.**

## 2. RESOLUTION 108: BOARD CERTIFICATION PARTICIPATION IN INSURANCE PLANS

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 108 BE ADOPTED.**

**Resolved, That MSSNY support legislation or regulation that allows physicians who complete their residency and are candidates for board certification according to their respective specialty NOT be denied participation in insurance plans based on board certification alone.**

Resolution 108 asks MSSNY to support legislation or regulation that allows physicians who complete their residency and are candidates for board certification according to their respective specialty NOT be denied participation in insurance plans based on board certification alone.

Your reference committee agrees with the concerns that led to the bringing of this resolution. Your reference committee was advised that MSSNY has also adopted several policy positions similar in this area already.

### **160.965      Tying Maintenance of Licensure to Maintenance of Certification**

All physicians still in practice should be encouraged and enjoined to participate in activities to improve and maintain the knowledge and skills necessary to render the highest quality of care to his/her patients. MSSNY strongly opposes any effort by the State of New York to require certification by any medical specialty board as a condition of obtaining or renewing the registration of a medical license in the State of New York. The MSSNY Division of Governmental Affairs will make our position PROACTIVELY known to all appropriate agencies. (HOD 2016-216, Reaffirmed in lieu of HOD 2017-205)

### **160.966      Maintenance of Certification**

The Medical Society of the State of New York takes a position and will lobby against any linkage of licensure to Maintenance of Certification. MSSNY will simultaneously advocate for a varied approach to ensure appropriate continuing education for physicians. (HOD 2016-213, Reaffirmed in lieu of HOD 2017-205)

### **160.972      Opposition to Mandatory Maintenance of Certification**

MSSNY opposes mandating Maintenance of Certification (MOC) until such time as evidence-based research demonstrates MOC is linked to improved patient outcomes. MSSNY acknowledges that the certification requirements within the MOC process are costly, time intensive and result in significant disruptions to the availability of physicians for patient care, and acknowledges and affirms the professionalism of individual physicians to self-determine the best means and methods for maintenance of their knowledge and skills. MSSNY will communicate to the American Medical Association and American Board of Medical Specialties examples of disproportional fees, onerous time requirements and unnecessary fragmentation of commonly

recognized specialties, and will bring a copy of this resolution to the AMA House of Delegates for its consideration. (HOD 2013-165 and 168, Reaffirmed in lieu of HOD 2017-205)

### **3. RESOLUTION 112: OPPOSE MEDICAID ELIGIBILITY LOCKOUT**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 112 BE ADOPTED.**

**RESOLVED, that MSSNY oppose ‘lock-out’ provisions that exclude Medicaid eligibles for lengthy periods merely for failing to meet paperwork burdens, and support provisions that permit them to reapply; and be it further**

**RESOLVED, that MSSNY introduce to the AMA a resolution to oppose ‘lock-out’ provisions that exclude Medicaid eligibles for lengthy periods merely for failing to meet paperwork burdens, and support provisions that permit them to reapply,**

Resolution 112 requests that MSSNY (1) oppose ‘lock-out’ provisions that exclude Medicaid eligibles for lengthy periods merely for failing to meet paperwork burdens, and support provisions that permit them to re-apply; and be it further (2) introduce to the AMA a resolution to oppose ‘lock-out’ provisions that exclude Medicaid eligibles for lengthy periods merely for failing to meet paperwork burdens, and support provisions that permit them to reapply.

### **4. RESOLUTION 114: REGULATION OF HOSPITAL ADVERTISING**

#### **RECOMMENDATION A:**

**THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE AMENDMENT BE ACCEPTED INSTEAD OF THE ORIGINAL RESOLUTION.**

**RESOLVED, that MSSNY and the AMA advocate for regulation to promote responsible hospital and medical advertising.**

#### **RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 114 BE ADOPTED AS AMENDED.**

Resolution 114 asks that MSSNY and the AMA urge increased regulation of hospital advertising with an aim of complete prohibition if hospitals cannot demonstrate an overall and cost-effective benefit to public health.

Your reference committee was informed of the various points of views concerning whether or not to prohibit hospital advertising. On one side are free-commerce advocates who say hospitals should be able to advertise just like any consumer products maker can. On the other

are those who believe the proliferation of health care advertising raises serious ethical issues that need to be addressed.

For most of this country's history, hospitals didn't advertise their services. That's because the American Medical Association banned the practice in its 1847 code of ethics, which declared the practice "derogatory to the dignity of the profession." It took until 1980 for that ban to be reversed, which it was when a circuit appellate court ruled that the AMA could no longer place restraints on advertising. Such bans, it said, violated the Federal Trade Commission Act protecting free commerce.

**Your reference committee also researched the debate that occurred in Vermont when this proposal was introduced by legislators. Some of the arguments against the proposal include:**

### **1. Interstate competition**

Even though an advertising ban would effectively level the playing field for Vermont hospitals, it would put local hospitals at a major disadvantage when competing with other New England organizations. Montpelier is less than 200 miles from Boston and its world-class hospitals. If Vermont consumers aren't aware of their local healthcare options, they'll be more likely to opt for the big names in the big city, effectively taking money out of the state. Now that won't look good come election time, will it?

### **2. Freedom of advertising**

Government interference in advertising isn't unprecedented, but a ban on hospital advertising would certainly bring it to the next level. The *Burlington Free Press* article points out that the courts have upheld advertising restrictions in the past, most notably on the tobacco industry. You know, the industry that sells a product that is detrimental to a person's health. As opposed to hospitals, whose main purpose is to keep people healthy. Such as—oh, I don't know—smokers who now have cancer?

### **3. It wouldn't even save that much**

Big picture: Hospital marketing budgets don't account for large portion of a hospital's annual budget. Fletcher Allen Health Care, a 500-bed hospital in Burlington, VT, spends less than 1% of its annual budget on advertising, spokesman Mike Noble told the *Burlington Free Press*. Besides, according to the laws of the free market, anything that is conducive to competition (such as advertising) ultimately drives cost down—exactly what the Vermont statesmen say they are trying to do with this ban.

### **4. This isn't England**

Until 2008, English hospitals weren't allowed to advertise either. Granted, they are all completely government funded. But even English hospitals can now promote themselves via print and radio ads, so long as they use correct statistics and don't bash other hospitals. You know something is wrong if National Health Service hospitals can market themselves and Vermont ones can't.

