

## **Assuring Our Patients Can Receive Timely Quality Care**

The stability of New York's world class but fragile health care delivery system is further threatened by the confluence of factors that are making it difficult for many physicians to remain in practice to deliver care to their patients. Timely access to care is threatened by the growing squeeze facing physicians between extraordinary overhead costs, led by the exorbitant cost of medical liability insurance, and decreasing payments from health insurers and Medicare. Moreover, physicians face administrative hassles like never before. Complying with state practice mandates and federal government reporting mandates, as well as complying with burdensome pre-authorization protocols for needed patient care and referrals all consume hours upon hours of time away from actual patient care.

Something has got to give. Our patients' ability to obtain timely quality care is at stake.

In a recent survey by MSSNY of member physicians, only 35% indicated that they would recommend to their children or other family members that they become physicians and only 22% indicated that they would recommend to medical students that they practice in New York State. This is not surprising given that nearly 83% indicated that the time they spend obtaining authorizations from health insurers for needed patient care had increased in the last three years, and nearly 60% indicating it had increased significantly. At the same time nearly 65% indicated that their compensation had decreased in the last 5 years, with 32% indicating it had decreased significantly.

Given these relentless hassles many physicians have chosen 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 cannot afford the tens of thousands of dollars of investments necessary to comply with government-imposed medical record and e-prescribing mandates, and are strongly considering retiring early or moving to other states with more favorable practice and business environments.

These problems have become even more urgent as nearly 1,000,000 New Yorkers became insured through the implementation of New York's Health Insurance Exchange. Expanded access to coverage is certainly a positive development for our patients, but many are unaware of the huge cost-sharing obligations their plans impose, and the narrow networks offered that limit patient choice of their physician.

MSSNY strongly supports a physician's right 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, policymakers need to be keenly aware of whether the significant increase in employment could erode the sacred physician-patient relationship, and drive up the costs of health care through creation of market dominant health care systems.

Efforts to expand health insurance coverage will not enhance the availability of timely quality care for patients unless steps are taken to assure the availability of appropriately trained physicians to provide this needed care. Conversely, legislators must reject well-intentioned but seriously misguided proposals that will further hinder access to care.

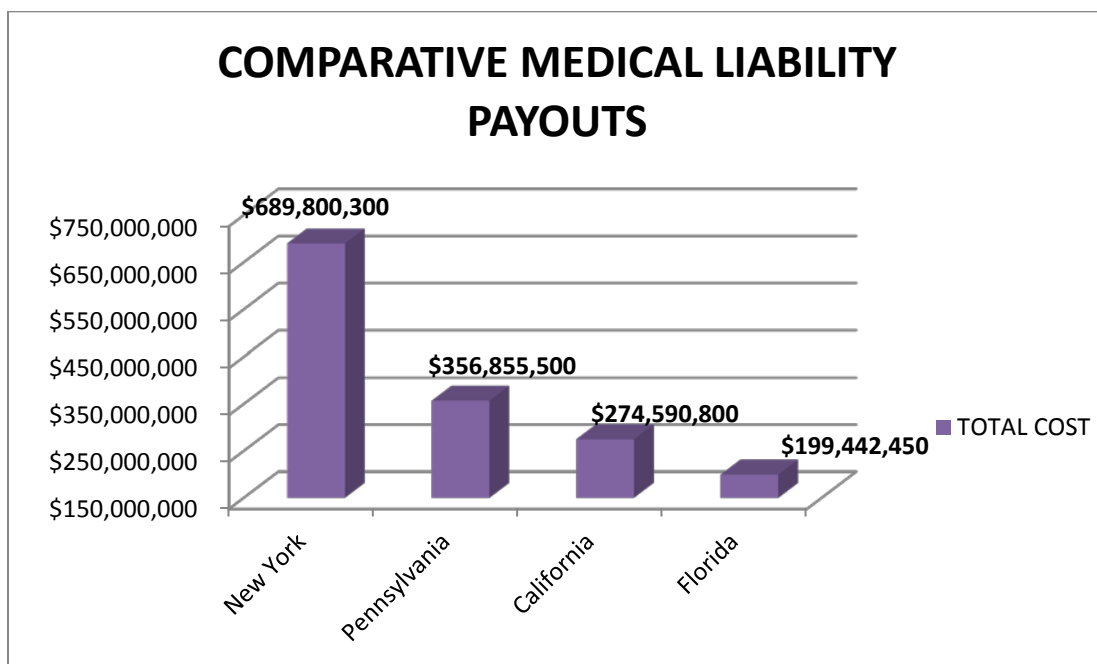
### **The Need for Medical Liability Reform**

