

MEDICAL SOCIETY OF THE STATE OF NEW YORK 2016 HOUSE OF DELEGATES

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

Presented by: Stephen Wade, MD, Chair

Madame Speaker and Members of the House of Delegates:

Your Reference Committee recommends the following consent calendar for acceptance:

FILE FOR INFORMATION

1. GA Report 1 – HOD- 2016 Legislative Program

RECOMMENDED FOR ADOPTION

2. Resolution 51 – Insurance Simplification of Explanation of Benefits (EOBs)
3. Sunset Review 16-A

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

4. Resolution 52 – Managed Care Contracts and “All Products” Clauses and Silent PPOs
5. Resolution 54 – Health Insurance Guarantee Fund
and
Resolution 55 - New York State to Reclaim Responsibility for State-sponsored Plans
6. Resolution 56 – Protection from Underpayment for Services
7. Resolution 57 – Underpayment Reconciliation
8. Resolution 59 – Ensuring FAIRHEALTH Integrity
9. Resolution 63 – Restoring Liability Limits
10. Resolution 64 – Reinstate Partial Medicare B Coinsurance Payments
and
Resolution 65 - Repeal of the New York State Medicare/Medicaid 20% Payment Change
11. Resolution 66 – Medicaid and Insurance Takeback Procedures
12. Resolution 67 – Regulation of PBM Companies
13. Resolution 68 – Require Alternative Mediation List after Denial
14. Resolution 69 - NYS Medical Malpractice Insurance Market Undergoing Upheaval

REFERRED TO COUNCIL

15. Resolution 53 – Expansion of Independent Dispute Resolution Process

RECOMMENDED NOT FOR ADOPTION

16. Resolution 62 – Medical Malpractice Reform to Medical Injury Compensation (No-Fault)

1 1. LEGISLATIVE AND PHYSICIAN ADVOCACY COMMITTEE (GA REPORT 1)

2
3 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE ANNUAL REPORT OF THE**
4 **LEGISLATIVE AND PHYSICIAN ADVOCACY COMMITTEE BE APPROVED AND FILED**
5 **FOR INFORMATION.**

6
7 Your Reference Committee noted that the Report of the Legislative and Physician Advocacy
8 was a presentation of the Medical Society's 2015 Legislative Program, which was approved by
9 the MSSNY Council at its meeting on November 5, 2015.

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12 2. RESOLUTION 51 - INSURANCE SIMPLIFICATION OF EXPLANATION OF BENEFITS

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14 **THE REFERENCE COMMITTEE RECOMMENDS: THAT RESOLUTION 51 BE ADOPTED.**

15
16 Resolution 51 asks MSSNY to seek regulation or legislation that would require all claims from a
17 health care provider relating to a single encounter be reported together on the same EOB,
18 rather than across multiple EOBs in order to make the claims process more simple and more
19 transparent.

20
21 Your Reference Committee heard testimony that highlighted the hassles faced by physician
22 offices and patients associated with tracking payments for claims for specific services. This
23 leads to confusion to patient and physician offices as to the proper co-payments to be collected.
24 The sponsors have also noted that this issue occurs across multiple specialties as well as with
25 multiple insurance companies. Therefore, your Reference Committee agreed that the
26 resolution be adopted.

27
28 3. SUNSET REVIEW (16-A)

29
30 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUNSET REPORT FOR**
31 **GOVERNMENTAL AFFAIRS AND LEGAL MATTERS (A) BE ADOPTED.**

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34 4. RESOLUTION 52 - MANAGED CARE CONTRACTS AND "ALL PRODUCTS" CLAUSES
35 AND SILENT PPOS

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37 **THE REFERENCE COMMITTEE RECOMMENDS: THAT SUBSTITUTE RESOLUTION 52 BE**
38 **ADOPTED IN LIEU OF RESOLUTION 52.**

39
40 **RESOLVED, that the Medical Society of the State of New York re-affirm MSSNY policies**
41 **165.903 and 265.963; and be it further**

42
43 **RESOLVED, that as MSSNY continues to advocate to prohibit health insurer "all product"**
44 **clauses any such legislation (1) require that the insurer must set forth separate terms**
45 **(including compensation terms) for each of the insurer's products that exist when the**
46 **contract is signed; (2) require that if an insurer introduces a new product after the**
47 **contract is signed, the insurer will not be permitted to unilaterally designate the**
48 **physician as a participant in that product; (3) enable that the physician be allowed to**
49 **choose either to participate or not participate in that new product; and (4) ensure that if**
50 **the physician chooses to participate, the insurer must reach an agreement with the**
51 **physician on business terms for that new product.**
52

1 Resolution 52 asks MSSNY to:

2

3 (1) Seek legislation in New York State to prohibit the inclusion of “all products” clauses, and any
4 clauses which would require the physician to participate in silent Preferred Provider
5 Organizations (PPOs), embedded in managed care contracts promulgated by private insurers
6 and managed care organizations (MCOs); and

7

8 (2) Incorporate in that proposed legislation the model contract language put forth by the
9 American Medical Association stating that (a) the managed care organization must provide
10 separate business terms (including compensation terms) for each of the insurer’s products that
11 exist when the contract is signed; (b) if the MCO introduces a new product after the contract is
12 signed, it will not be permitted to unilaterally designate the physician as a participant in that
13 product; (c) the physician must be allowed to choose either to participate or not participate in
14 that new product; and (d) if the physician chooses to participate, the insurer must reach an
15 agreement with the physician on business terms for that new product.

