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MEDICAL SOCIETY OF THE
STATE OF NEW YORK

2013 Legislative Program

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The Medical Society of the State of New York’s Division of Governmental Affairs wishes to express its gratitude to the following County Medical Societies and Specialty Societies for their invaluable assistance in the preparation of our 2013 Legislative Program.

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New York State Radiological Society  
New York Chapter, American College of Surgeons
New York Society for Surgery of the Hand  
New York State Thoracic Society
PROLOGUE

I am pleased to introduce you to MSSNY’s Legislative Program for 2013. MSSNY advocates for New York physicians of every specialty and from every region, as well as the patients these physicians serve. This Legislative Program will outline our legislative goals for the upcoming year.

The devastation caused by hurricane Sandy exemplifies how crisis and critical challenges can affect our profession and our state. So too it highlights the importance of working together to improve the lives of our friends, families, patients and colleagues. To this end, the members of the Medical Society, an Association with an over two hundred year history of devotion to service, stands ready to assist in recovery and reconstruction efforts for Sandy, and our emergency preparedness agenda remains high in importance.

We are witnessing unprecedented times of change for this profession, but also significant challenges in the ability of the health care system to serve out its duty to the public. The landscape of our vast and complex healthcare delivery system is changing economically, structurally and technologically. Such changes should not interfere with the ability of patients to access medical care. As physicians, we heal the patients, but working together with our policymakers we must repair the ailing healthcare system. Our legislative goals are designed to assure patient access to high quality and affordable medical care within these emerging models of care delivery.

We are committed to working with our legislative representatives toward accomplishing these goals as outlined in the program.
# MEDICAL SOCIETY OF THE STATE OF NEW YORK
## 2013 LEGISLATIVE PROGRAM
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**CONCLUSION**  
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I. PRESERVING PATIENTS’ ABILITY TO SEE THE PHYSICIAN OF THEIR CHOICE

The stability of New York’s health care system is under duress due to the multitude of factors which are making it harder for physicians to remain in practice. Physicians are being squeezed between extraordinary overhead costs, led by the startlingly high cost of medical liability insurance, and decreasing payments from health insurers and Medicare. Moreover, physicians face administrative burdens like never before. Completing and updating credentialing forms, federal government reporting mandates, complying with time-consuming pre-authorization requirements for needed medical care and referrals, and confirmations of eligibility, etc. all consume hours upon hours of time that take time away from taking care of patients.

It’s certainly understandable why many physicians are choosing the route of becoming employees – lessening their paperwork burden and providing more time to actually be a doctor. Moreover, many physicians, particular older physicians, have indicated that they are simply “fed up” and are strongly considering retiring early or moving to other states with more favorable practice and business environments.

MSSNY supports the concept that a physician should be free to define a business model to practice medicine that is most appropriate to that physician and his/her patients, whether that be as part of a solo or small practice, as part of a large group, or as an employee of a hospital. However, legislation is needed to preserve the ability of physicians to have a meaningful choice as to which practice environment suits them best, so as to protect the sanctity of the physician-patient relationship, and patients’ ability to obtain care from the physician of their choice.

A. THE NEED TO REFORM NEW YORK’S LIABILITY SYSTEM

Many New York physicians must pay extraordinary medical liability premiums to remain in practice. After a precipitous jump (up 55-80%) in premiums from 2003 to 2008 followed by two years of legislatively mandated “freeses”, premiums have continued to rise. Currently, many New York physicians pay premiums that far exceed $100,000 and in some cases even exceed $300,000. These costs are not sustainable.

Faced with similar problems, many other states have passed comprehensive medical liability reform legislation. According to the Texas Alliance for Patient Access, 90% of Texas physicians have seen a minimum 30% reduction in their premiums since the enactment of comprehensive reform there in 2003. In Los Angeles, California, in a state where strong medical liability reforms were enacted in the mid-1970s, Ob-GYNs pay less than 1/3 the premiums that New York physicians pay. As noted below, in both these states, medical liability premiums have gone down significantly since 2003 while the opposite has occurred in New York.