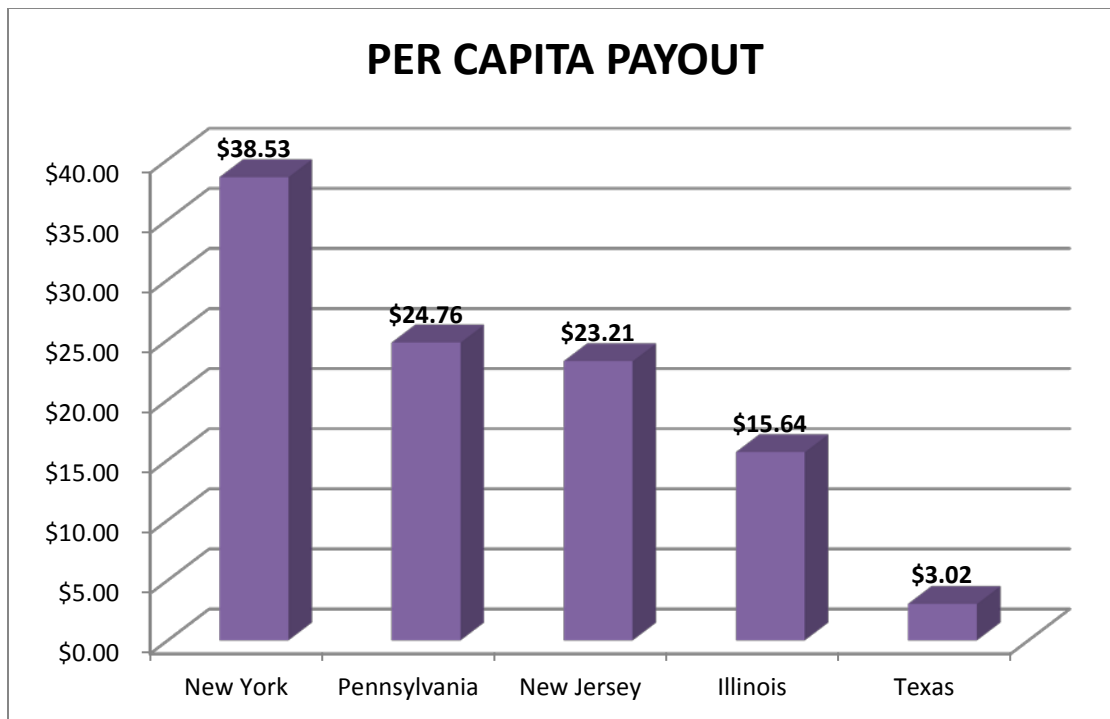
New York physicians continue to pay liability premiums that far exceed those in any other state. After liability premiums for New York physicians shot up 55-80% between 2003 to 2008 before the Legislature intervened to impose rate freezes in 2008 and 2009, medical liability premiums have

continued to steadily rise. Many New York physicians pay liability premiums that far exceed \$100,000 and some even exceed \$300,000! For example, for just a single year of coverage, the cost of medical liability coverage for the 2014-15 policy year was:

- \$338,252 for a neurosurgeon in Nassau and Suffolk counties;
- \$186,639 for an Ob-GYN in Bronx and Richmond counties;
- \$132,704 for a general surgeon in Kings and Queens counties; and
- \$134,902 for an vascular surgeon or cardiac surgeon in Bronx and Richmond counties

Little wonder, as malpractice payouts in New York State continue to be far out of proportion to the rest of country. For example, in 2013, according to a report by Diederich Healthcare and reported in the March 15, 2014 *Washington Post*, New York State had by far and away the highest number cumulative medical liability payouts (\$689,800,300), nearly two times greater than the state with the next highest amounts, Pennsylvania (\$356,855,500), and far exceeding states such as California (\$274,590,800) and Florida (\$199,442,450).