16

17 Your Reference Committee agrees with the sponsors of the resolution. Your Reference
18 Committee heard testimony that it is unfair for physicians to be required by health insurance
19 companies to participate in all products offered by that insurer, or to require participation in
20 products that may not even have been in existence when the physician signs the contract.
21 Your Reference Committee was advised that MSSNY had adopted several policies supporting
22 the right of physicians to participate those insurance products the physician believes is fair.
23 These policies also recognize the difficulty associated with securing legislation to prohibit such
24 clauses, and also call for greater transparency when a plan contract includes provisions
25 enabling assignment of the contract. Your reference committee was advised that MSSNY has
26 supported legislation (A.2918, Pretlow) to prohibit a health insurer from requiring a physician to
27 participate in all products offered by that insurer as a condition of participating in a Child Health
28 Insurance Plan (CHIP) product offered by that insurer. MSSNY has also supported legislation
29 introduced in previous legislative sessions (for example, A.8884, Quart, of the 2013-14
30 Legislative Session) that would have, among other provisions, prohibited the assigning of a
31 physician’s contract without their consent, as well as prohibiting coercion to participate in future
32 products offered by that insurer. Your reference committee recommends that these existing
33 MSSNY policies be re-affirmed in lieu of the first resolved. Your reference committee also
34 agrees with the provisions of the second resolved, and urges that it be incorporated into the
35 substituted resolution.

36

37 **165.903 Contract Termination - Merged MCOs:** MSSNY continues to support the ability of a
38 physician to choose the health plans and the health plan products with which they will
39 participate, and continues to oppose efforts by health plans to require physicians to participate
40 with all affiliates of a particular plan or all products offered by a particular plan; and should
41 health plans continue to have the ability to require physicians to participate in all its affiliates,
42 MSSNY will advocate for legislation to assure that:

43

44 (a) newly merged health plans are required to follow the termination protocols of the health plan
45 that provides more beneficial terms to the physician; and

46

47 (b) permits the physician wishing to terminate from the health plan and all its affiliates to
48 execute such termination by contacting the plan with which the physician originally contracted.
49 (HOD 2007-69).

50

51 **265.963 All Products Clause in Insurance Participating Provider Contracts:** MSSNY will
52 seek legislation to ban “all products” clauses in health care plan participating provider contracts,

1 and to bar health care plans from requiring participation in any other products as a requisite for
 2 participation in Child Health Plus or Family Health Plus. (HOD 2000-68; Reaffirmed HOD 2014)
 3
 4

5 5. RESOLUTION 54 - HEALTH INSURANCE GUARANTEE FUND

6 AND

7 RESOLUTION 55 - NEW YORK STATE TO RECLAIM RESPONSIBILITY FOR STATE-
 8 SPONSORED PLANS
 9

10
 11 **THE REFERENCE COMMITTEE RECOMMENDS: THAT SUBSTITUTE RESOLUTION 54 BE**
 12 **ADOPTED IN LIEU OF RESOLUTIONS 54 AND 55.**
 13

14 **RESOLVED, That the Medical Society of the State of New York continue to advocate for**
 15 **the enactment of a Health Insurance Guarantee Fund to pay outstanding claims in the**
 16 **event of an insolvency by a health insurance company; and be it further**
 17

18 **RESOLVED, that the Medical Society of the State of New York continue to advocate to**
 19 **assure the availability of funds to pay the outstanding claims of Health Republic, either**
 20 **through a Health Insurance Guarantee Fund or use of other state monies; and be it**
 21 **further**
 22

23 **RESOLVED, the Medical Society of the State of New York continue to work with the**
 24 **Department of Financial Services to assure strong oversight of the financial integrity of**
 25 **health insurance companies operating in New York State.**
 26

27 Resolution 54 asks that:

28
 29 (1) With the closing of Health Republic in November 2015, resulting in physicians and hospitals
 30 being owed well in excess of \$100 million in unpaid claims, MSSNY seek legislation/regulation
 31 that would create a Health Insurance Guarantee Fund, to pay outstanding claims in the event of
 32 an insolvency or bankruptcy by a health insurance company; and
 33

34 (2) The above referenced Health Insurance Guarantee Fund be made retroactive to include all
 35 outstanding and denied claims submitted to Health Republic.
 36

37 Resolution 55 asks MSSNY to:

38
 39 (1) Support an educational plan to inform providers of the financial risks and potential lack
 40 coverage in the event of plan insolvency; and
 41

42 (b) Seek by legislation and/or regulation, the establishment of an industry indemnity fund to
 43 cover services rendered and monies owed in the event of exchange plan insolvency.
 44

45 Your Reference Committee agrees with the concerns identified by physicians who testified in
 46 support of both resolutions. MSSNY surveys have shown that physicians are owed tens of
 47 millions of dollars for unpaid claims as a result of the demise of Health Republic. Your
 48 Reference Committee was advised that MSSNY has worked closely with the Greater New York
 49 Hospital Association in support of legislation (A.9311/S.6667) to enact a "Guarantee Fund" to
 50 assure claims are paid in the event of an insurer going into liquidation. Because it was not
 51 entirely clear whether the legislation could be made retroactive to account for the claims of
 52 Health Republic, as well as concerns from many legislators that insurers would simply pass the

1 cost onto their insureds, MSSNY also strongly advocated for the use of existing state funds to
2 pay these outstanding claims. Importantly, this advocacy resulted in both the State Senate and
3 Assembly including language in their respective “one-House” Budget proposals to better assure
4 these claims were paid. After extensive negotiations, the finally enacted State Budget created a
5 “Health Republic Insurance of New York fund” to collect state-derived settlement monies for the
6 purposes of paying outstanding HR claims once the liquidation of HR is completed. While this
7 is an important “placeholder” provision, further legislation will be needed to determine the
8 specific amounts of money to be allocated from state settlements into this fund, as well as
9 setting forth the manner by which claims out of this fund will be paid. The resolution should
10 reflect both support generally for a Guarantee Fund and also support to assure Health Republic
11 claims are paid. Since both resolutions 54 and 55 deal essentially with the same topic, your
12 Reference Committee recommends adoption of the above substituted resolution to (1) support
13 the creation of a Guarantee Fund; (2) support action to assure the payment of outstanding
14 Health Republic claims and (3) support continued strong oversight of health insurers operating
15 in New York State to prevent against further health insurer insolvencies.