## **5. No definition of marketing**

One of the biggest hints that this proposal won't come to anything is that it doesn't define "marketing and advertising." Where would they draw the line? Promoting quality and satisfaction scores? Interacting with the media via public relations? Holding educational info-sessions for consumers? Each of these functions has value to both the hospital and the public.

## **6. Unintended consequences**

If Vermont does ban hospital marketing, there would inevitably be a trickledown effect. Media outlets would lose advertising money, creative and consultant firms would lose clients, and hospital marketers would lose their jobs—none of which would go over well among voters in the Green Mountain State.

They say there's no such thing as a sure thing, but the odds are definitely against this advertising ban ever becoming law. But if it does I'll be sure to write a numbered list of why I was wrong.[i]

[i] <http://www.healthleadersmedia.com/marketing/six-reasons-proposed-hospital-advertising-ban-will-never-pass?page=0%2C1>

Your reference committee was also notified that a group of faculty from the University of Pittsburgh and Carnegie Mellon published an article in the *American Journal of Bioethics* suggesting that the risk that hospital ads will mislead patients is so great that hospitals should be subject to the same regulations that govern ads for prescription pharmaceuticals. In the *American Journal of Bioethics* piece, University of Pittsburgh physician Yael Schenker and her co-authors spotlight a number of concerns, including the fact that ads featuring patients who were cured by the hospitals they are praising do not include information about the risks presented by the procedures they underwent, or the overall success rates for such procedures.

## **5. RESOLUTION 101 – PRESERVING THE ANESTHESIA CARE TEAM MODEL**

### **RECOMMENDATION A:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE FIRST RESOLVE OF RESOLUTION 101 BE ADOPTED.**

**RESOLVED, that MSSNY will develop a policy in support of physician supervision of nurse anesthetists, and be it further**

### **RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE SECOND RESOLVE OF RESOLUTION 101 BE AMENDED BY ADDITION AND DELETION:**

**RESOLVED, that MSSNY will seek to have legislation introduced and signed into law in New York State stipulating that a patient undergoing any medical treatment requiring anesthesia in a hospital or ambulatory surgical center, regardless of where the hospital**

or ambulatory surgical center is located and regardless of the type of health insurance coverage, be guaranteed that a physician-anesthesiologist will either personally administer or supervise a nurse anesthetist in the administration of anesthesia or the operative that a designated surgeon, who has agreed to medically supervise the nurse anesthetist.

### **RECOMMENDATION C:**

#### **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 101 BE ADOPTED AS AMENDED.**

Resolution 101 asks that (1) MSSNY develop a policy in support of physician supervision of nurse anesthetists; and (2) MSSNY will seek to have legislation introduced and signed into law in New York State stipulating that a patient undergoing any medical treatment requiring anesthesia in a hospital or ambulatory surgical center, regardless of where the hospital or ambulatory surgical center is located and regardless of the type of health insurance coverage, be guaranteed that a physician-anesthesiologist will either personally administer or supervise a nurse anesthetist in the administration of anesthesia will medically supervise the nurse anesthetist.

Your reference committee agrees with the concerns that led to the introduction of this resolution. Your reference committee heard testimony regarding a number of adverse pieces of legislation proposed in the New York State Budget and other legislation that has been introduced over the years. Your reference committee was notified that MSSNY has supports legislation to address this issue. The bill, A.1829 Morelle / S.4422 DeFrancisco, intends to preserve the physician led anesthesia team approach in a manner consistent with existing standards of care and NYS Health Code. This bill clarifies the existing standard of anesthesia care by describing the role of the physician anesthesiologist and nurse anesthetist. This bill also requires the physician-anesthesiologist and/or operative physician accept medical responsibility for the surgical patient undergoing anesthesia and supervision of the nurse anesthetist. This bill is supported by MSSNY.

Additionally, MSSNY has already adopted the following policy:

#### **110.998 Non-physician Practitioners in Today's Health Care Delivery Systems:**

Consequently, MSSNY strongly opposes any expansion of the scope of practice of non-physician practitioners which would undermine the quality of health care and compromise public safety. In certain government forums, non-physician practitioners are advocating that they should receive the same amount of compensation paid to physicians for certain services. MSSNY specifically opposes any policy which would implement "parity" of payment between physician and non-physician providers. MSSNY supports the implementation of a differential payment structure based upon the provider's level of training, skill, expertise, responsibility and practice costs. Such a payment structure must necessarily recognize the inherent distinctions which exist between the extent of physician education and training as compared to that of non-

physicians. Such distinctions in education, training, legal recognition and scope of practice demonstrate beyond argument the lack of any “equivalency” of service despite the claims by some non-physician practitioners.

6. RESOLUTION 102 – PROTECTING PATIENTS FROM HIGH DRUG PRICES  
AND  
RESOLUTION 105 – MAINTENANCE MEDICATIONS AND PHARMACY PARITY

**THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 102 BE ADOPTED IN LIEU OF RESOLUTIONS 102 AND 105.**

**RESOLVED, That the Medical Society of the State of New York urge legislation that prohibits pharmacies to charge higher prices (from pharmacy benefit managers or insurance plans) than the actual pharmacy price of the medication; and be it further**

**RESOLVED, that the Medical Society of the State of New York advocate for patients to have a choice to receive maintenance prescriptions from either a mail order pharmacy or a brick-and-mortar pharmacy without any financial penalty.**

Resolution 102 asked that (1) The Medical Society of the State of New York urge legislation that prohibits pharmacy prices under a pharmacy plan (from insurance and or PBM) that are purchased from local or mail order pharmacies be higher than the cost without a drug plan; (2) That the Medical Society of the State of New York urge legislation that would mandate that the price of medication purchased without a plan should be the same for consumers in the pharmacy or online.

Resolution 105 asked that the Medical Society of the State of New York advocate for patients to have a choice to receive maintenance prescriptions from either a mail order pharmacy or a brick-and-mortar pharmacy without any financial penalty.

Your reference committee agrees with the concerns that led to the bringing of this resolution. Your reference committee was informed that MSSNY recently adopted policy that urged MSSNY to support legislation prohibiting ‘pharmacist’ gag clauses on pharmacists’ in contracts.

Your reference committee heard the testimony of several physicians that stressed the importance of ensuring that individuals without health insurance don’t have to pay a higher price than the cost of a drug. Additionally, there was a lot of feedback from physicians who testified on supporting additional requirements in the resolution including regulating the costs of hospital drug prices for patients. The reference committee agreed with the concerns outlined above but believes that these issues would likely supersede MSSNY’s ability to address these concerns through State legislation. Your reference committee found that mandating some drug prices whether from a pharmacy or online is not feasible and cannot be regulated solely by New York State.