Additionally, the report indicated that the New York per capita medical liability payment of \$38.83 far exceeded was far away the highest in the country, exceeding the second highest state Pennsylvania by 57% (\$24.76), the third highest state New Jersey by 67% (\$23.24), and the fourth highest state Massachusetts by 74% (\$22.37). Remarkably, it was nearly 13x greater than Texas!

Furthermore, it is noteworthy that physicians in other states which have enacted medical liability reform in recent years pay substantially lower premiums. For example, according to the Texas Alliance for Patient Access, 90% of the physicians in Texas have seen their premiums drop at least 30% since enactment of their medical liability reform law in 2003.

We can no longer sustain such an expensive, inequitable and fatally flawed medical liability adjudication system if we wish to assure that our healthcare system will be able to accommodate the demand that will inevitably come as our population ages and becomes more resource-dependent, as well as the nearly 1,000,000 newly insured patients who are starting to receive coverage through New York's new health insurance Exchange. We need comprehensive reform of our flawed civil justice system and reduction in our medical liability costs, not legislation that increases costs and exacerbates existing problems.

Among the measures which must be enacted include:

- Creating Alternative Systems for Resolving Medical Liability Cases
  - Neurologically Impaired Infants No-Fault fund
  - Promoting medical courts
  
- Medical Liability Tort Reforms
  - Reasonable limits on non-economic damages
  - Identifying and assuring qualified expert witnesses
  - Eliminating joint and several liability
  - Identifying a physician supplying a Certificate of Merit
  - Immunizing statements of apology or regret
  - Immunity for physicians providing pro bono care

## Preventing Untenable Expansions Of Liability

At the same time that physicians and hospitals face these extraordinary costs, remarkably some interest groups continue to pursue legislation that would radically increase these costs. MSSNY will continue to strenuously oppose any measure to expand the damages recoverable in medical liability actions, including legislation that would:

- Create a “date of discovery” rule for New York’s statute of limitations for 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.

Enactment of any of these measures would have calamitous consequences on our health care system. Efforts to reform our medical liability adjudication system must be comprehensive!

### Attorney Contingency Fees if Statutory Limit Were to be Repealed

MEDICAL LIABILITY AWARD	ATTORNEY FEE ALLOWABLE UNDER CURRENT LAW	ATTORNEY FEE IF STATUTORY CONTINGENCY FEE LIMIT REPEALED	POTENTIAL ATTORNEY FEE % INCREASE
\$500,000	\$137,500	\$166,666	21%
\$1,000,000	\$237,500	\$333,333	40%
\$5,000,000	\$650,000	\$1,666,666	156%
\$10,000,000	\$1,150,000	\$3,333,333	190%

## Health Insurance Reform

### Reform of New York’s Exchange

New York officials are to be praised for their efforts to create a highly effective health insurance Exchange largely free of the glitches faced by many other states and the federal government. However, there are shortcomings with many of the health insurance products sold through New York’s Exchange that must be fixed in order to be sure patients receive the care they expect to receive in obtaining this coverage.

These issues have included significant inaccuracies on insurer websites regarding which physicians are actually participating in these Exchange networks (For example, a recent MSSNY survey showed that over ¼ of the physician respondents indicated that an insurer incorrectly listed them on its website as a network participating physician); vague communications with physician offices that fail to

clearly specify that physicians are being directed to participate in Exchange products unless they opt out; failure to specify payments for care delivered to patients enrolled in Exchange products; and, for many, discovering that the payments for such care are grossly inadequate compared to other products offered by that insurer with whom the physician was participating. Exacerbating the problem of more limited networks is the fact that there are virtually no coverage options enabling patients to see the physician of their choice.

A Senate hearing in January 2014 provided a necessary forum to examine these concerns. Moreover, there was significant media coverage of patients enrolling in Exchange plans believing their physicians were network participants when in fact they were not. We very much want to work with policymakers to see New York’s Exchange fulfill its promise to provide New Yorkers with a marketplace to purchase affordable and comprehensive health insurance coverage.