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18 **6. RESOLUTION 56 - PROTECTION FROM UNDERPAYMENT FOR SERVICES**

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20 **THE REFERENCE COMMITTEE RECOMMENDS THAT: SUBSTITUTE RESOLUTION 56 BE**
21 **ADOPTED IN LIEU OF RESOLUTION 56.**

22

23 **RESOLVED, that the Medical Society of the State of New York re-affirm MSSNY policies**
24 **165.917 and 265.985; and be it further**

25

26 **RESOLVED, That the Medical Society of the State of New York urge the NYS Department**
27 **of Health, NYS Department of Financial Services and Attorney General’s office to require**
28 **health insurance companies to provide complete fee schedule information; and be it**
29 **further**

30

31 **RESOLVED, that the Medical Society of the State of New York advocate for legislation,**
32 **regulation or other appropriate policy intervention to assure health insurers pay**
33 **physicians for medical services in accordance with the fees specified in the physician’s**
34 **contract even if the physician’s submitted charge is less than the fee schedule amount.**

35

36 Resolution 56 asks MSSNY to:

37

38 (1) Seek legislation to mandate insurers to release complete fee schedule information annually
39 or whenever changes are made and not merely direct a physician to calculate the fee schedule
40 from the RVU and conversion factor information; and

41

42 (2) Work with the New York State Department of Financial Services to draft measures which
43 would ensure that health insurance companies be mandated to pay physicians for documented
44 medical services performed in accordance with the patient’s insurance plan whether or not
45 the physician has billed at the allowable rate.

46

47 Your Reference Committee agrees with the concerns of the sponsor of the Resolution. Your
48 Reference Committee heard testimony where health insurers were only providing contracted
49 physicians with RVU and conversion factor information, and not a complete fee schedule. New
50 York State Public Health Law section 4406–c (5a) provides: "Contracts entered into between a
51 plan and a health care and a Physician shall include terms which prescribe (a) the method by
52 which payments to a Physician, including any prospective or retrospective adjustments thereto,

1 shall be calculated . . .” MSSNY has adopted many policies on this issue previously. MSSNY
 2 has also supported legislation introduced in previous legislative sessions (for example, A.8884,
 3 Quart, of the 2013-14 Legislative Session) that would, among other provisions, expressly
 4 assure that physicians receive a complete fee schedule specific to their specialty. In addition to
 5 re-affirming these policies, your reference committee recommends an additional resolved
 6 calling upon MSSNY to press state agencies to require health insurers to provide this
 7 information to their contracted physicians. Your Reference Committee also recommended that
 8 the second resolved of the original resolution be amended to clarify that the physician must
 9 submit their charge in order to be paid at the insurer’s fee schedule amount.

10
 11 **165.917 Carriers’ Failure to Obey PHL 4406-c (5A) Release of Fee Schedule:** MSSNY will
 12 work with the NYS DOH to amend appropriate provisions of law to assign monetary penalties
 13 for failure to comply with requests for fee schedules. Failing legislative relief, MSSNY will study
 14 the feasibility of bringing appropriate legal action against carriers in New York who are identified
 15 as refusing to provide requested fee schedule data. (HOD 2003-52; Reaffirmed HOD 2013).

16
 17 **265.985 Third Party Fee Schedule:** MSSNY will seek legislation at both state levels and
 18 national levels that would mandate insurers to make available their complete fee schedules,
 19 coding policies, and utilization review protocols to physicians prior to signing a participant
 20 contract and whenever any changes are made to the foregoing. (HOD 1998-262; Reaffirmed
 21 HOD 2014).

22 23 24 7. RESOLUTION 57 - UNDERPAYMENT RECONCILIATION

25
 26 **THE REFERENCE COMMITTEE RECOMMENDS: THAT SUBSTITUTE RESOLUTION 57 BE**
 27 **ADOPTED IN LIEU OF RESOLUTON 57.**

28
 29 **RESOLVED, that the Medical Society of the State of New York seek legislation to**
 30 **mandate insurers to identify underpayments discovered through an audit and return**
 31 **such payment to the physician, including accrued interest; and be it further**

32
 33 **RESOLVED, that if a pattern of underpayments is discovered in such insurer audit, that**
 34 **such findings be extrapolated across the entire time period reviewed in the audit, and be**
 35 **used to offset overpayment amounts due to the insurer.**

36
 37 Resolution 57 asks MSSNY to seek legislation to mandate insurers to reconcile underpayments
 38 discovered through audit process by making restitution to the physician for the full price of the
 39 service, including accrued interest.

40
 41 Your Reference Committee agrees with the concerns of the sponsor of the resolution. MSSNY
 42 has adopted numerous policies calling for it to seek legislation and regulatory relief to address
 43 abuses by carriers in auditing physicians for so-called overpayments of previously paid claims.
 44 MSSNY strenuously advocated to secure the enactment of legislation in 2006 that generally
 45 placed a 2-year limit on the time frame for health insurers to audit these claims. MSSNY has
 46 since sought the enactment of legislation to address further identified abuses, such as
 47 legislation to eliminate the use of extrapolation (A.3354/S.720) and legislation to require the
 48 valid statistical sampling methods for extrapolation audits (A.1193/S.2303) that recently pass
 49 the Assembly. However, there does not appear to be any MSSNY policy setting forth a policy
 50 to require plans to identify underpayments during an audit to offset alleged overpayments.
 51 Therefore, your Reference Committee supports the goals of this resolution. To assist with
 52 achieving the intent of the resolution, your reference committee suggests amendments to

1 require health insurers to affirmatively: 1) identify underpayments when conducting an audit, 2)
 2 requiring insurers to extrapolate such underpayments across the length of time as the claims
 3 under review in the audit; and 3) assure that such underpayments can be used to offset
 4 overpayments that are to be paid back.