Your reference committee agrees with the concerns expressed in this resolution. Your reference committee was advised that New York has already enacted a law that bars insurers or employers from forcing patients to use mail-order plans for prescription drugs. Instead, consumers are guaranteed the choice of having their prescriptions filled either through mail-order or at the local drugstore, without any added copayments or fees. Legislation approved in 2011 was designed to level the playing field between mail order and retail pharmacies. When signing that law (Chapter 597 of the Laws of 2011), Governor Cuomo insisted on a chapter amendment that required “that the retail pharmacy must agree in advance to accept the same reimbursement rate and applicable terms and conditions established for mail order pharmacies.” This was necessary because, as the Federal Trade Commission (FTC) noted in a letter regarding the originating legislation, the proposal included the language “comparable price,” which according to the FTC, would have reduced competition and raised prices, and thereby harmed consumers.

In addition to delivering economies of scale that help dampen rising pharmaceutical costs, mail order pharmacy services provide education, assessment and monitoring related to prescriptions as well as 24/7 phone access and support for patients. This is critical to specialty pharmacy drugs that are high cost and highly complex in terms of dosage and monitored results. The Governor’s chapter amendment requires retail pharmacies to not only match prices but also ensure they would provide the additional services—to support high quality standards designed to boost patient safety.

Additionally, your reference committee was informed that additional legislation has already been introduced to further protect consumers. The bill, S.3484 Golden /A.4786 Joyner) would create a new Article 40 of the General Business Law (GBL) to regulate the business practices around the delivery of mail order pharmacy benefits. The bill includes not just those New Yorkers who are governed by State law in the individual and small group markets, but also those New Yorkers who receive their health insurance benefit from federally-regulated entities such as union welfare funds, employer sponsored health insurance plans, and the New York State Health Insurance Plan (NYSHIP). Federal law normally exempts these entities from state law changes. Under this legislation, if Article 40 of the GBL is deemed to be violated, the New York Attorney General has enforcement powers, and may seek a civil penalty of not more than ten thousand dollars for each violation.

## 7. RESOLUTION 103: PHARMACEUTICAL SHORTAGES OF IV BAGS

### **RECOMMENDATION A:**

**THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE AMENDMENT BE ACCEPTED INSTEAD OF THE ORIGINAL RESOLUTION.**

**RESOLVED, That the Medical Society of the State of New York ask the American Medical Association to urge legislation and/or regulatory flexibility to allow for the safe expansion of purchasing medical supplies, equipment and pharmaceuticals from various countries abroad at a time of shortage.**

**RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 103 BE ADOPTED AS AMENDED.**

Original Resolution 103 requested that the Medical Society of the State of New York: (1) advocate legislation allowing purchasing of IV bags from Canada; and (2) ask the American Medical Association to urge legislation allowing for international purchase of IV bags; and be it further and (3) ask the American Medical Association to urge legislation to support and sustain medical manufacturing in Puerto Rico.

Your reference committee agrees with the concerns expressed in this resolution. Your reference committee was advised that significant actions have been taken by the federal government to try to address these issues. The goal of the amended resolution was to expand supporting regulatory flexibility in the face of shortages for various medical supplies, devices and pharmaceutical products.

**8. RESOLUTION 104: COVERED DRUGS DURING INSURANCE ENROLLMENT YEAR**

**THE REFERENCE COMMITTEE RECOMMENDS:**

**RECOMMENDATION A:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE FIRST RESOLVE OF RESOLUTION 104 BE AMENDED BY ADDITION:**

RESOLVED, That the Medical Society of the State of New York **urge the American Medical Association** to ask for federal legislation or regulation, whereby Medicare plans and HMO plans would not be permitted to change the covered drugs during the enrollment year; and be it further

**RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE SECOND RESOLVE OF 104 BE ADOPTED.**

**RESOLVED, That the Medical Society of the State of New York seek legislation or regulation, whereby Pharmacy Benefit Managers (PBMs) and large pharmacy systems would not be permitted to ask prescribers to change prescriptions during the year unless there were medical evidence that the change would benefit the patient;**

**RECOMMENDATION C:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE THIRD RESOLVE OF RESOLUTION 104 BE ADOPTED.**

**RESOLVED, That the Medical Society of the State of New York ask for legislation or regulation whereby, during the enrollment year, no required changes would be imposed on prescribers (such as a change from brand to generic, or a change from brand to another brand).**

**RECOMMENDATION D:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 104 BE ADOPTED AS AMENDED.**

Original Resolution 104 asks that the Medical Society of the State of New York: (1) ask for federal legislation or regulation, whereby Medicare plans and HMO plans would not be permitted to change the covered drugs during the enrollment year; and (2) seek legislation or regulation, whereby Pharmacy Benefit Managers (PBMs) and large pharmacy systems would not be permitted to ask prescribers to change prescriptions during the year unless there were medical evidence that the change would benefit the patient; and (3) ask for legislation or regulation whereby, during the enrollment year, no required changes would be imposed on prescribers (such as a change from brand to generic, or a change from brand to another brand).

Your reference committee heard broad support for MSSNY to support these resolutions. A minor change was needed to the first resolve since it urged federal action. Over the years, MSSNY has heard various concerns regarding the need to prevent mid-year formulary changes. In response to these concerns raised by physicians previously, MSSNY has already adopted the following policies:

**70.937 Pharmacy Benefit Managers Medical Necessity Criteria for Prescribed Medications**

MSSNY will seek regulation or legislation limiting Pharmacy Benefit Manager requests for information to pertinent and relevant information which demonstrates that a patient meets medical necessity for prescribed medications. (HOD 2017-103)

**70.946 Generic Drug Pricing**

The Medical Society of the State of New York (MSSNY) recognizes that generic drugs are not identical to their brand name precursors. MSSNY will advocate to ensure that a patient's physician has final decision-making authority regarding which prescription medications are necessary for that patient's well-being and it will further advocate to ensure the availability of affordable prescription medications for patients, including opposition to sudden unjustified price increases in prescription medications.