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<th>COMPARISON – NY OB-GYN PREMIUMS VS. CA &amp; TX</th>
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<td>California (Los Angeles, Orange)</td>
</tr>
<tr>
<td>Texas (Brownsville, Laredo, El Paso)</td>
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<tr>
<td>New York (Long Island)</td>
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2004 Premium
2007 Premium
2011 Premium

Source: Medical Liability Monitor, 2011

The problems of the medical liability adjudication system do not just impact physicians – they impact the cost of all health care. Several studies have shown that billions of dollars are unnecessarily spent each year due to the
practice of defensive medicine, such as unnecessary MRIs, CT scans and specialty referrals. A 2009 study by the Congressional Budget Office (CBO) showed that enactment of medical liability reforms would reduce the federal deficit by $54 billion over 10 years largely due to reducing defensive medicine. The group Patients for Fair Compensation recently estimated that enactment of comprehensive medical liability reform could actually reduce defensive medicine costs by $650 billion.

Some positive steps have occurred to begin to address this problem, including the establishment of a medical indemnity fund and Office of Court Administration demonstration projects to facilitate early negotiation of medical liability allegations. While promising, these programs have yet to produce tangible premium relief. We must do more. New York must follow the lead of the many, many other states who have passed legislation to bring down the gargantuan cost of medical liability insurance. Similar action must be taken on the federal level. Among the measures which must be enacted include:

- Medical Liability Tort Reforms
  - Reasonable Limits on Non-Economic Damages
  - Identifying and Assuring Qualified Expert Witnesses
  - Eliminating Joint and Several Liability
  - Identifying physician supplying a Certificate of Merit
  - Immunizing statements of apology or regret
  - Immunity for physicians providing pro bono care

- Creating Alternative Systems for Resolving Medical Liability Cases
  - Neurologically Impaired Infants No-Fault fund
  - Promoting medical courts

- Assuring Adequate Funding for Excess Medical Liability Insurance Program

- Requiring hospitals to provide tail liability coverage for employed physicians

B. PREVENTING UNTENABLE EXPANSIONS OF LIABILITY

At the same time that physicians and hospitals faced unprecedented efforts to constrain the costs of health care by policymakers and insurance companies, others continue to pursue legislation that would radically increase already overwhelming liability insurance costs. MSSNY will continue to oppose any measure to expand the damages recoverable in medical liability actions, including legislation that would:

- Create a “date of discovery” rule for the statute of limitations in medical liability actions – Estimated to increase premiums by 15%.
- Expand “wrongful death” damages to permit “pain and suffering” – Estimated to increase premiums by 53%.
- Permit the awarding of pre-judgment interest in tort actions – Estimated to increase premiums by 27%
- Eliminate the current statutory limitations on attorney contingency fees in medical liability cases – Estimated to increase premiums by over 10%.
- Prohibit ex-parte interview by defense counsel of the plaintiff's treating physician.
- Require a non-settling defendant to choose before trial whether to reduce their liability by either 1) the amount paid by the settling defendant or 2) by the equitable share of the settling defendant as determined by the jury

C. ASSURING FAIR PAYMENT FOR PATIENT CARE

Permitting Physicians to Collectively Negotiate

Most regions of New York State are dominated by just one or two health insurance behemoths. This market power enables these insurers to dictate the specifics of physicians’ contracts and tell them to “take it or leave it.” There is
little if any ability to negotiate. A physician who does not accept these contracts risks losing the ability to provide care to a large number of patients. As a result, most physicians simply cannot afford to walk away.

It is our patients, however, who most often bear the brunt of this market dynamic because the physicians’ inability to negotiate result in the imposition of unnecessary barriers for patients in need of care. These barriers include: cumbersome pre-authorization processes that delay our patients from receiving needed care and testing; arbitrary limitations on necessary prescription medications; and overly aggressive hurdles imposed to limit patients’ ability to receive care from the specialist physician of their choice.