5
 6
 7 **8. RESOLUTION 59 - ENSURING FAIR HEALTH INTEGRITY**

8
 9 **YOUR REFERENCE COMMITTEE RECOMMENDS: THAT SUBSTITUTE RESOLUTION 59**
 10 **BE ADOPTED IN LIEU OF RESOLUTION 59.**

11
 12 **RESOLVED, that the Medical Society of the State of New York continue to work with Fair**
 13 **Health to assure optimal physician charge data collection and presentation**

14
 15 Resolution 59 asks MSSNY to advocate for appropriate legislative and regulatory changes to
 16 ensure the integrity of FAIRHEALTH data, including:

- 17
 18 (1) All former insurance company executives and anyone with any ties to the insurance
 19 industry be removed from the FAIRHEALTH board of directors and
 20
 21 (2) All insurers be required to submit data to the FAIRHEALTH database and
 22
 23 (3) FAIRHEALTH only use charges from out-of-network services (not the “usual” charges
 24 that are reported as part of an in-network fee submission, that the in-network physician
 25 would have hypothetically charged had he or she been out-of-network), and
 26
 27 (4) FAIRHEALTH exclude no more than a small percentage of out-of-network data charges
 28 as “invalid” for one reason or another, and
 29
 30 (5) When data is sparse for a given code in a given geo-zip, FAIRHEALTH should
 31 “extrapolate” data from the true out-of-network charges from other similar codes in the
 32 same geo-zip, and make clear, upon request, the basis for this extrapolation, and
 33 (6) FAIRHEALTH make public which insurers are currently submitting data, and
 34
 35 (7) FAIRHEALTH start a rational formal auditing process, that compares data provided by
 36 the insurers with actual data from physicians gathered independently by FAIRHEALTH,
 37 not just with other data provided by insurers from other geographical regions, and
 38
 39 (8) FAIRHEALTH investigate promptly any complaints by physicians that its data is
 40 inaccurate, and
 41
 42 (9) FAIRHEALTH promptly correct any discovered errors in its statistics and issue a note of
 43 error on its website so physicians, insurers, and patients will be aware of the error and
 44 its correction, and
 45
 46 (10) FAIRHEALTH report all inaccurate data given to it by insurance companies to an
 47 appropriate legal authority who would impose harsh penalties on insurers for such
 48 activity.
 49

50 Your Reference Committee shares the concerns with the sponsor of the resolution regarding
 51 assuring FAIRHEALTH has complete and comprehensive physician charge data in which to
 52 develop its usual and customary database. Your Reference Committee heard testimony

1 regarding the importance of assuring that such data be accurate. At the same time the
 2 reference committee also heard testimony that the resolution inaccurately portrays how Fair
 3 Health accumulates and presents physician charge data as it sets forth what is usual and
 4 customary. Your Reference Committee was advised that several MSSNY physician leaders
 5 were helpful to the creation of the FAIRHEALTH database, an outgrowth of the lawsuits by
 6 MSSNY against United healthcare for its used of manipulated Ingenix database.
 7 However, your Reference Committee is concerned with MSSNY calling for government
 8 intervention. As part of the comprehensive out of network law enacted in 2014, MSSNY
 9 strenuously fought to assure that the FAIRHEALTH database was the benchmark for
 10 calculating UCR. MSSNY fought back against efforts by the health insurance industry to
 11 designate other databases or the woefully inadequate Medicare fee schedule as the benchmark
 12 for out of network coverage. Some legislators even sought to prevent the use of the Fair Health
 13 database because they believed that physicians were artificially inflating UCR values in the
 14 database. In this regard, your Reference Committee was very concerned that MSSNY
 15 publically attacking FAIRHEALTH could cause legislative support for its designation as the out
 16 of network benchmark to erode. Your reference committee was also advised that MSSNY staff
 17 routinely facilitates meetings with FAIRHEALTH staff when physicians raise issues regarding
 18 possible inaccuracies in the Fair Health data. Therefore, your Reference Committee
 19 recommends adoption of the above substitute resolution calling on MSSNY to continue to work
 20 collaboratively with FAIRHEALTH to address concerns raised by physicians instead of seeking
 21 legislation or regulation. Indeed, during the Reference Committee hearing, a representative of
 22 the sponsor of the resolution suggested the above language as a substitute.

23
 24

25 9. RESOLUTION 63 - RESTORING LIABILITY LIMITS

26

27 **THE REFERENCE COMMITTEE RECOMMENDS: THAT SUBSTITUTE RESOLUTION 63 BE**
 28 **ADOPTED IN LIEU OF RESOLUTION 63.**

29

30 **RESOLVED, that the Medical Society of the State of New York seek legislation to restore**
 31 **limits on physician liability to those individuals with whom there is an established**
 32 **physician-patient relationship; and be it further**

33

34 **RESOLVED, that MSSNY in conjunction with its General Counsel continue to educate**
 35 **physicians regarding the consequences of the *Davis v. South Nassau* case which**
 36 **extends to third parties with no patient-physician relationship the right to sue such**
 37 **physician.**

38

39 Resolution 63 asks MSSNY to seek legislative relief to restore limits on physician liability to
 40 those individuals that have established the physician-patient relationship and not to include
 41 third-party individuals.