The Medical Society will continue to work with the Department of Financial Services, Department of Health and Attorney General's office to expedite reviews of situations where insurers and their agents improperly delay responding to requests for pre-authorization of

needed medications and further, MSSNY will advocate for sufficient fines to be imposed on insurers who fail to respond to pre-authorization requests in a timely manner. (HOD 2015-52)

**70.971      Administration of Prescription Drug Programs Insuring Patient Access to Necessary Medication:**

MSSNY will:

1. Express its concern to the New York Department of Health and the Department of Health and Human Services that the programs concerning prescription drugs be administered in such a way that patients will not be denied access to necessary medication; and
2. Oppose any third party payer reducing reimbursement beyond or below a physician's and/or other health care practitioner's cost; and
3. Support activity to ensure that all fair administrative costs be considered for reimbursement; and
4. Coordinate with the Pharmacists Society of the State of New York in a concerted effort to insure proper access to pharmaceutical drugs for all patients in New York State. (Council 1/25/01; Reaffirmed Council 1/22/04)
5. Vigorously advocate for fair and reasonable reimbursement for chemotherapy and other vaccines. (Council 1/22/04 addition) Policy 70.971 Reaffirmed HOD 2014

**70.974      Restrictive Formulary Medication Benefits Plans:**

MSSNY supports enactment in the State of New York of a pharmacy benefits management law that will regulate managed pharmacy benefit plans to prohibit interference in the doctor-patient relationship, to prevent interruption of ongoing medical care treatment and to promote access to medication that is consistent with accepted standards of appropriate medical care and treatment, to provide patients with advance notice of benefit limits and the right to pursue external review of medications denied due to formulary restrictions.

MSSNY supports legislation that requires that where a prescription is denied due to formulary restrictions the prescription drug must be dispensed to the patient for the pendency of the internal or external appeal process.

MSSNY will educate physicians and patients regarding the right to pursue external review when patients are denied or provided unequal access to medications because of formulary restrictions. (HOD 00-78; Reaffirmed HOD 2001-53; Reaffirmed HOD 2011; Reaffirmed HOD 2016-67)

**70.975**            **Continued Coverage for Prescription Medications From Health Plan Drug Formularies:**

MSSNY will seek appropriate legislation that would allow a patient suffering from a chronic condition to continue to be reimbursed for medically necessary prescription drugs subsequently removed at the discretion of a health plan from its drug formularies provided that the patient's physician believes that there is no appropriate alternate drug on the formulary. (HOD 1998-74; Reaffirmed HOD 2001-53; Reaffirmed HOD 2011)

**70.976**            **Restrictive Formulary Drug Prescription Sanction Through Managed Care:**

MSSNY will develop and propose legislation or regulation requiring (a) pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary; (b) which prohibits managed care entities, and other insurers, from disciplining, or withholding payment from physicians because they have prescribed drugs to patients which are not on the insurer's formulary or have appealed a plan's denial of coverage for the prescribed drug; (c) which ensures that all pharmacy benefit management companies and insurers which use restrictive drug formularies be required to impanel an independent group of physicians to determine the composition of the drug formulary; (d) will request the American Medical Association to examine the feasibility of establishing a standardized process for formulary development applicable to all managed care plans. (HOD 1998-55; Reaffirmed HOD 2001-53; Reaffirmed HOD 2011)

**70.998**            **Generic Drug Substitution:**

The members of the Medical Society of the State of New York are as interested as any other group of citizens in the State, if not more so, in eliminating unnecessary costs in the delivery of health care and are actively engaged in developing measures that will lead to the most effective use of the dollars expended on health care, provided that none of these measures results in a lowering of the quality of medical care available to and afforded the public. Two measures that could lead to a wider use of generic drugs should be considered:

- (1) The first is to conduct controlled, scientifically valid studies to conclusively establish that generic drug substitutes are equivalent in bio-availability and therapeutic equivalence. Disturbing reports have appeared in scientific medical literature that seriously question whether generic drugs approved by the FDA do, in fact, satisfy these criteria. In the face of such doubts, it is understandable that physicians will be reluctant to authorize drug substitutes for medications with which they are familiar by experience. The necessary studies do entail expenditure of money and delays, but these are small prices to pay when one is primarily concerned with providing the very best available drug to an ill patient.
- (2) A second major deterrent to physicians readily agreeing to generic drug substitution is the question of their liability if a substitute, of which they have insufficient knowledge and no control in choice, should prove to be ineffective for the purpose intended and the patient suffers thereby. Our Society has had correspondence with both the State and Federal governments to determine the limitations of a physician's liability and the responses have been equivocal. It is

our interpretation, as the Law now stands, that the physician may still be liable. An unequivocal statement of acceptance, of complete liability, by either the Federal or State government, in the event of untoward effects developing solely from the use of a generic drug substitute such as was promulgated for the swine flu immunization program, would remove this anxiety from the physician's mind and encourage wider use of generic substitution.

There is a basic principle to be stressed in the consideration of this subject, namely, that no law should curb the professional judgment of a physician in the treatment of his patient. Years of intensive schooling and training mark the education of a physician and his licensure. It is such training that establishes the physician as the one best able to determine the most effective means of therapy for the individual problems of a particular patient. It is most earnestly hoped that no inadequate substitute for this professional judgment, based solely on cost, will ever be enacted. (HOD 1983 Reaffirmed HOD 2013)

**70.999      Generic Drug Prescription Forms:**

MSSNY is in favor, whenever possible, of reducing the cost of care to the patient.

Understanding that the freedom of the physician to specify a brand name remains inviolable and accepting the value of the freedom from liability incorporated in a 1982 generic drug substitution legislative proposal, The MSSNY adopted the position of not opposing a bill so long as the method of specifying brand name drugs on prescription forms remains simple, such as D.A.W. (in place of "Dispense as Written") or checking one of two boxes.

(HOD 1982; Reaffirmed HOD 2013)

**75.000      Drugs And Medications:**

(See also Abortion and Reproductive Rights, 5.000; Drug Dispensing, 70.000; Home Health Care, 135.000; Pharmaceutical Advertising, 227.000; Public Health & Safety, 260.000; Reimbursement, 265.000; Sports and Physical Fitness, 290.000)

**75.973      Appeals Process for Medications with Prescribed Dosing:**

The Medical Society of the State of New York will seek regulation and/or legislation to ensure that Medicare, Medicaid and insurance plans in New York State allow physicians to make dosing adjustments for approved medications to allow the patient to achieve therapeutic levels regardless of their body mass index, as well as differing metabolic considerations. The dose administered should be within the purview of the treating practitioners based on clinical parameters, documented in the medical record. (HOD 2015-263, referred to Council, substitute resolution adopted 1/21/2016)