To this end, the logistical issues identified by the patients in these articles will be addressed soon to assure patients will truly be able to access the coverage that they have expected to receive. We urge that the Legislature and the Governor work together to address these concerns, including legislation, regulation, or other appropriate means to require that:

- Health insurers have comprehensive networks to assure enrollees receive timely needed care;
- Health insurer network listings are accurate
- Health insurers offer patients the option of receiving care from a physician outside the plan’s network

### **Addressing Health Insurer Administrative Hassles**

Health plans, whether offered inside or outside New York’s Exchange, routinely engage in an array of tactics to inappropriately delay and deny needed care and treatments for patients when coverage for such care is requested, and delay and deny fair payment to physicians when needed care is delivered. These tactics adversely impact patients and exacerbate the already hostile practice environment facing physicians in New York that is making it harder and harder to remain in practice to deliver the care expected by our patients.

The ideal solution to these problems is the **enactment of legislation strongly supported by MSSNY that would enable independently practicing physicians to negotiate relevant patient care terms with insurance companies** in areas where only a few insurance companies dominate. As noted below, most regions of the State have one or two plans that dominate their respective markets, forcing physicians to accept “take it or leave it contracts” that give insurers great powers to limit patient care and limit patients’ ability to access the physicians of their choice:

#### **Health Insurer Penetration – Selected NY MSAs**

<b>MSA</b>	<b>Insurer 1</b>	<b>Insurer 2</b>	<b>Share % of Top 2 Insurers</b>
<b>Albany-Schenectady-Troy</b>	CDPHP (33%)	United (18%)	<b>51%</b>
<b>Binghamton</b>	Excellus (39%)	United (27%)	<b>66%</b>
<b>Buffalo-Cheektowaga-Tonawanda</b>	Independent Health (34%)	Excellus (22%)	<b>56%</b>
<b>New York-White Plains-Wayne, NJ</b>	United (31%)	Emblem (22%)	<b>53%</b>
<b>Rochester</b>	Excellus (39%)	MVP (35%)	<b>74%</b>

<b>Suffolk-Nassau</b>	United (43%)	Emblem (21%)	<b>64%</b>
<b>Syracuse</b>	Excellus (49%)	United (23%)	<b>72%</b>

Source: AMA, *Competition in Health Insurance*, 2014 Update

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.

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.

In addition, MSSNY supports a series of reforms to reduce these hassles to patients getting needed care, including legislation and/or regulation that would:

- **Reduce Administrative Burdens to Delivering Care**
  - Require health plans to use appropriate specialty care guidelines when reviewing medical necessity determinations;
  - Require medical necessity determinations be made by physicians practicing in the same or similar specialty as the physician recommending treatment;
  - Requiring a health plan to have an expedited manner to override a health plan step therapy protocol. Recent surveys from MSSNY and the Academy of Family Physicians showed that 90% of physicians indicated that step therapy protocols at least “sometimes” adversely affected their patients and 46% indicated that it “frequently” adversely affected patients.
  - Requiring use of uniform prior authorization forms
  - Assure Continuity in Prescription Drug Coverage when formularies/prescription tiers change;
  - Assure inclusion of patient cost-sharing information on Health Plan ID cards;
  - Assure greater transparency when a physician contracts with a rental network entity (i.e. MagnaCare, MultiPlan). Physicians often find themselves participating in networks for plans that they did not contract directly with because their contract is assigned. Physicians need to be notified when these assignments occur, with the opportunity to opt-out of these contracts.
  
- **Assure Fair Payment for Providing Needed Patient Care**
  - Require insurer payment to physicians for advocating for patients to receive necessary imaging, medications or lab studies;
  - Require insurers to follow uniform code review policies;
  - Reduce the time frame in which health plans may recoup payments made to physicians;
  - Prohibit health plan recoupment based upon lack of coverage where health plan previously confirmed eligibility of such patient;
  - Prohibit health plans from using extrapolation to determine a refund demand amount;
  - Assure fair payment for facility fees for physicians to cover significant overhead cost of maintaining certification for office-based surgical practices.
  - Requiring insurers to permit patients to assign payments to their out of network treating physicians. Often insurers force patients who pay for the right to see a physician of their

choice outside the plan's network to be "chased down" for payment by their treating physicians because the patient is not allowed to assign payment to the physician.