42

43 Your Reference Committee agrees with the concerns expressed by the sponsor of the
 44 resolution. On December 16, 2015, the New York Court of Appeals in the *Davis v. South*
 45 *Nassau Communities Hospital* decision departed from long held precedent and determined that
 46 “where a medical provider has administered to a patient medication that impairs or could impair
 47 the patient’s ability to safely operate an automobile, the medical provider has a duty to third
 48 parties to warn the patient of that danger”. In that case, a bus driver sued a physician (and the
 49 hospital where he practiced) who gave an ER patient a narcotic when then drove their car into
 50 the bus driver after falling unconscious. While the Court of Appeals opined that the cost to a
 51 physician to fulfill the duty should be a “small one”, because under the duty, the physician only
 52 needs to give the patient warning that the medication administered to the patient may impair the

1 patient's ability to drive, long time MSSNY General Counsel Don Moy has warned that the ruling
 2 could create a "slippery slope" leading to a myriad of other types of treatment where a physician
 3 may be held to owe a duty to the general public rather than just their patients. Therefore, your
 4 Reference Committee recommends that MSSNY take the steps identified in the resolution.
 5 Your Reference Committee also recommended an additional resolved clause that MSSNY
 6 continue to educate physicians regarding the consequences of this court decision.
 7
 8

9 10. RESOLUTION 64 - REINSTATE PARTIAL MEDICARE PART B COINSURANCE
 10 PAYMENTS

11 AND

12 RESOLUTION 65 - REPEAL OF NEW YORK STATE MEDICARE/MEDICAID 20% PAYMENT
 13 CHANGE

14
 15 **THE REFERENCE COMMITTEE RECOMMENDS THAT: SUBSTITUTE RESOLUTION 64 BE**
 16 **ADOPTED IN LIEU OF RESOLUTIONS 64 AND 65.**
 17

18 **RESOLVED, that the Medical Society of the State of New York continue to advocate for**
 19 **legislation to restore New York State Medicaid coinsurance payments for patients**
 20 **insured by both Medicare and Medicaid; and be it further**
 21

22 **RESOLVED, that the Medical Society of the State of New York work with physicians and**
 23 **patient advocacy groups across the State to identify and bring to the attention of**
 24 **policymakers access issues affecting patients as a result of the elimination of Medicaid**
 25 **coinsurance payments for these dually eligible patients; and be it further**
 26

27 **RESOLVED, that the MSSNY delegation to the AMA House of Delegates advance a**
 28 **resolution calling upon the AMA to support federal legislation to require the coverage of**
 29 **the coinsurance payments for patients insured by both Medicare and Medicaid.**
 30

31 Resolution 64 asks MSSNY to:

32
 33 (1) work with New York State Medicaid and the State Legislature to reverse this policy and
 34 reinstate partial Medicare Part B coinsurance payments immediately no matter what the
 35 Medicare reimbursement; and
 36

37 (2) that this matter be forwarded to the AMA for appropriate corrective legislative action at the
 38 federal level, since physicians have unfairly received inadequate payment for services
 39 rendered.
 40

41 Resolution 65 asks MSSNY to:

42
 43 (1) Alert the New York State Department of Health – Office of Medicaid Management
 44 (NYSDOH-OMM) to the real and potential patient access problems resulting from the July 1,
 45 2015 change in payment policy whereby the total Medicare/Medicaid payment to the physician
 46 will not exceed the amount that the physician would have received for a Medicaid-only patient
 47 and if the Medicare payment is greater than the Medicaid fee, no additional payment will be
 48 made, and urge NYSDOH-OMM to have this policy rescinded;
 49

50 (2) Barring any positive resolution as a result of discussions with the NYSDOH – OMM, that
 51 MSSNY seek to have legislation/regulation introduced to repeal the payment policy change
 52 made to New York State Social Services law which was imposed on July 1, 2015; and

1
2 (3) Refer the July 1, 2015 payment policy change to its legal counsel for review and, if
3 applicable, seek injunctive relief to determine if this change was properly vetted and addressed
4 by all impacted parties through the appropriate legislative and regulatory channels.
5

6 Your Reference Committee agrees with the concerns of the sponsors of this resolution and
7 identified by testifiers. As part of the 2015-16 State Budget, the State Legislature and the
8 Governor eliminated the remaining 20% of the 20% Medicare coinsurance for dual eligible
9 patients. For example, for a hypothetical health care service where the Medicare allowed fee
10 was \$200, after Medicare paid \$160, Medicaid would pay \$8 (20% of the \$40 balance – the
11 State Legislature eliminated most of the crossover payments back in 2003). This step has
12 exacerbated financial hardships faced by many medical practices across the State who treat a
13 high number of dual eligible payments, including oncologists and cardiologists. Your Reference
14 Committee was advised that MSSNY advocated in the context of the recently adopted State
15 Budget to have these monies restored, including developed grassroots materials for physicians
16 to use and coordinating its advocacy with lobbyists for oncological groups. While the New York
17 State Senate including funding in its one House Budget proposal to restore this cut, the
18 Legislature and the Governor could not agree to a funding stream in the final State Budget.
19 Therefore, more advocacy on this issue is needed. MSSNY was advised by its General
20 Counsel that, even though a lawsuit brought by MSSNY in the early 1990s challenging
21 crossover cuts at that time was successful, a similar lawsuit brought now would had little chance
22 of success given that the Balanced Budget Act of 1997 gave State Legislatures' authority to
23 eliminate Medicaid coinsurance payments for dual eligible payments. Because both
24 Resolutions 64 and 65 reference the same topic, your Reference Committee recommends that
25 the two Resolutions be combined and adopt the above-referenced action steps. Moreover, your
26 Reference Committee believes that MSSNY should urge the AMA to advocate to Congress to
27 eliminate the law that permits states to eliminate Medicaid crossover payments.
28
29

30 11. RESOLUTION 66 - MEDICARE AND INSURANCE TAKEBACK PROCEDURES

31
32 **THE REFERENCE COMMITTEE RECOMMENDS THAT: SUBSTITUTE RESOLUTION 66 BE**
33 **ADOPTED IN LIEU OF RESOLUTION 66.**
34

35 **RESOLVED, That the Medical Society of the State of New York collaborate with the**
36 **Healthcare Association of New York State (HANYs) and the AMA to ensure when a**
37 **patient hospitalization is retrospectively found not to meet criteria for inpatient**
38 **admission, then the take back amount be only the difference between the cost of the**
39 **admission and the cost of necessary observation for that patient stay; and be it further**
40