“There is a need to restore fairness in the contracting process between health care providers and large managed care plans by allowing such providers to join together to negotiate contract provisions. That’s exactly what this legislation is designed to do,” - Senator Kemp Hannon, News LI.com, June 23, 2011

To address this inequity in negotiating power, MSSNY is urging the New York State Legislature to enact legislation that would permit independently practicing physicians to come together under close state supervision to collectively negotiate participation contracts with health insurance plans. The bill would enact in New York State a “State Action exception” to federal antitrust rules that was articulated by the US Supreme Court in a landmark 1943 decision that permitted collective action under close state supervision to vindicate legitimate public interests. While the Federal Trade Commission (FTC) does not favor “state action immunity” exceptions to federal jurisdiction, the exception is well recognized and has been enacted in a number of states. MSSNY will also work with the American Medical Association to seek enactment of legislation on the federal level to permit collective negotiation by physicians, as well as to limit antitrust exemption provisions afforded to health insurers that may permit them excessive domination and anti-competitive control over physicians in any given market.

These legislative reforms are badly needed. With insurer consolidation, regional markets continue to be further dominated by a dwindling number of health insurance behemoths. According to a 2012 report from the American Medical Association, 85% of the enrollees in the commercial managed care market in New York State were enrolled in just 5 health insurance companies.

NEW YORK HEALTH INSURANCE ENROLLMENT

<table>
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<th>MSA</th>
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<th>Insurer 2</th>
<th>Share % of Top Two Insurers</th>
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<tr>
<td>Albany-Schenectady-Troy</td>
<td>CDPHP (31%)</td>
<td>Wellpoint (21%)</td>
<td>56%</td>
</tr>
<tr>
<td>Binghamton</td>
<td>Excellus (45%)</td>
<td>United (23%)</td>
<td>68%</td>
</tr>
<tr>
<td>Buffalo-Cheektowaga-Tonawanda</td>
<td>Health Now (48%)</td>
<td>Independent Health (19%)</td>
<td>67%</td>
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<tr>
<td>Poughkeepsie-Newburgh-Middletown</td>
<td>Wellpoint (32%)</td>
<td>United (26%)</td>
<td>58%</td>
</tr>
<tr>
<td>Syracuse</td>
<td>Excellus (45%)</td>
<td>United (21%)</td>
<td>66%</td>
</tr>
<tr>
<td>Rochester</td>
<td>Excellus (43%)</td>
<td>MVP (36%)</td>
<td>79%</td>
</tr>
<tr>
<td>Nassau-Suffolk</td>
<td>Wellpoint (39%)</td>
<td>United (31%)</td>
<td>70%</td>
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Source: AMA, Competition in Health Insurance, 2012 Update
Moreover, according to the AMA report, almost all regions of New York State have substantial market domination by just one or two health insurers.

The new dynamic created by this legislation will not increase the cost of health care but will re-distribute existing dollars away from insurance company profits and to the provision of necessary care for patients. Moreover, reductions in cost would result from greater standardization of administrative procedures which often now vary from plan to plan. Perhaps most importantly, the bill grants broad powers to the State to prevent joint health care provider negotiations from going forward if it is believed that such negotiations would have an adverse impact on patient access to care, including concerns regarding increases in the cost of health care.

With health insurance company domination likely to grow in New York as a result of the creation of its Health Insurance Exchange, as well as implementation of the mandate to purchase health insurance, we must protect the ability of the patient’s physician to be an advocate for the patient.

**Transparency and Fair Payment for Out of Network Care**

Many employers and individuals choose insurance plans that permit them to receive care from the physician of their choice. However, several insurance companies have made this coverage option more theoretical than real. Legislation must be enacted to assure that employers and patients get the coverage they paid for. Without it, patients could face a major financial burden should they or their family members find themselves in need of highly specialized medical care.

As Attorney General, Governor Cuomo sought to end deception in out of network coverage by requiring health insurers to discontinue the use of the flawed Ingenix database. The database, maintained by a wholly owned subsidiary of United Healthcare, was manipulated to delete higher charges which resulted in much higher than necessary out of pocket costs for patients. The fines received from the insurers, totaling nearly $100 million, were directed to create a new entity, FAIR Health, to create a database to assure patients have accurate information regarding the true cost of out of network medical care. However, several insurance companies have essentially tried to “end run” the settlement by switching to methodologies for covering out of network care, such as a percentage of the woefully inadequate Medicare fee schedule, that result in grossly insufficient payments from insurers. This leaves the patient with staggering out of pocket responsibilities. This problem was extensively documented in 2012 articles in the *New York Times* and *Daily News*.