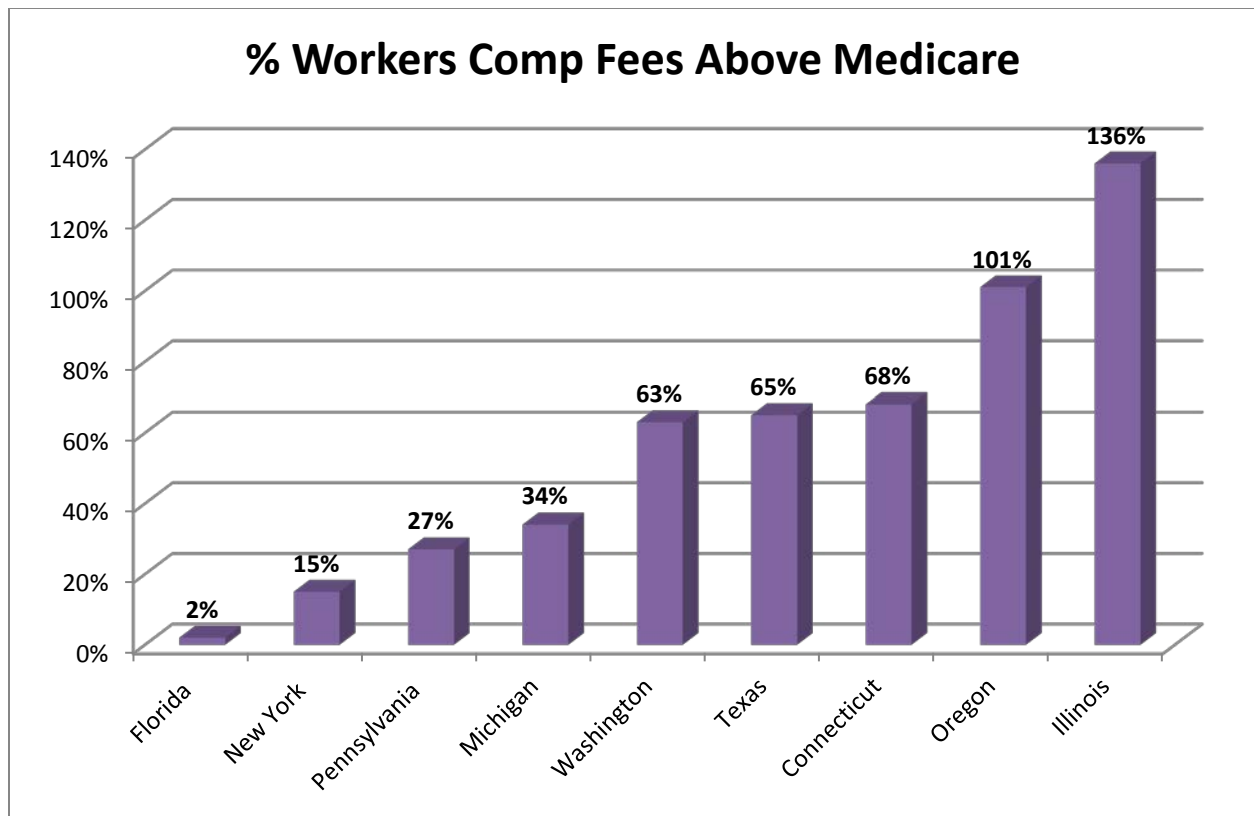
## **Assuring Fair Workers Compensation /No-Fault Reform**

MSSNY commends the New York Workers Compensation Board for its efforts to attempt to reengineer New York's often-criticized Workers Compensation program to reverse the trend of physicians dropping out of the WC program. We very much want to work with the Board to assure injured workers in New York have access to a wide array of quality physicians to provide timely needed care so as to facilitate their ability to return to work. A number of reforms have been advanced, but some are serious need of revision. MSSNY will advocate for:

- **Assuring fair payments for medical care to injured workers** – According to studies, New York Workers Compensation spends far less on medical care, on a percentage basis, than most other states. Moreover, a recent report by the Workers Compensation Research Institute indicated that payments to New York physicians for WC were actually, on average, among the lowest in the country (see chart below). Yet New York State has proposed to change its fee schedule methodology to mirror that of Medicare.