41 **RESOLVED, that MSSNY collaborate with HANYs and the AMA to ensure that, for any**
42 **care provided to hospital patients who have Medicare, managed Medicare, or commercial**
43 **insurance, hospitals have the option to rebill denied inpatient claims as outpatient**
44 **claims, when a physician using clinical judgment makes a prospective decision to admit**
45 **a patient who is later not found to meet admission criteria;**
46

47 **RESOLVED, that the MSSNY advocate to assure that the time frame for a public or**
48 **private payer to audit a claim after payment of such claim be limited to the time period**
49 **that a physician or hospital has to submit the claim to such public or private payor**
50 **following the delivery of care; and be it further**
51

1 **RESOLVED, that the Medical Society of the State forward this resolution for**
2 **consideration at the next AMA Annual House of Delegates Annual Meeting.**

3
4 Resolution 66 asks MSSNY to:

5
6 (1) Collaborate with the Hospital Association of New York (HANYs) to ensure when a patient
7 hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take
8 back amount be only the difference between the cost of the admission and the cost of
9 necessary observation for that patient stay;

10
11 (2) Collaborate with HANYs to ensure that for any care provided to hospital patients who have
12 Medicare, managed Medicare, or a commercial insurer that no penalty be levied on the hospital
13 when a physician using clinical judgment makes a prospective decision to admit a patient who
14 is later found not to meet criteria for admission;

15
16 (3) Collaborate with HANYs to ensure that hospitals get paid at least minimum compensation
17 for any care provided to any patient who has Medicare, managed Medicare or commercial
18 hospital insurance; and

19
20 (4) Forward this resolution to the American Medical Association.

21
22 Your Reference Committee agrees with the concerns of the sponsors of the resolution.
23 Hospitals and physicians face great dilemmas in deciding whether to place patients treated in
24 the hospital in "observation" status versus as an "inpatient". Part of the problem is the "two
25 midnight" rule under Medicare which requires a patient to stay in a hospital at least "two
26 midnights" in order to have the admission covered under Medicare Part A. Claims for patients
27 placed in "observation" status are paid at a lesser Part B amount, but there is greater certainty
28 that the claims will be paid. If a claim is submitted as a Part A inpatient admission, and then
29 found by audit that the care should not have been designated as "inpatient", then the amounts
30 paid by Medicare to the hospital must be paid back. Of significant concern, the claim may not
31 even be paid at the lesser "observation" level if the claim is not re-submitted within one year of
32 providing the initial care. This places enormous pressure on the admitting physician to be
33 "correct" in its assessment that the patient should be an inpatient rather than in observation
34 status. A recent change of Medicare policy does provide greater discretion to the physician to
35 assess whether a patient should be "admitted" or in "observation" but it does not fully address
36 this issue. Your Reference Committee was advised that HANYs representatives agreed that
37 assuring at least payment at the observation level would be very helpful, and suggested as well
38 that it was important that the hospital have the opportunity to re-bill the claim as an
39 "observation" claim. In addition, your Reference Committee noted that it is unfair that Medicare
40 and health insurers can review claims for a far longer period of time than the physician or
41 hospital has to submit a claim following the date of service. Therefore, your Reference
42 Committee recommends that the substitute resolution be adopted.

43
44 12. RESOLUTION 67 - REGULATION OF PBM COMPANIES

45
46 **THE REFERENCE COMMITTEE RECOMMENDS THAT: SUBSTITUTE RESOLUTION 67 BE**
47 **ADOPTED IN LIEU OF RESOLUTIONS 67.**

48
49 **RESOLVED, that the Medical Society of the State of New York re-affirm MSSNY policies**
50 **70.974 and 120.939; and**
51

1 **RESOLVED, that the Medical Society of the State of New York continue to advocate for**
 2 **legislation to regulate the practices of Pharmaceutical Benefits Managers; and be it**
 3 **further**

4
 5 **RESOLVED, that the Medical Society of the State of New York continue to advocate for**
 6 **legislation to ensure that physicians have the final say in choosing which medications**
 7 **his or her patients should receive, and limit the ability of PBMs to interfere with the**
 8 **treatment recommendations of a physician prescribing medications for their patient.**

9
 10 Resolution 67 asks MSSNY to:

11
 12 (a) Work for legislation or regulation requiring that drug manufacturers be allowed to directly
 13 distribute their drugs to pharmacies;

14
 15 (b) Ask the New York State Department of Health and Department of Financial Services to
 16 require transparency in the prices of drugs and the sources of price escalation;

17
 18 (c) Work for legislation or regulation requiring the percentage profit of the PBMs be regulated;

19
 20 (d) Ask for investigation of the relationship of PBMs and HMOs or insurance companies, as an
 21 antitrust violation;

22
 23 (e) Work for legislation or regulation prohibiting PBMs from buying physician practices; and

24
 25 (f) Work for legislation or regulation prohibiting PBMs from regulating care.

26
 27 Your Reference Committee agrees with the concerns that led to the advancement of this
 28 resolution. Your reference committee heard extensive testimony regarding Pharmacy Benefits
 29 Managers (PBMs) creating administrative hassles to physicians when they seek to assure their
 30 patients can get the medications they need. While actions by PBMs are regulated by New York
 31 managed care utilization reviews laws that are applicable to health insurance companies and
 32 the agents acting on their behalf, there are no laws that expressly directly regulate PBMs. Your
 33 reference committee was advised that MSSNY has previously adopted policy calling for the
 34 regulation of PBMs. In addition, your reference committee was also advised of legislation that
 35 MSSNY is seeking to address prior authorization hassles, including legislation (A.2834/S.3419),
 36 to assure physicians have an expeditious manner to override any step therapy or fail first
 37 protocol that may be used by an insurer to limit access to a particular medication. While your
 38 reference committee heard overwhelming testimony about the component of this resolution to
 39 regulate PBMs, it heard little regarding other aspects of this resolution. At the same time, your
 40 reference committee was concerned that some of the other suggested changes within
 41 Resolutions 67 are potentially overbroad including calls for drug companies to be permitted to
 42 distribute drugs to pharmacies, antitrust investigation of PBMs, and prohibiting PBMs from
 43 purchasing medical practices. While many of the topics within the resolution potentially had
 44 merit, your reference committee recommended to simplify this resolution to focus the resolution
 45 on the focus of those testifying - assuring stronger regulation of PBMs that are interfering with
 46 physician treatment decisions and creating unnecessary hassles.