“The switch ‘certainly creates the appearance that insurers are trying to end-run the settlement and keep out-of-network payments low’,” – DFS Superintendent Benjamin Lawsky, April 24, 2012 *New York Times*

MSSNY supports legislation to require health insurers to clearly disclose to patients and employers the scope of their out of network coverage, set as a percentage of the likely costs of care as set forth in the FAIR Health database. Moreover, MSSNY supports legislation to require health insurers offering a policy for out of network coverage to assure that there is significant coverage of such costs.

**Preventing Overbroad Audits**

Some health plans seek to recoup payments from physicians years after making payment. Contesting these repayment demands is difficult and requires extraordinary legal and other defense costs. These plans impose a variety of tactics to intimidate physicians into settling the dispute, sometimes at a cost of tens of thousands or even hundreds of thousands of dollars. While the Legislature passed a law in 2006 that took initial steps to limit the timeframe for such refund demands, further reforms are needed.

MSSNY supports legislation to reduce the time within which health plans can demand such refunds, as well as to assure that meaningful fines and penalties are imposed on health plans which inappropriately allege abusive billing or fraud to evade the statutory time limit for demanding such refunds. Moreover, MSSNY supports legislation to prohibit a health plan from determining a demanded refund amount through extrapolation of only a few reviewed charts.
Moreover, such take-backs should never occur where the plan has given pre-authorization for care. A 2007 law established a general rule prohibiting health plans from subsequently denying coverage for care it pre-authorized, but there are several exceptions to that law. To address this problem, MSSNY will seek the enactment of legislation to provide greater assurance that care pre-authorized by a health insurer is paid and not subsequently recouped.

**Creating Administrative Simplification**
MSSNY supports legislation or other means to limit the obstacles placed by some insurers on the ability of patients to receive the care recommended by their physician, as well as to assure physicians are paid fairly for providing this care. One recent study showed that physicians spent the equivalent of three work weeks annually on administrative tasks required by health plans, with a cumulative cost of $31 billion, and a per physician cost of nearly $70,000. MSSNY supports a number of measures to reduce the administrative hassles experienced by physicians, and expand the time they can devote to providing patient care, including:

- Reducing Burdens to Obtaining Prior Authorization including requiring health plans to use appropriately trained physicians to review medical necessity decisions and compensating physicians for excessive time spent obtaining such authorizations;
- Assuring Continuity in Prescription Drug Coverage when formularies/prescription tiers change;
- Requiring insurers to follow uniform code review policies;
- Hastening the time frame for insurers to make payment of physician claims;
- Assuring inclusion of patient cost-sharing information on Health Plan ID cards;
- Assuring fair payment for facility fees for physicians to cover significant overhead cost of maintaining certification for office-based surgical practices.

![Average Practice Cost of Interacting with Health Plans by Specialty](image)

*Source: Changes in Healthcare Financing & Organization, March 2010*

**Fair Workers Compensation/No-Fault Reform**
MSSNY supports legislation to assure the continued availability of physicians to provided needed care to injured workers and auto accident victims, including:

- Assuring fair payments for medical care to injured workers;
- Reducing undue administrative burdens;
- Preventing rigid implementation of the Workers Compensation Medical Guidelines;
- Limiting the Use of Diagnostic Radiological Networks;
- Opposing inappropriate limitations on No-Fault claims submissions;
- Providing coverage for Necessary Care Provided to Intoxicated Drivers.
D. FEDERAL ISSUES AFFECTING ACCESS TO CARE

Urgent Need for Reform of the Flawed Medicare Payment Formula

Unless action is taken by Congress, physicians face a draconian 27% cut in their Medicare payment on January 1, 2013. While Congress has repeatedly passed measures over the last decade to prevent the imposition of these cuts, the short-term fixes and recent tendency of Congress to retroactively fix the cuts has left many physicians concerned and doubtful whether their offices can sustain continued participation in the Medicare program.