**165.941      Coordination of Pharmacy Benefit into Existing Health Plans:**

MSSNY will seek legislation which would preclude health care plans from requiring physicians to deviate from an already established drug regimen (formulary) based solely upon cost factors associated with less expensive, but possibly less effective drugs. The aforementioned legislation should include coordination of a pharmacy benefit into already existing health plans. MSSNY will strongly encourage the development and utilization of technologies to allow physicians to instantly access the established drug of any health plan with which the physician

maintains a contractual relationship. (HOD 2000-56; Reaffirmed HOD 2001-53; Reaffirmed HOD 2011; Reaffirmed HOD 2015-57)

**195.966      Interaction by the Medicare Part D Carriers with the Physician  
Community re Drug Dosages:**

MSSNY will:

- (1) Advise the Regional Office of the Centers for Medicare and Medicaid Services (CMS) that physicians are very concerned with the manner in which the Medicare Part D carriers are interacting with the physician community regarding drug dosages. Physicians find utilization review activities that demand the completion of cumbersome forms and submission of chart notes unwarranted and believe that these activities interfere with the practice of medicine; and
- (2) Urge the CMS Regional Office to re-evaluate the manner in which their Medicare Part D carriers interact with the physician community and instruct their Medicare Part D carriers that the dosage levels provided to the geriatric community for a variety of prescribed drugs often differ from the standard of FDA approved indications and/or therapeutic dosages (Council 3/3/08).

**9. RESOLUTION 106: RESTRICTING FAXES FROM PHARMACY BENEFIT MANAGERS**

**RECOMMENDATION A:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE FIRST RESOLVE OF RESOLUTION 106 BE AMENDED BY ADDITION.**

**RESOLVED, That the Medical Society of the State of New York ask the American Medical Association to support limiting the use of faxes by Pharmacy Benefit Managers (PBMs) and large pharmacy systems (such as Express Scripts, OptumRx, Humana) sent to physicians;**

**RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE SECOND RESOLVE OF RESOLUTION 106 BE AMENDED BY SUBSTITUTION:**

**RESOLVED, That the Medical Society of the State of New York be committed to the goal of finding cost effective strategies for physicians and suggests that the American Medical Association work with the Medical Society of the State of New York to convene a work group of stakeholders, including physicians, health plans associations, health insurers, large pharmacy systems and their pharmaceutical benefit managers to develop cost effective alternatives to contact physicians for prescriptions and requests for prior authorization electronically, rather than by fax, whenever possible.**

**RECOMMENDATION C:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 106 BE ADOPTED AS AMENDED.**

Resolution 106 urges the Medical Society of the State of New York (1) seek legislation or regulation whereby Pharmacy Benefit Managers (PBMs) and large pharmacy systems (such as Express Scripts, OptumRx, Humana) would be required to limit all faxes they sent to physicians to three pages or less; and (2) seek legislation or regulation requiring Pharmacy Benefit Managers (PBMs) and large pharmacy systems to contact physicians for prescription refills electronically, rather than by fax, whenever possible.

Your Reference Committee agrees with the concerns that led to the advancing of this resolution. Your reference committee heard testimony that described the significant financial burdens associated with the increasing costs attributed to faxing documents. However, your reference Committee had concerns about the challenges of getting legislation passed in New York to address this issue and suggested bringing all stakeholders together to try to address the issues presented.

**10. RESOLUTION 107: WORKFORCE DEVELOPMENT FOR ADDICTION TREATMENT BY PHYSICIANS**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 107 BE AMENDED BY DELETION.**

**RESOLVED, that MSSNY support the temporary use of State funding to establish and to support addiction medicine fellowships in New York State.**

**RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 107 BE ADOPTED AS AMENDED.**

Resolution 107 urged MSSNY to temporarily support the use of state funding to establish and to support addiction medicine fellowships in New York State. Your reference committee thought it was prudent and efficient not to restrict this resolution by including temporary. Your reference committee understands that the opioid epidemic is recognized by physicians, patients and government as a real and growing public health issue. This resolution was offered as one strategy to address the opioid epidemic.

The Medical Society of the State of New York is a member of the AMA's Task Force to Reduce Opioid Abuse. Established in 2014, this task force has embraced four concepts for implementation throughout the nation. The Task Force believes that physicians have a professional obligation to reverse the nation's opioid epidemic.

The 5 goals of The Task Force are:

- Increase physicians' registration and use of effective PMPs
- Enhance physicians' education on effective, evidence-based prescribing
- Reduce the stigma of pain and promote comprehensive assessment and treatment
- Reduce the stigma of substance use disorder and enhance access to treatment
- Expand access to naloxone in the community and through co-prescribing

MSSNY recognizes the severity of this public health epidemic and is committed to implementing solutions to combat it. In New York, we have already reduced the incidence of doctor shopping by 86% because physicians are checking the Prescription Monitoring Program prior to prescribing a controlled substance. We have also supported legislation to increase access to naloxone to reduce deaths from overdose. We have also supported efforts increase voluntary education and training for physicians on safe prescribing practices.

Additionally, the Medical Society of the State of New York, in conjunction with the New York State Office for Alcoholism and Substance Abuse Services has created an accredited CME On-Line course on Pain Management and opioid abuse. According to IMS data, New York has seen substantial decreases in the number of prescriptions written for oxycodone, hydrocodone and other controlled substances. New York's utilization rate for these medications is below other states that currently require prescriber education of opioid medications. Our efforts have proven successful, but there's more work to accomplish in trying to fight the opioid epidemic.

#### 11. RESOLUTION 109: COMPREHENSIVE MINIMAL FACILITY SECURITY STANDARDS

##### RECOMMENDATION A:

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE FIRST RESOLVE OF RESOLUTION 109 BE ADOPTED.**

**RESOLVED, That the Medical Society of the State of New York reaffirm policy 315.992- "Violence Against Physicians, Health Care workers and Others"; and be it further**

##### RECOMMENDATION B:

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE SECOND RESOLVE OF RESOLUTION 109 BE AMENDED BY ADDITION AND DELETION.**

**RESOLVED, That the Medical Society of the State of New York advocate for ~~comprehensive~~ appropriate minimal facility security standards for all New York State licensed hospitals be developed by a broad based professional advisory panel.**

**RECOMMENDATION C:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 109 BE ADOPTED AS AMENDED.**

Resolution 109 urges the Medical Society of the State of New York to (1) reaffirm policy 315.992 - "Violence Against Physicians, Health Care workers and Others"; and (2) advocate for comprehensive minimal facility security standards for all New York State licensed hospitals to be developed by a professional advisory panel with appropriately mandated enforcement.