47
 48 **70.974 Restrictive Formulary Medication Benefits Plans:** MSSNY supports enactment in the
 49 State of New York of a pharmacy benefits management law that will regulate managed
 50 pharmacy benefit plans to prohibit interference in the doctor patient relationship, to prevent
 51 interruption of ongoing medical care treatment and to promote access to medication that is
 52 consistent with accepted standards of appropriate medical care and treatment, to provide

1 patients with advance notice of benefit limits and the right to pursue external review of
2 medications denied due to formulary restrictions.

3
4 MSSNY supports legislation that requires that where a prescription is denied due to formulary
5 restrictions the prescription drug must be dispensed to the patient for the pendency of the
6 internal or external appeal process.

7
8 MSSNY will educate physicians and patients regarding the right to pursue external review when
9 patients are denied or provided unequal access to medications because of formulary
10 restrictions. (HOD 00-78; Reaffirmed HOD 2001-53; Reaffirmed HOD 2011).

11
12 **120.939 Physician-Directed Medication Access:** The Medical Society of the State of New
13 York will continue to advocate for: Legislation which will ensure that the physician's judgment
14 regarding the necessity of a particular medication for their patient prevails over an insurer's
15 judgment, including for all patients insured through Medicare and Medicaid;

16
17 Legislation or regulation that would prohibit an insurer from denying care for needed
18 treatment or medications unless it is reviewed by a physician of the same specialty as the
19 treating physician; and

20
21 Legislation, regulation, or other appropriate means to assure that health plans consult with
22 appropriate specialty physicians in the creation of formularies and policy regarding drug tiers.
23 (HOD 2015-53)

24
25

26 **13. RESOLUTION 68 - REQUIRE ALTERNATIVE MEDICATION LIST AFTER DENIAL**

27
28
29

**THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 68 BE
ADOPTED IN LIEU OF RESOLUTION 68.**

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**RESOLVED, that the Medical Society of the State of New York advocate to assure that
health insurers provide physicians an alternative list of medications when coverage for
such medication is denied instead of directing them to their website; and be it further**

35
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38

**RESOLVED, that the Medical Society of the State of New York advocate to assure health
insurers create interfaces between physician e-prescribing systems and the insurer's
prescription formulary.**

39
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41

Resolution 68 asks MSSNY to seek regulation to require insurance companies to provide an
alternative list of medications when coverage for the original medication is denied.

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Your reference committee agrees with the concerns of the sponsor of the resolution regarding
the hassles associated with making having health insurers provide coverage for the medications
that patients need. Your reference committee heard testimony and have themselves
experienced numerous situations where a health insurer or PBM referred a physician to a web
site to identify the alterative medication instead of informing such physician over the phone or
having a simple interface with the physician's EMR or e-prescribing system. Such medication
lists are not always easily identifiable on the insurer's website, and can be time consuming to
research. Therefore, your Reference Committee recommends adoption of the above
substituted resolution.

1 14. RESOLUTION 69 – NYS MEDICAL MALPRACTICE INSURANCE MARKET
 2 UNDERGOING UPHEAVAL

3
 4 **THE REFERENCE COMMITTEE RECOMMENDS: THAT SUBSTITUTE RESOLUTION 69 BE**
 5 **ADOPTED IN LIEU OF RESOLUTION 69.**

6
 7 **RESOLVED, that the Medical Society of the State of New York actively monitor and**
 8 **regularly communicate with the Department of Financial Services to ascertain the**
 9 **financial status of the various medical malpractice insurance companies operating in**
 10 **New York State; and be it further**

11
 12 **RESOLVED, that the Medical Society of the State of New York continue to regularly**
 13 **update its members regarding the financial status of these insurers as well as the**
 14 **benefits of obtaining medical liability insurance coverage from a licensed New York**
 15 **insurer, including information regarding the coverage for claims from the existing State**
 16 **guarantee fund in the event that a medical liability insurer becomes insolvent.**

17
 18 Resolution 69 asks the Medical Society of the State of New York to promptly investigate all of
 19 the following:

- 20
 21 1. The public financial status of Physicians Reciprocal Insurers (PRI);
 22
 23 2. The position of the NYS Department of Financial Services on this matter and plans
 24 addressing the matter,
 25
 26 3. The legal implications/responsibilities faced by our members with PRI, specifically
 27 a. The responsibilities of our members should PRI not be able to defend /pay claims
 28 for past dates of service.
 29 b. The protection offered if a physician changes insurers if the coverage is via;
 30 i. Occurrence policy
 31 ii. Claims-made policy
 32
 33 4. Implication of changing insurers if you have a claims-made policy and:
 34 a. You may be entitled to “free” tail coverage based upon age and duration of policy
 35 from an old insurer
 36 b. You may soon be entitled to “free” tail based upon age and duration of policy
 37 from an old insurer; and be it further
 38

39 The resolution also asks MSSNY publish this report promptly to our members and share same
 40 with the Department of Insurance and our legislators.
 41

42 Your Reference Committee heard testimony regarding the concerns with the financial stability of
 43 medical liability insurer PRI, which writes policies for many New York physicians. Your
 44 reference committee was advised that it would be very unlikely for PRI to be declared insolvent
 45 by the Department of Financial Services since there is a law that has been in effect for many
 46 years that makes it very difficult for DFS to declare a medical malpractice insurer insolvent
 47 unless it “Is found, after examination, to be in such condition that its further transaction of
 48 business will be hazardous to its policyholders, creditors, or the public”. Moreover, even if PRI
 49 were to go insolvent, since it is a licensed New York medical malpractice insurer then
 50 malpractice claims up to \$1 million would be paid from a Guarantee Fund. However, your
 51 reference committee believes it is important to again remind physicians the fact that this
 52 Guarantee fund does not apply if a physician receives medical liability insurance coverage from

1 a non-regulated company such as a risk retention group. Therefore, your reference committee
2 recommends adoption of the substituted resolution that would have applicability to all
3 physicians, not just those who are insured through PRI.

