Access to quality and timely physician care has become more difficult as the practice climate for physicians in New York State has deteriorated. Due to an untenable economic squeeze between rising practice costs and reductions in payments, more and more physicians are being forced to close their practices and join large health systems to be able continue to delivering patient care. According to a recent Averete study, the number of physicians who have become hospital employees in New York nearly doubled from 2012-2015.

Patients benefit most when physicians have a real choice as to which practice setting is best suited to them, whether that is a small group, large group, or employed by a health system. However, too many physicians who have dedicated their professional lives to caring for their communities are finding that they have no real choice. While in some cases administrative burdens may be reduced, this trend can also result in reduced patient options, elimination of jobs for non-physician support staff, and reduced physicians’ ability to be patient advocates. Worse still, many experienced physicians have indicated they may retire from practice early, further exacerbating barriers to care.

Wait times for needed patient care, including in the emergency departments (ED), will only get worse unless action is taken to improve New York’s practice climate. For example, a recent HANYS study indicated that, across upstate New York, 86% of hospitals EDs indicated there were times when a patient needed to be transferred because a needed specialist was not available.

New York was recently ranked by Wallet Hub as the WORST state in the country to be a physician, due to its low payments for care combined with exorbitant costs. One of the reasons for this designation is the extraordinarily expensive cost for medical liability insurance in New York State.

Report: New York Worst State For Doctors
Source: WHEC News 10 Article, April 10, 2017

<table>
<thead>
<tr>
<th>Best/Worst States to Be a Doctor</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>1</td>
</tr>
<tr>
<td>Minnesota</td>
<td>2</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>4</td>
</tr>
<tr>
<td>Colorado</td>
<td>13</td>
</tr>
<tr>
<td>Arizona</td>
<td>14</td>
</tr>
<tr>
<td>Texas</td>
<td>16</td>
</tr>
<tr>
<td>Florida</td>
<td>24</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>31</td>
</tr>
<tr>
<td>California</td>
<td>40</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>46</td>
</tr>
<tr>
<td>New York</td>
<td>51</td>
</tr>
</tbody>
</table>

At the same time, health insurers continue to shrink their networks and cut payments for care delivered, reducing the ability of physicians to pay these exorbitant premiums. Moreover, Medicaid, Medicare and other payors are demanding participation in various value-based payment programs which require extensive infrastructure investment such as upgraded EHR systems. Failure to meet these criteria could result in significant payment cuts.

Exacerbating these problems is the significant increase in patient cost sharing requirements including increasingly unaffordable deductibles. A MSSNY survey reported that nearly 21% of responding physicians indicated that 25-50% of their patients now face deductibles of $2,500-$5,000. And just when it couldn’t get any worse, the New York State Legislature passed one-sided malpractice expansion legislation in 2017 that will drive up exorbitant liability premiums by an additional 10%. Its little wonder that “physician burnout” is on the rise.

Physicians need legislation to preserve their ability to deliver care to patients, and they need rejection of legislation that would make existing problems even worse. The goal of MSSNY’s 2018 Legislative Program is to assure the enactment of policies that enable New Yorkers to continue to have meaningful access to New York’s world-class doctors and healthcare institutions.

**PHYSICIAN COLLECTIVE NEGOTIATION AND OTHER INSURANCE REFORMS**

MSSNY supports legislation (A.4472 and S.3663) that would permit independently practicing physicians to collectively negotiate patient care terms with market dominant health insurers.
Due to market concentration in most regions of the State, most physicians have no choice but to participate with market-dominant insurers. If they don’t, they risk losing the ability to treat many patients altogether. Exacerbating this dynamic is the fact that many physicians have been dropped from networks of insurers, severing long-standing patient-physician treatment relationships. For instance, in the fall of 2015 and again in 2017, Emblem Health decided to pare hundreds of physicians from their network, with virtually no ability of these physicians to challenge these patient care disruptions.

A recent MSSNY survey reported that over 25% of the responding physicians were completely dropped from an insurer’s network in the past 2 years; and over 40% indicated that they had not been asked to participate in a new product offered by that insurer over the same time. Of greatest concern, nearly 80% of physicians reported situations where their patients could not receive care promptly because the insurer lacked an adequate network.

Have you had the experience where one of your patients could not quickly receive the care they need due to the inadequacy of a health insurer’s network?