While it would provide long-overdue increases for some physicians, it could impose disastrous cuts to other physicians, and severely jeopardize injured workers' access to needed care. In some cases, it could trigger staggering cuts of 50-60% for services frequently provided to injured workers, and perhaps even drive some of these physicians out of business altogether. A recent survey by the New York State Society of Orthopedic Surgeons concluded that over 80% of orthopedists would be less likely to treat injured worker patients in response to these cuts. MSSNY will advocate to assure fee schedule changes enhance patient access to needed care, rather than diminish it.

- **Reducing undue administrative burdens including streamlining burdensome claim forms.** It is estimated that the hourly practice expense for physicians who accepted workers' compensation patients is 2.5 to 3 times the hourly practice expense with caring for Medicare patients. A few years back, the WCB had to suspend the use of new C-4 medical claim reporting forms in the Rochester region of the State in response to many physicians dropping out of the program due to the complexity of the form. Physicians want to care for injured workers but cannot realistically do because of this overwhelming paperwork requirement. The new medical portal created by the WCB for submitting claims should be helpful for reducing physicians' administrative burden, but in addition the complexity of the reporting forms must be reduced.
- **Assuring carriers pay claims timely.** Too often carriers ignore physician submission of claims, leading to unfair payment delays and unnecessary frictional costs for the program. We are pleased that the Board will know have a greater ability to punish insurance carriers who unfairly delay payments as a result of a new requirement that claims be submitted to a WCB medical portal rather than to the individual carriers.
- **Assuring continued access by auto accident victims to necessary care.** MSSNY opposes carrier-driven efforts to impose overbroad restrictions on the ability of physicians to be paid fairly by No-Fault carriers for the care they provide to auto accident victims. MSSNY also supports legislation to assure coverage for necessary care provided to intoxicated drivers beyond the emergency department.



## Federal Health Care Reform

### The Need For Reform Of The Medicare Sustainable Growth Rate (SGR) Formula

The ability of physicians to continue to deliver care is impacted by a number of federal policies that can only be addressed by Congress. These issues include:

Unless action is taken by Congress, physicians face a draconian 21% cut in their Medicare payments on March 31, 2015. While Congress has passed several measures in recent years to prevent the imposition of similar scheduled cuts, the short-term fixes and recent tendency of Congress to retroactively fix the cuts after permitting them to go into effect has left many physicians concerned and doubtful whether their offices can sustain continued participation in the Medicare program. According to a recent *Wall Street Journal* article, the number of physicians who have opted out of the Medicare program nearly tripled between 2009 and 2012.

These cuts are driven by the flawed SGR formula 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. While physician overhead costs have gone up dramatically in the last decade, and other health care providers have received annual increase, Medicare physician payments are on average at the same level as they were 10 years ago.

A permanent repeal of this grossly unfair SGR formula must be enacted.



## **Enactment of The 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 the Medicare Patient Empowerment Act, legislation 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 Requirement to Implement ICD-10 Coding**

Physicians across the country face huge costs associated with complying with a CMS mandate to change their disease coding systems from ICD-9 to ICD-10 on October 1, 2015. Implementing the new mandated ICD-10 code sets requires physicians and their office staff to contend with 68,000 outpatient diagnostic codes — a five-fold increase from the current 13,000 codes. This is a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers. Physicians will be responsible for all of these costs, which, depending on the size of a medical practice, are estimated to range from tens of thousands to millions of dollars.

For example, according to a February 2014 study commissioned by the AMA, the estimated price for a small practice to meet ICD-10 requirements will range from \$56,639 to \$226,105. The study also noted that the estimated cost for medium size practices was \$213,364 - \$824,735, and from \$2,017,151 - \$8,018,364 for large practices.

MSSNY has joined many other state and national specialty societies across the country as well as the AMA in asking CMS for a further delay in this implementation. Legislation to repeal this requirement was introduced in Congress and must be enacted.

## **Fixing PPACA**

- Repeal of the Independent Payment Advisory Board (IPAB)
- Assuring taxes imposed on health insurers are not passed along to consumers and physicians
- Eliminating the Excise Tax on comprehensive health insurance coverage
- Assuring additional funding for health insurance cooperatives