4
5
6 **15. RESOLUTION 53 - EXPANSION OF IDR PROCESS**

7
8 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 53 BE REFERRED**
9 **TO COUNCIL.**

10
11 Resolution 53 asks MSSNY to seek legislation/regulation expanding the role of the Independent
12 Dispute Resolution process (as established by the Surprise Medical Bill law which went into
13 effect on March 31, 2015), to include ALL denials/reductions in benefit payments by health
14 plans for medically necessary services provided by physicians and not have the IDR process
15 limited to “emergency services” by out of network practitioners.

16
17 Your Reference Committee is sympathetic to the concerns of the sponsors of the resolution.
18 Your Reference Committee heard testimony regarding the need for an expedited mechanism to
19 resolve claims where an insurer denies or reduces payment. The IDR process referred to in the
20 resolution, enacted in 2014, is currently applicable for the claims of out of network physicians
21 who provide “emergency” patient care or where such physicians’ involvement in a patient’s
22 treatment in a hospital or ambulatory surgical center is considered to be a “surprise” to the
23 patient. To encourage a swift resolution to this process, and to better assure physicians are
24 paid promptly for the care they have provided, the statute requires that a decision by IDR entity
25 be made within 30 days of the submission of the dispute to IDR. Your Reference Committee
26 was concerned that permitting all care denials or reductions in payment to be appealed to this
27 IDR mechanism could cause significant delays for resolving existing out of network claims
28 submitted to the IDR process. Moreover, there are multiple mechanisms for physicians to
29 appeal such denials or reductions, including taking an External Appeal when a claim has been
30 denied (which requires the review of physicians in the same or similar specialty), or filing a
31 Prompt Payment complaint to the Department of Financial Services. It was unclear how
32 whether this resolution would supersede these existing remedies, or whether the physician
33 would have a choice of which remedy to pursue. Given these questions, as well as concerns
34 with interfering with the functioning of the recently implemented IDR process, your Reference
35 Committee recommends that this resolution be referred.

36
37
38 **16. RESOLUTION 62 - MEDICAL MALPRACTICE REFORM TO MEDICAL INJURY**
39 **COMPENSATION (NO-FAULT)**

40
41 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 62 NOT BE**
42 **ADOPTED.**

43
44 Resolution 62 asks MSSNY to urge New York State to institute a system to compensate
45 patients for injuries arising from medical treatment, omitting the requirement that the clinicians
46 involved be proven negligent.

47
48 Your Reference Committee is sympathetic to the concerns that prompted the bringing of this
49 resolution. For decades many commentators have suggested that medical liability claims be
50 removed from the current tort system and instead be addressed through a No-Fault system that
51 is suggested by this proposal, going back to first commission to study New York’s medical
52 malpractice system in the mid-1970s. MSSNY has adopted multiple policies (130.953 and

1 130.993) calling for support for legislation to establish a No-Fault system for adjudicating the
2 claims of neurologically impaired infants. However, the Patient compensation system
3 contemplated by this resolution goes far beyond the claims of N/I infants and MSSNY has not
4 adopted policy in either support or opposition to creating a broad No-Fault system for medical
5 liability cases.

6
7 Your Reference Committee also heard extensive testimony in opposition this resolution. In
8 addition, the committee was advised that legislation such as that suggested in this resolution
9 has been opposed by other state medical societies, including Florida, Georgia and Tennessee.
10 As part of a document setting forth why it opposes this proposal, PIAA noted "Proponents of the
11 no-fault approach (sometimes referred to as a patient compensation system) fail to note several
12 important facts, one of which is that 70% of all medical liability claims filed are found to be
13 meritless and result in no payment. The no-fault approach would change the system by paying
14 most if not all of these claims. In addition, it would likely pay additional claims that so obviously
15 lack merit they are not even filed today. The end result is that dramatically more funds will be
16 paid to individuals who are not victims of medical negligence." There was also concern with
17 these claims being reported to the NPDB.

18
19 Moreover, last year a similar resolution was rejected by the MSSNY Council (after it was
20 referred from the HOD). The rationale was that, since MSSNY already has many other
21 preferable tort reform advocacy goals contained within its Legislative Program, such as a cap
22 on non-economic damages, expert witness reform, Certificate of Merit reform and medical
23 courts, MSSNY should continue to devote substantial advocacy efforts to achieving these goals.
24 A similar resolution was also brought to the AMA House of Delegates at the 2015 Interim House
25 of Delegates where it was referred for further study. Therefore, given the concerns with the
26 possible costs of this proposal, the fact that it has been previously opposed, as well as the fact
27 that it is under review by the AMA, your Reference Committee recommends that this Resolution
28 not be adopted.

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Your Chairperson is grateful to the Committee Members, namely, Stephen Wade, MD, Michael Pisacano, MD, William Barrick, MD, Terence Clarke, MD, William R. Spencer, MD, and Pratistha Koirala.

Your Reference Committee Chairman also wishes to express his appreciation to Morris "Moe" Auster, Esq., Anna Cioffi for their help in preparation of this report.

Respectfully submitted,

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