**315.992      Violence Against Physicians, Health Care Workers and Others:**

MSSNY will work with the New York State Society of Internal Medicine and other recognized specialty societies, to formulate, within current budgetary constraints, a public and professional awareness campaign in response to the recent trends towards violence against physicians and other health care workers in the performance of their duties. MSSNY shall condemn, without exception, the violence or threat of violence to physicians, health care workers and other individuals who are practicing according to their conscience, and in compliance with the law. (HOD 99-202; Reaffirmed Council 11/13/03; Reaffirmed HOD 2013)

Your reference committee agrees with the concerns expressed in this resolution but also heard physician concerns that work in rural and critical access hospitals. The concerns including avoiding painting all types of hospitals with the same brush and wanted to adapt the resolution of ensuring that the concerns and financial restraints of smaller rural hospitals were considered.

Your reference committee was notified that existing law already requires public employers including public hospitals to initiate a written workplace violence prevention program, which would include a list of risk factors at the worksite. Employers would be required to take corrective action to mitigate any risk. This law ensures that the risk of workplace assaults and homicides is evaluated by affected public employers and their employees and those employers design and implement workplace violence protection programs to prevent and minimize the hazard of workplace violence to public employees.

Every public employer with at least twenty full time permanent employees is required to develop and implement a written workplace violence prevention program for its workplace or workplaces that includes:

- a. a list of the risk factors;
  - b. the methods the employer will use to prevent incidents of occupational assaults and homicides at such workplace or workplaces, including but not limited to the following:
    - (1) Making high-risk areas more visible to more people;
    - (2) Installing good external lighting;
    - (3) Using drop safes or other methods to minimize cash on hand;
    - (4) Posting signs stating that limited cash is on hand;
    - (5) Providing training in conflict resolution and nonviolent self-defense responses;
- and;

(6) Establishing and implementing reporting systems for incidents of aggressive behavior.

5. Employee information and training.

a. Every employer with at least twenty permanent full time employees shall make the written workplace violence prevention program available, upon request, to its employees, their designated representatives and the department.

Any employee or representative of employees who believes that a serious violation of a workplace violence protection program exists or that an imminent danger exists shall bring such matter to the attention of a supervisor in the form of a written notice and shall afford the employer a reasonable opportunity to correct such activity, policy or practice.

This referral shall not apply where imminent danger or threat exists to the safety of a specific employee or to the general health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

b. If following a referral of such matter to the employee's supervisor's attention and after a reasonable opportunity to correct such activity, policy or practice the matter has not been resolved and the employee or representative of employees still believes that a violation of a workplace violence prevention program remains, or that an imminent danger exists, such employee or representative of employees may request an inspection by giving notice to the commissioner of labor that such violation or danger. Such notice and request shall be in writing, shall set forth with reasonable particularity the grounds for the notice, shall be signed by such employee or representative of employees, and a copy shall be provided by the commissioner to the employer or the person in charge no later than the time of inspection, except that on the request of the person giving such notice, such person's name and the names of individual employees or representatives of employees shall be withheld. Such inspection shall be made forthwith.

Your reference committee was also informed that a new study by Zippia reveals hospitals are the most dangerous worksites for New York employees.

Employees have a right to expect a reasonably safe workplace under New York law. The New York Workers' Compensation Code makes specific provisions for safety in the workplace.

Employers which do not follow these laws are subject to regulatory penalties (such as suspension of a business license), fines, civil lawsuits and even criminal charges.

Hospital workers face a myriad of potential hazards while carrying out their daily duties, including:

- Workplace violence (typically from patients, who may suffer from dementia, have a history of violence, be under extreme stress or impaired under the influence of drugs/ alcohol);
- Back injuries, primarily due to patient lifting requirements;
- Illness due to working in close proximity to those with infectious diseases;
- Needle injuries.

According to the Occupational Safety and Health Administration (OSHA), hospitals have reduced worker injuries over the last several decades, but not as effectively as other industries. The need to protect physicians and employees who are simply doing their job is self-evident and the goal of this resolution is strongly supported by our committee.

The resolution was amended to ensure that we understand the needs of rural hospitals, critical access hospitals, and not impose burdensome mandates that put small hospitals at risk. The amended version tries to encourage a more collaborative approach with our allies and work to ensure appropriate enforcement.

**12. RESOLUTION 110: NYS DOH EMPLOYMENT OF IMMEDIATE JEOPARDY FOR SURGICAL ATTIRE**

**RECOMMENDATION A:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE FIRST RESOLVE OF RESOLUTION 110 BE ADOPTED.**

**RESOLVED, That the Medical Society of the State of New York urge the New York State Department of Health to reconsider its use of Immediate Jeopardy in alleged instances of lack of “proper” surgical attire.**

**RECOMMENDATION B:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT THE SECOND RESOLVE OF RESOLUTION 110 BE AMENDED BY ADDITION AND DELETION.**

**RESOLVED, that the Medical Society of the State of New York advocate to use measures by the New York State Department of Health that are less disruptive ~~than immediate jeopardy~~ to ensure compliance with policies set forth by a hospital.**

**RECOMMENDATION C:**

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 110 BE ADOPTED AS AMENDED.**

Resolution 110 asks (1) That the Medical Society of the State of New York urge the New York State Department of Health to reconsider its use of Immediate Jeopardy in alleged instances of lack of “proper” surgical attire; and (2) That the Medical Society of the State of New York to advocate for measures by the New York State Department of Health that are less disruptive than Immediate Jeopardy to ensure compliance with the surgical attire policies set forth by the hospital.

Your reference committee made small changes to the original resolution to try to expand the second resolve to include more than just surgical attire. The committee heard extensive testimony that urged the resolution be expanded because the issue was broader than solely limited to surgical attire.

### 13. RESOLUTION 111: OPPOSITION TO MEDICAID WORK REQUIREMENTS

**THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE AMENDMENT BE ACCEPTED INSTEAD OF THE ORIGINAL RESOLUTION.**

**RESOLVED, that MSSNY oppose instituting work requirements on Medicaid eligibles due to its uncertain health implications, and be it further**

**RESOLVED, That MSSNY urge our American Medical Association to reaffirm AMA policy H-290.961.**

Original resolution 111 asked (1) that MSSNY oppose instituting work requirements on Medicaid eligibles due to its uncertain health implications, and (2) that MSSNY introduce a resolution to the AMA to oppose instituting work requirements on Medicaid eligibles due to its uncertain health implications.