<table>
<thead>
<tr>
<th>Yes</th>
<th>78.65%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>21.35%</td>
</tr>
</tbody>
</table>

records, and burdensome insurer pre-authorization requests. Physicians must be given a realistic opportunity to negotiate these patient care delivery terms with insurers on a level footing.

Other Needed Insurance Reforms
In addition to the collective negotiation legislation, MSSNY also supports legislation that would:
- Protect against unfair insurer narrowing of networks by providing due process protections for physicians whose contracts are not renewed by insurance companies (S.3943/A.2704);
- Requiring health insurance companies to make out-of-network coverage options available for patients who want to purchase such coverage (S.5675/A.7671);
- Prohibit health insurers and hospitals from requiring board certification as a condition of network participation and medical staff membership (A.4914);
- Require payment parity between services provided via teledmedicine (S.834/A.1421); and
- Enact numerous reforms to reduce insurer-imposed hassles experienced by physicians as articulated in the American Medical Association’s Prior Authorization principles.

Each of these concerns could also be resolved if New York were to enact a physician collective negotiation bill.

MEDICAL LIABILITY REFORM
MSSNY continues to support legislation to enact needed reforms to New York’s grossly dysfunctional medical liability adjudication system. As noted above, New York was recently named the worst state in the country to be a physician, in large part due to our overwhelming liability costs. Moreover, New York already has by far and away the highest liability costs in the country, nearly double the total payouts of the second highest state Pennsylvania and far exceeding states such as California, Florida and Texas—not only cumulatively, but also on a per-person basis.
Remarkably, the total payouts from New York were greater than the entire 12-state mid-western region! In some cases, physicians (obstetricians and neurosurgeons on Long Island) pay more than $200,000 per year for their premiums. MSSNY supports a number of legislative initiatives, including many that have proven successful in reducing costs in many other states. These legislative proposals include:

- Placing reasonable limits on non-economic damages (such as A.4913 and S.6781);
- Assuring qualified expert witnesses in trials and for signing Certificates of Merit (A.4913);
- Promoting statements of apology from a physician to a patient by protecting them from admission at a medical liability trial (A.2372);
- Alternative systems for resolving liability claims including medical courts or a Neurologically Impaired Infants Fund; and
- Continued funding for the Excess Medical Malpractice Insurance Program.

At the same time, it is imperative legislators reject “stand-alone” measures to expand medical liability that would most certainly exacerbate these problems, such as legislation that would:

- Eliminate statutory limitations on attorney contingency fees (such as A.4866/S.6738) - Estimated 10% premium increase.
- Expand “wrongful death” damages to permit “pain and suffering” (A.1386/S.411) - Estimated 53% premium increase.
- Permit the awarding of pre-judgment interest - Estimated 27% premium increase.
- Prohibit ex-parte interview by defense counsel of the plaintiff’s treating physician (A.1404/S.243).
- Change loss share rules regarding non-settling defendants (A.1500/S.412).

PRESERVING ACCESS TO CARE FOR INJURED WORKERS

MSSNY continues to work proactively with groups representing injured workers to reduce the hassles they face in receiving need care and treatment. Legislation enacted in 2017 requires stronger criteria for those to serve as Independent Medical Examiners and efforts to hasten the resolution of Workers Compensation claims. MSSNY also continues to work closely with the WC Board on efforts to minimize the administrative hassles associated with implementing a drug formulary and implementing new impairment guidelines. However, MSSNY continues to strongly oppose overreaching efforts that would marginalize physician participation in the WC system, such as legislation (A.8319 and S.5344) that would make it harder for injured workers to receive needed care from their treating physicians by:

- Inappropriately expanding PPOs and Limited choice of physician in Workers Compensation;
- Inappropriately expanding the role of physician extenders under the WC program without sufficient physician oversight, and
- Inappropriately eliminating the role of county medical societies in reviewing applications to become authorized WC providers.
Instead, efforts should be undertaken to reduce administrative hassles that discourage physicians’ participation in the WC program.

**IMPROVING CARE QUALITY**

MSSNY physicians are involved in numerous efforts to improve care quality across our state. These include leadership roles within the various regional DSRIP Performing Provider Systems as well as extensive participation in New York’s numerous value-based payment workgroups. As these efforts are undertaken with the best intentions of improving care quality, however, it is important that such programs not overreach and create unreachable tasks or goals that interfere with the timely delivery of care.