These cuts are driven by a flawed formula called the Sustainable Growth Rate (SGR) which penalizes physicians by lowering their payments when growth in the use of medical care exceeds the GDP. This is done despite the fact that service use is driven by factors outside physician control such as patient health needs, emerging technology and public policy changes. When factoring in cuts to the Medicare conversion factor in 2002 along with some very minor increases in the conversion factor since then, Medicare payments are on average level with what they were 10 years ago. These cuts must be prevented and the SGR formula must be repealed.

Support Medicare Patient Empowerment Act

It is imperative that Congress consider alternative solutions to fix this SGR problem if we are to assure that seniors will continue to have access to their physicians. One such solution is legislation, the Medicare Patient Empowerment Act, that would permit Medicare patients to have the option to privately contract with the physician of their choice, regardless of such physician’s participation status in Medicare, with CMS providing the patient with a partial contribution towards the cost of such care.
Repeal of the Independent Payment Advisory Board
MSSNY supports legislation to repeal the Independent Payment Advisory Board (IPAB). A component of PPACA, the purpose of the IPAB is to make recommendations to Congress to cut Medicare spending and payments starting in 2015. Particularly problematic is the requirement that the recommendations of the IPAB will go into effect unless a supermajority of Congress enacts legislation to prevent such cuts, a task which likely will be extremely difficult. This would give the unelected members of IPAB extraordinary powers to reduce Medicare reimbursement and threaten seniors’ access to care.
II. ENHANCING QUALITY OF CARE

A. PHYSICIAN LED TEAM-BASED CARE IS BEST FOR PATIENTS

Patients benefit most from the combined care of a team, headed by a physician, whose education and training enables them to oversee the actions of the rest of the team to provide the patient with optimal medical treatment. MSSNY supports this concept and will continue to work toward achieving this goal. MSSNY opposes any expansion of scope of practice of non-physician health care providers that will enable them to practice beyond their education and training, and/or without physician supervision, collaborative agreement, or required physician referral. Specifically, MSSNY opposes expansion or creation of scope of practice for:

- Nurse practitioners independent practice;
- Nurse anesthetists independent practice;
- Naturopaths providing primary medical care;
- Oral and maxillofacial dental surgeons performing surgery unrelated to dental health;
- Optometrists prescribing certain therapeutic pharmaceutical agents;
- Pharmacists conducting medical assessments, ordering or interpreting lab tests;
- Nurse practitioners to admit a patient to an inpatient mental health unit or to become a “psychiatric examiner” to evaluate a defendant’s fitness to stand trial; and
- Any other scope of practice expansion that could negatively affect patient outcome

MSSNY will seek to preserve the term “physician” for the exclusive use of MDs and DOs, or their foreign equivalents. It is vital that patients are made aware of the credentials of the health care provider caring for them. MSSNY will oppose legislation that would alter the corporate practice of medicine by allowing limited license providers to be business partners with physicians in a medical practice. MSSNY will also seek to define “surgery” and limit its performance to licensed physicians, dentists and podiatrists, as appropriate. MSSNY will seek enactment of a Truth in Advertising law to assure that the advertisements of all health care professionals adequately inform the public of their own professional credentials. Additionally, MSSNY will work to educate the public and policymakers of the potential negative implications on continuity of patient care and quality outcome which are presented by the development of the retail clinic care delivery model. MSSNY will also seek legislation to provide for the licensure of medical assistants, anesthesia assistants and assistants in orthopedic surgery and regulating the practice of such professionals. MSSNY will proactively work with the Office of the Professions and the Department of Health to protect against pharmacists who inappropriately advertise what immunizations they are allowed to administer.

B. ENHANCING QUALITY OF CARE THROUGH PEER REVIEW

Current law impedes peer review by permitting Trial Bar access to statements made at a peer-review meeting by a physician who subsequently becomes a party to a malpractice action which involves the conduct which was the topic of the discussion at the peer-review meeting. MSSNY will work to enact legislation which would extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees within hospitals and in office-based settings. MSSNY will also advocate to protect from discovery by OPMC any statements made or information obtained during the course of a peer-review proceeding.