AMA already has existing policy on work requirements:

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Your reference committee heard broad support for the enactment of this resolution. Your reference committee was also informed that MSSNY along with various other health care and patient advocates have consistently urged congressional representatives to prevent the loss of needed health insurance coverage for millions of patients across the country. These proposals force everyone to work irrespective of their ability to work which could endanger patient safety and cause disastrous health care implications on individuals. Your reference committee discussed that regardless of your political leanings and individual perspective of the Affordable Care Act, MSSNY should oppose any proposals that hold medical care hostage.

Your reference committee was informed of the joint principles of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association and the American Psychiatric Association.

These organizations adopted various principles seeking to ensure that state waivers “first, do no harm” to current or future enrollees. These organizations urged the Centers for Medicare and Medicaid Services (CMS) to avoid creating barriers to coverage and care by requiring enrollees to pay significantly higher premiums, deductibles, copayments and other out-of-pocket costs for Medicaid enrollees compared to current federal and state requirements and/or by establishing time limits on eligibility. Studies show higher premiums and a relatively small increase in cost sharing creates barriers to coverage and access to care, especially for those with the lowest incomes. Additionally, these groups warned against the dangers of imposing work

requirements, lock-outs, premiums, and other out-of-pocket costs will limit access to preventive and primary care services and inhibit Medicaid beneficiaries from seeking care that helps them avoid costlier health conditions and maintain wellness.

#### 14. RESOLUTION 115: CHIROPRACTOR (D.C.) SCOPE OF PRACTICE

##### **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 115 BE REFERRED TO COUNCIL.**

Resolution 115 asks that MSSNY: (1) reaffirm and seek further regulations in support of current AMA and MSSNY accepted policies on Clinical Diagnostic Electromyography; and (2) advocate for a State level taskforce to study the recent expansion of chiropractic scope of practice in New York and any outcomes that this has had on patient care including the impact on health care costs in New York; and (3) advocate for amendment changes to the New York Education Law regarding needle electromyography currently performed by chiropractors (4) advocate to the appropriate agencies, including the State of New York Insurance Department and the State of New York Workers' Compensation Board, as they relate to the care of individuals sustaining automobile and work-related injuries, respectively, that these principles be adapted into current and future statutes; and (5) expand the principles established in MSSNY Policy 110.998: "Non-physician Practitioners in Today's Health Care Delivery Systems" to apply to chiropractic scope of practice in New York State.

Your reference committee heard extensive testimony. Your reference committee was informed that Electromyography (EMG) is a diagnostic procedure utilizing an electrical device that monitors neuromuscular activity in the human body. Chiropractors employ EMG to detect structural imbalance, distortion or subluxation of or in the vertebral column.

Electromyography is a diagnostic tool which is useful for the purpose of detecting structural imbalance, distortion or subluxations in the human body and related conditions. The use of electromyography is currently approved by the State Board for Chiropractic pursuant to section 73.3 of the Regulations of the Commissioner, since it has not been disapproved by the federal Food and Drug Administration (FDA).

"Education Law, Section 6551(3), provides that 'a license to practice chiropractic shall not permit the holder thereof to... utilize electrical devices except those devices approved by the board as being appropriate to the practice of chiropractic.

Furthermore, Part 73.3 of the Regulations of the Commissioner of Education provide that 'pursuant to section 6551(3) of the Education Law, licensees may use any electrical devices essential to their practice provided such devices have not been disapproved by the federal Food and Drug Administration or its successors, or by the department."

Needle or 'invasive' electromyography has not been disapproved by the federal Food and Drug Administration, nor has the Department deemed these devices to be inappropriate to the

practice of chiropractic. The State Board for chiropractic and the State Education Department currently allows the use of invasive electromyography by chiropractors. Consequently, electromyography may be used in the practice of chiropractic in this state, for the purpose of the diagnosis of “nerve interference and the effects thereof” resulting from “distortions, misalignments or subluxations in or of the vertebral column”

Some studies have indicated that some family physicians, as well as patients are increasingly open to a more collaborative approach with chiropractors for treatment strategies to address back pain. Many patients also believe that chiropractors have become valued members of the health care team.

Existing MSSNY policy:

**35.997      Limited License Practitioner - Physician Relationship:**

Whether a physician should have professional relations with chiropractors must be the individual choice of the physician, based on what the physician believes is in the best interest of the patient. As with any limited license practitioner, a physician should be mindful of state laws which prohibit a physician from aiding and abetting a person with limited license in providing services beyond the scope of his license. (Council 1/26/89; Reaffirmed HOD 2013)

15. RESOLUTION 100 – SAVING LIVES AND MONEY

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 100 NOT BE ADOPTED.**

Resolution 100 urges the Medical Society of the State of New York and the American Medical Association consider endorsing the Saving Lives/Money Health Plan proposed by Newt Gingrich in his 2003 book.

While cost controls are the primary factor influencing the recommended resolution, MSSNY has long standing policy that encourages that both access and quality are equally essential objectives which must not be compromised by any planned system restructuring. In fact, cost control cannot be achieved if either access or quality is not satisfactorily addressed. Additionally, your Reference Committee was informed that MSSNY has longstanding policy that includes urging both the New York State legislature and Congress to take meaningful action on tort reform and has supported to use of Medical Savings Accounts. Additionally, in his book, “Saving Lives and Saving Money” and in other policy positions over the years, Newt Gingrich has supported privatizing Medicare payments, advocated for Medicare vouchers and urged to block grant Medicaid.

Your reference committee is concerned that a number of topics included in Newt Gingrich’s cost cutting proposals can ultimately reduce payments to doctors for care delivered. The suggestions included in this proposal could be controversial on the floor and encompasses so different topics that it will likely be difficult to reach a consensus agreement.

Your reference committee was advised that MSSNY has also adopted policy in a number of areas on health insurance reform and that it is even more broad proposed in this resolution.

**130.987      Health System Reform - MSSNY Principles:**

MSSNY is sensitive to the compelling circumstances generating the movement towards health care system reform in New York State and nationally. The Society is cognizant of the need to control health care costs while advocating the provision of health insurance coverage to the entire population of this state, including our 2.5 million citizens who are currently uninsured. While cost controls are the primary factor influencing the reform process, MSSNY believes that access and quality are equally essential objectives which must not be compromised by any planned system restructuring. In fact, cost control cannot be achieved if either access or quality is not satisfactorily addressed.