**Improving Electronic Health Record Functionality**

Electronic health records systems were intended to improve care quality and enhance care management. At the same time, many physicians believe that the cumbersome nature of these systems is actually disruptive rather than helpful to patient care delivery. For example, a recent *Annals of Family Medicine* study reported that, during a typical 11.4-hour workday, primary care physicians spent nearly six hours on data entry and other tasks with EHR systems, instead of time spent with patients. Moreover, a recent AMA study reported that, compared to five years ago, more physicians are “dissatisfied” or “very dissatisfied” with their EHR system. Furthermore, these systems are extraordinarily expensive. An AHRQ study reported that the real-life cost of implementing an EHR system within a five-physician practice exceeded $160,000. And physicians face payment penalties from Medicare even if they routinely use EHR in their practices. Therefore, it is not surprising that, to date, only 57% of New York physicians have been able to connect to the State Health Information Network (SHIN-NY).

While much of the policies regarding the interoperability and usability of EHR system are driven by federal law and regulations, it is imperative that New York not make these problems worse. Until these problems are adequately resolved, MSSNY will continue to oppose requirements to connect to the SHIN-NY, including legislation that would require urgent care or office-based surgery centers to adopt EHR and connect to the SHIN-NY (S.2248/A.8077)

**E-prescribing**

As of March 27, 2016, the ISTOP law required electronic transmission of all prescriptions. The law provided limited exceptions to this mandate and allows for the issuance of a one-year renewable 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 advocate revising New York’s Prescription Monitoring Program (PMP) so that it can be checked directly from their EHR or e-prescribing systems. Currently, the systems do not interface with one another, which adds more unnecessary administrative burden to the delivery of care. While New York has for many years led the nation in PMP checks, in 2016 it was surpassed by Ohio in large part due to the seamless connection between Ohio’s PMP and the EMR systems of Ohio physicians and prescribers. MSSNY will work towards a similar interoperable system in New York.

**Assuring Participation in Peer Review**

Current law impedes peer review quality improvement efforts by permitting attorneys access to statements made at a peer-review meeting by a physician who subsequently becomes a party to a malpractice action. To enhance the free discussion of quality improvement, MSSNY supports legislation to extend existing confidentiality protections to all statements at peer-review quality assurance committees within hospitals, in office-based settings and across integrated care settings (A.2460/S.3661).

**Truth in Advertising**

Public advertisements for healthcare services will sometimes contain misleading terminology regarding the specific qualifications of those who claim to be “doctors” and “board certified”. Therefore, MSSNY supports legislation that would ensure appropriate identification for all health care professionals in their interactions with patients, and to require that advertisements for services identify the license type of the health care provider,
Protecting Physician Peer Support Efforts

MSSNY supports legislation to extend the existence of MSSNY's Committee for Physicians Health (CPH), and to clarify the scope of its existing statutory liability protections (S.2245/A.2703). The CPH program was developed over 30 years ago to provide needed peer counseling services to physicians thought to be suffering from alcoholism, drug abuse or mental illness. Hundreds of physicians are served by this program each year, which helps to return these physicians to care delivery once healthy. However, the very existence of this extraordinarily beneficial program is threatened by a recent judicial interpretation that limits the scope of CPH's immunity. Moreover, with increasing reports of physician "burnout", MSSNY also supports legislation to provide liability protection for organizations that facilitate physician peer support, similar to protections already provided to bar association peer support activities.

Eliminating Health Care Disparities

Many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. MSSNY Committee to Eliminate Healthcare Disparities seeks to increase awareness of how factors such as race, ethnicity, culture and religious beliefs, sexual orientation; gender and gender identity contribute to both health and healthcare disparities and to ensure that all New Yorkers receive the best possible care. Committee goals include:

- Working to prevent and manage diseases that are prevalent in underrepresented groups, including diabetes, hypertension, and cancer, through educational programming for physicians; and
- Working to promote and expand programs that attract 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 to address the shortage of physicians in medically underserved areas of New York State.