C. ENHANCING CARE THROUGH E-PRESCRIBING

E-prescribing is one of several solutions advanced to improved patient safety and quality of care through clinical decision support and ready access to patient medication history. Legislation enacted in 2012, requires the creation of a “real time” prescription drug monitoring registry to provide enhanced information to prescribers and pharmacists concerning prescriptions obtained by patients for controlled substances. This law also mandates the electronic submission of all prescriptions by December 31, 2014. Regulations setting forth standards for e-prescriptions will be promulgated by the end of 2012. The law requires that the registry be compatible with e-prescribing technology which for the first time will facilitate the electronic transmission of controlled substances. The federal regulations specifically require software with two-factor identification for e-prescribing of narcotics. These products are slowly being certified and marketed. Not all physicians, however, are interested in purchasing e-prescribing technology. The law does provide certain exceptions to the e-prescribing mandate and
allows for the issuance of a renewable one year waiver to physicians who can demonstrate economic hardship, technological limitations that are not reasonably within the control of the physician, or other exceptional circumstance. MSSNY will work to assure that the waiver process is available to physicians for whom purchase and implementation of e-prescribing technology is impractical. Additionally, MSSNY will work to assure the simplification of the process by which a physician secures an exception to use a paper prescription. MSSNY will also work to assure that the technologies used as part of the prescription drug monitoring registry are compatible with all e-prescribing systems so that physician consultation with the registry is streamlined. Moreover, MSSNY will work to enable registered nurses working with a physician to be authorized to send an electronic prescription to the pharmacy much like a prescription today is phoned into a pharmacy by a nurse upon the verbal order of a physician.

D. ELIMINATION OF HEALTH CARE DISPARITIES

MSSNY’s Committee to Eliminate Health Care Disparities works to ensure that all New Yorkers receive the best possible care. This work includes attracting a more diversified physician workforce, increasing the numbers of minority faculty teaching in medical schools, expanding medical school pipeline programs in rural and urban areas, and adoption of legislation that addresses the root problems. The Committee, in conjunction with the American Medical Association, conducts Doctors Back to School programs, in which physicians go into middle and high schools in areas with high minority populations and talk to students about choosing medicine as a career. Cultural Competence and Health Literacy are both extremely important aspects of providing optimum health care to minority populations. Securing private reimbursement for language services for patients with limited English proficiency is essential. The collection and aggregation of health care and demographic data on a regional and institutional level is also necessary to facilitate analysis by race and ethnicity. MSSNY’s long-standing commitment to finding real solutions to improve access to high-quality medical care for all New Yorkers is reflected in the work of its Committee to Eliminate Health Care Disparities.

E. ATTRACTING AND RETAINING PHYSICIANS IN NEW YORK STATE

The Center for Health Workforce Studies reported recently that the in-state retention of new physicians has gradually declined from a high of 54% in 1999 to a low of 44% in 2011. “Proximity to family” is the main reason cited by new physicians who plan to practice outside of New York. When physicians were asked to report all reasons for leaving New York, 60% indicated better salary offered outside New York, followed by more desirable locations outside New York (56%) and cost of living in New York (50%). This is particularly troubling as demand for physician services continues to outpace physician supply, particularly in ophthalmology, urology, psychiatry, pathology, general internal medicine, general/family medicine, and otolaryngology. There are areas of the state and populations that are already underserved by the current physician supply. The implications of the forecasts for these areas and populations are dire. New York must do more to attract and retain physicians. New York must:

- Reduce the overhead burden shouldered by physician practices through meaningful civil justice reform.
- Enhance revenue to physician practices by leveling the playing field for physicians in their negotiations with health insurers and by assuring the offering of out of network coverage which significantly reimburses for the reasonable cost of services.
- Continue an adequately funded Excess Medical Liability program to assure that physicians will have the coverage needed to protect them from personal financial exposure to escalating medical liability awards.
- Put additional resources toward the Doctors Across New York program and modify eligibility to assure a more equitable balance of awards between institutionally based and private practice physicians.
• Assure that the State Education Department’s International Medical School Advisory Committee appropriately addresses issues associated with access of medical students attending offshore medical schools to long-term clinical clerkship programs in New York State.
• Create income tax credits for physicians who practice in specialty shortage areas.
• Defeat any proposal to directly or indirectly tax medical services, medical devices or products or sites of service.
• Defeat any proposal to increase the biennial physician registration fee.