MSSNY believes that eventual stability of the state health care delivery system must be fundamentally predicated upon: (1) Universal access to high quality care for all New Yorkers; (2) Redirection of economies derived from renovation of a flawed system with its significant inefficiencies and frequent misallocation of resources to a more cost-effective service delivery structure; (3) Finance reform in conjunction with a price competitive market-based pluralistic system; (4) Meaningful physician input concerning relevant key aspects of any system reform.

Consequently, MSSNY believes that the following principles should be embodied in any reform of the state health care delivery system: (1) All New Yorkers regardless of health and income status should have access to high quality, affordable and basic health care; (2) Comprehensive health care reform should be achieved through a collective partnership encompassing the consumer, business, labor, health provider, health insurance and government sectors which would build on the positive elements of our current pluralistic health care system; (3) An independent health care access oversight authority comprised of pertinent private and public sector representatives should be established to monitor and assess the quality of care provided under the reform; (4) Health system reform should provide sufficient tax and financial incentives to create an environment of consumer cost consciousness which would compel vigorous price competition among health care insurers; (5) Competition among insurers should be predicated on required offering of the standard benefits program developed under the auspices of the proposed independent health care access oversight authority; (6) Individuals should have the right and responsibility to obtain, at minimum a standard benefits package, and finance a portion of cost of their care according to their means. State government and employer contributions should supplement the purchase of such insurance as appropriate, with tax incentives provided to employees and employers for the purchase of the lowest priced comparable coverage among insurers (as identified by the independent authority). Coverage beyond the standard package may be procured at additional cost, but without tax relief for the purchaser; (7) State financing, coupled with the necessary federal Medicaid/Medicare waivers, should be provided for the purchase of a standard benefits package by the indigent, elderly, uninsured and unemployed; (8) Health insurance system reform should be designed to: (a) Aid small business in the provision of health insurance to their employees; (b) Promote

community rating; (c) Eliminate preexisting condition exclusions; (d) Guarantee renewability and portability; (e) Control premium increases; (f) Guarantee consumer choice of insurer, inclusive of programs providing freedom of choice of physicians; (9) Medical liability tort reform, including limitations on non-economic damages, should be enacted in concert with health care system restructuring to mitigate the costly practice of defensive medicine, while continuing to protect the legitimate interests of the patient community; (10) Practice parameters should be developed by physicians experts as useful educational tools for assuring the delivery of quality care and providing an affirmative defense in legal actions premised upon physician negligence; (11) Electronic claims processing (unrelated to a single payor authority) in conjunction with the development of a uniform claim form should be achieved in an effort to mitigate the current high administrative costs of health insurance operations; (12) Reimbursements for a defined service should be the same regardless of the site of that service (office, home, hospital settings, etc.) thereby establishing ambulatory care payment parity; (13) The residents of New York State should assume greater responsibility for their health by the imposition of financial sanctions directed toward mitigating unhealthy behaviors, taking appropriate preventive measures, and making conscientious cost effective determinations concerning the utilization of health care services; (14) The system must be structured to induce all insurers to function in the most cost-effective manner possible so as to ensure the mitigation of administrative costs, and application of the maximum amount possible of the premium dollar to health care benefits; (15) All providers of health care should be committed to adhering to the highest standards in the provision of patient care and interaction with health insurers. (16) Organized medicine, as represented by MSSNY, should be authorized to represent physician interests in negotiating the establishment of fees with insurers and other payors. (17) MSSNY is committed to organize physicians into an integrated risk-sharing entity in order to offer an alternative to capitated plans and to permit private practicing physicians to compete effectively in the managed care/managed competition arena in both the public and private payor market. (Council 6/3/93; Reaffirmed HOD 01-256; Reaffirmed HOD 2011 and also Reaffirmed AMA Substitute Resolution 203, Health System Reform Legislation (below):

RESOLVED, That our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- Health insurance coverage for all Americans;
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps;
- Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials;
- Investments and incentives for quality improvement and prevention and wellness initiatives;
- Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care;
- Implementation of medical liability reforms to reduce the cost of defensive medicine; and

- Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens; and be it further

RESOLVED, That our American Medical Association advocate that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation; and be it further

RESOLVED, That our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States; and be it further

RESOLVED, That our American Medical Association support health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients; and be it further

RESOLVED, That it is American Medical Association policy that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians; and be it further

RESOLVED, That our AMA actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician; and be it further

RESOLVED, That our AMA actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals; and be it further

RESOLVED, That our AMA actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: 2

Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services;  
Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system;  
Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk adjusted;  
Redistributed Medicare payments among providers based on outcomes,

quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate;

Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; and

Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest; and be it further

RESOLVED, That our American Medical Association continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy; and be it further

RESOLVED, That our American Medical Association use the most effective media event or campaign to outline what physicians and patients need from health system reform; and be it further

RESOLVED, That national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal; and be it further

RESOLVED, That creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform; and be it further

RESOLVED, That effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform; and be it further

RESOLVED, That our American Medical Association reaffirm AMA policy H-460.909 Comparative Effectiveness Research.

(Note: Also Filed for Information is the Final Report of MSSNY's Subcommittee on Health System Reform, chaired by Dr. Robert Scher, which was adopted by the MSSNY House of Delegates.)

**130.988      Medical Savings Accounts:**

MSSNY vigorously supports the introductions of Medical Savings Accounts (MSAs) in New York State and will support legislation such as that embodied in State Assembly Bill 6249A and its companion Senate Bill 69A calling for the establishment of tax-favored Supplemental Insurance Accounts (which essentially embody the MSA concept), subject to subcommittee interaction with State legislators for an opportunity to: (a) provide additional MSSNY input and possible suggested modifications to the aforementioned Assembly/State bills; (b) exchange views with hopeful enlistment of legislative support.

MSSNY supports expansion of the subcommittee charge to timely interact with representatives of the insurance, banking and business sectors as well as the Council on Affordable Health Insurance for educational purposes and for an in-depth investigation and assessment of: (a) the economic ramifications of MSAs; (b) the level of insurer/consumer interest in MSAs; (c) alternatives or modifications to the basic MSA concept as may be appropriate, necessary and feasible.

MSSNY vigorously supports the right of individuals to select their own health insurance plan and to receive the same tax-exempt treatment for individually purchased insurance as for employer-purchased coverage. (Council 12/19/96)

MSSNY will seek state and federal legislation that would enable individuals to create medical savings accounts for health care purposes which would encompass the concepts of utilization of pretax dollars, tax-free accumulations, and non-penalized withdrawals for health care and other related purposes. (HOD 1995-85; Policy Reaffirmed HOD 2014)