F. CONTINUE STATUTORY RECOGNITION AND FUNDING FOR THE COMMITTEE FOR PHYSICIANS’ HEALTH

The Medical Society will work to secure the continuation of the statutory authority for the operation of the Committee for Physician’s Health (CPH) program to enable CPH to identify, refer to treatment and subsequently monitor physicians impaired by chemical dependency or psychiatric illness. The Committee’s authorization is slated to expire on June 30, 2013. The Committee for Physicians’ Health has been reviewed by the Department of Health throughout its operation and has been found to be a strong, professionally managed, clinically sound program which meets the needs of the physicians it serves and the expectations of the Department of Health and the Legislature which periodically authorized its continuation. There has been no increase in the fee which underwrites the work of CPH since the establishment of the program. Over the same period of time, CPH has tripled its volume and expanded its services. The work of CPH would be greatly enhanced by increasing the monies allocated to CPH. The Medical Society will work to assure that additional monies are allocated to sustain the work of the Committee for Physicians Health.
III. PUBLIC HEALTH

A. PRESERVING NEW YORK’S PUBLIC HEALTH

Public health is community health and is the basis for people to live long, healthy lives. A key component of public health is the prevention strategies that help promote “good health” and are some of the prevention strategies contained in the national health care reform. For New York State, the key is providing resources to communities, including physicians, remains an important component of good public health. By creating population-based programs to address the main causes of disease, disability and health disparities, in conjunction with stronger health care coverage and delivery, will ultimately lead to improved health outcomes for New Yorkers. Encouraging healthy behavior through legislation or taxation has become an important tool in achieving some of the recent goals of public health. The New York State Public Health and Planning Council’s Public Health Committee has established an Ad-Hoc Committee of which the Medical Society is a member. This Ad-Hoc Committee will lead the development of New York’s next five year state health improvement plan for the period 2013-2017.

B. PREVENTION OF CHRONIC DISEASES

The Medical Society of the State of New York believes that primary prevention of diseases is important to the health and well-being of all New Yorkers. The Medical Society believes that a component of the state’s Essential Health Benefits must include coverage for many preventive screening measures such as blood pressure, diabetes, and cholesterol tests, mammograms and colonoscopies. Heart disease is still the leading cause of death for all Americans; and stroke ranks as the third leading cause of death. High blood pressure, elevated cholesterol, lack of physical activity, poor nutrition and tobacco use are the primary risk factors for CVD and Stroke. Cancer is the second leading cause of death in New York State. Screening and early detection are the best strategies in fighting cancer. MSSNY continues to support initiatives to reduce the incidents of obesity in New York State. The Medical Society is a strong proponent of a healthy lifestyle and has developed policies in support of good nutritional choices for all New Yorkers. The Medical Society has advocated strongly for screening programs as a mechanism for preventing the burden of these chronic diseases. We note that under health care reform counseling will be offered to individuals for quitting smoking, losing weight, eating healthfully and reducing alcohol use.

C. IMMUNIZATIONS AND INFECTIOUS DISEASES

Disease prevention is the key to public health. Vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals. Vaccines are responsible for the control of many infectious diseases that were once common in the United States, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenza type b (Hib). Immunization is a sound public health policy and one that this country has chosen to implement. The Medical Society supports universal state purchase for all vaccinations and will continue to oppose any further religious, medical or philosophical exemptions to New York State law. The Medical Society also supports the administration of Human Papillomavirus (HPV) Vaccine to females and males as means of preventing the transmission of HPV, cervical cancer and HPV-associated disease to individuals. In addition, the Medical Society supports the immunizations of adults to prevent diseases including the Hepatitis B. The Medical Society advocates for use of the adult and child schedule for immunizations as developed by the Advisory Council on Immunization Practices (ACIP). Sexually Transmitted Diseases (STDs) are one of the most the nation’s critical public health challenges today. The Centers for Disease Control and Prevention (CDC) estimates that there are estimates that there are 19 million new infections every year in the United States and young people account for nearly half of all cases. According to the CDC, STD screening can help detect disease early and, when combined with treatment, is one of the most effective tools available to protect one’s health and prevent the spread of STDs to others. MSSNY will continue to advocate for early screening and testing for STDs. Early detection of the HIV infection means that infected patients will have the opportunity to live years longer when treatment is initiated prior to the development of symptoms. The Medical Society continues to support the routinization of HIV testing for individuals ages 13-64.
D. PUBLIC HEALTH PREPAREDNESS, ENVIRONMENTAL AND GLOBAL HEALTH

The continued need to prepare New York State residents for a public health emergency in New York State was reinforced last year with the advent of Hurricane Irene and Hurricane Lee and the subsequent flooding wreaked havoc on upstate New York with flooding. The after affects continued as many upstate residents struggle to put their lives back together. The advent of Hurricane Sandy, the destruction, the flooding and the overall financial costs to New York State, has now made preparedness an imperative. The Medical Society is committed to helping to prepare residents and physicians for the next public health emergency and will continue to educate physicians on emergency preparedness. The Medical Society is pleased that the New York State DOH Commissioner of Health Nirav Shah, MD will identify the most qualified outside experts to advise him in the review of hydraulic fracturing and its impact of public health. Only after the DOH evaluation is completed will a decision be made to permit high volume hydraulic fracturing in New York State. The Medical Society of the State of New York in 2010 developed policy calling for a moratorium on hydraulic fracturing until such time as a health assessment was conducted.

E. REPRODUCTIVE HEALTH, HEALTHY WOMEN AND CHILDREN

Nationally, uninsured women account for 20% of the population of women ages 18 to 64. Many lower income women historically did not qualify for Medicaid, did not have access to employer-sponsored coverage, and either could not afford insurance or qualify for individual policies. Health reform holds the potential to greatly expand access to coverage for millions of currently uninsured women and stabilize coverage for many more. This insurance coverage means that women will have access to care without copays for many prevention screening components such as mammography, reproductive care, pre-natal and maternal care. Ensuring that women have access to reproductive and sexual health care services can help to reduce unintended pregnancy, and help to promote knowledge about screening and services available. Preconception and prenatal care are essential in reducing birth defects and low birth rates. The Medical Society will continue to support health and sexual health education amongst adolescents, and will continue to support the regional perinatal centers. The Medical Society of the State of New York will oppose any legislation that criminalizes the exercise of clinical judgment in the delivery of medical care. The Medical Society supports efforts to expand access to emergency contraception, including making emergency contraception pills more readily available.

F. MENTAL HEALTH AND SUBSTANCE ABUSE

A healthy lifestyle is imperative to good public health, but sometimes mental health conditions, such as depression and anxiety can affect a person’s ability to make positive and healthy choices. At the same time, a person’s physical health may also be impacted by chronic diseases and those diseases can impact on a person’s mental health and decrease their ability to make positive lifestyle choices. Through its policy paper, “Protecting New York State’s Children in the 21st Century”, the Medical Society has expressed concerns that many young people, become involved in drug and other substance use, due to poor self-esteem or poor social skills. It is important to create an environment that empowers young people not to drink or use other substances. The Medical Society supports brief interventions, such as Screening, Brief Intervention and Referral to Treatment (SBIRT) within the primary care center to help identify alcohol and other drug abuse. The Medical Society also believes that the comprehensive approach to drug abuse, including prescription drug abuse, should be undertaken by New York State.
CONCLUSION

Recognizing that our health care delivery system is currently the subject of unprecedented examination, analysis, and change the Medical Society of the State of New York wishes to reiterate its commitment to policies which will meaningfully enhance the delivery of affordable medical care of the highest quality. The proposals set forth in our 2013 Legislative Program are not an all-inclusive list of our goals, nor are they an exhaustive list of the health issues that will be addressed in Albany during the upcoming State legislative session. Whatever the issue, organized medicine will work to assure that the interests of our physician members and, most importantly, the interests of our patients are fully recognized and reflected in all health policies and health legislation adopted by the State of New York during the coming year. We can do nothing less.