Preserving Physician-Led Team Based Care

There are many different types of health care providers who each provide essential care for our patients. However, 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 continues to support legislation that would enable otolaryngologists to dispense hearing aids at fair market value (A.195). However, MSSNY opposes any expansion of the scope of practice of non-physician health care providers that will enable them to practice beyond their education and training. These bills include:

- Opposing legislation to...Inappropriately expand the ability of podiatrists to treat up to a patient's knee (A.1881/S.4734)
- Opposing legislation to provide "title protection" for nurse-anesthetists, which could pave the way for independent practice (A.442/S.1385)
- Opposing legislation to permit optometrists to use and prescribe a wide variety of oral drugs (A.6751/S.5235)
- Opposing legislation to grant prescribing privileges to psychologists (A.2851/S.4498)
- Opposing legislation expand the scope of dentists beyond restoring and maintaining dental health (A.4543/S.3551)
- Opposing legislation to permit corporately owned retail clinics (A.958)

PROMOTING AND PRESERVING PUBLIC HEALTH

Addressing the Opioid Abuse Crisis

New York's physicians have worked assiduously to respond to the opioid and heroin abuse epidemic that has ravaged this state and country. As a member of the American Medical Association's Opioid Task Force, MSSNY has worked to increase physician awareness and leadership to promote and amplify best practices to respond to this crisis. To that end, MSSNY has educated over 11,000 prescribers since January 2017 regarding
best practices for assuring responsible patient pain management. Moreover, in 2016, physicians and other prescribers made over 18 million checks of New York’s PMP – a 9% increase from 2015. As a result, the prescribing of opioids in New York State has decreased 13%. Physician efforts have also led to a 90% decrease in so-called “doctor shopping” of patients inappropriately seeking opioid medications. MSSNY has also worked with the AMA to address concerns with policies imposed on hospitals that may contribute to this problem.

Equally important is assuring proper treatment for those facing addiction. There has been an increase in the use of Medication Assisted Treatment (MAT) and naloxone by physicians and other prescribers in New York. Moreover, MSSNY supports legislative efforts to enhance insurance coverage for treatment beds; strongly encourages all physicians and hospitals to advocate to patients various substance abuse treatment options available to them in treating addiction, including buprenorphine; encourages physicians and other medical staff to become voluntarily certified to prescribe buprenorphine and encourages collaboration with multi-stakeholders for integrated MAT for the management of addictions. However, MSSNY remains concerned about legislative efforts to place arbitrary limits on prescribing of controlled substances or limitations on medical decision making by minors (such as S.5949 and S.5670). MSSNY also supports changes in state and federal law that allow for the safe disposal of medication and supports the concept of pharmaceutical companies paying for these disposal costs.

Addressing Tick Borne Illnesses
Each year, more than 30,000 cases of Lyme disease are reported nationwide, and studies suggest the actual number of people diagnosed with Lyme disease could actually be about 300,000. Despite these numbers, a recent national survey reported that nearly 20% of people surveyed in areas where Lyme disease is common were unaware that it was a risk. MSSNY will continue to educate its physicians on tick-borne illnesses and will work with the NYS DOH on creating awareness for both patients and physicians. As a member of the DOH Antimicrobial Resistance Prevention and Control Task Force, MSSNY continues to be concerned, however, about inappropriate antibiotic prescribing which leads to drug resistance. Furthermore, MSSNY is gravely concerned about the appearance of *Candida auris*, emerging multidrug-resistant yeast in New York State causing invasive healthcare-associated infections with high mortality.

Disease Prevention
Prevention of diseases continues to remain a top MSSNY priority and the best way to prevent these diseases is through immunizations. MSSNY supports legislation or regulation that would remove religious exemptions for immunizations and would also oppose any additional exemptions for immunizations (A.8123A/S.6141A). MSSNY supports efforts to require pharmacies to inform adult patients that they have the option of having the immunization recorded into the registry. MSSNY also continues to strongly support legislation (A. 273/S. 3945).
to prohibit the sale of tobacco, e-cigarettes and nicotine dispensing devices and products to anyone less than 21 years of age.

Women’s Health
Preserving the ability for women to have access to reproductive and sexual health care services is a key public health component. MSSNY supports efforts to expand access to emergency contraception, including making emergency contraception pills more readily available and will continue to support sexual health education programs amongst adolescents. MSSNY will oppose any legislation that criminalizes the exercise of clinical judgment in the delivery of medical care.

Other Important Public Health Issues
- MSSNY supports legislation to prohibit the sale or distribution of Kratom in New York State. (A.231)
- MSSNY supports efforts to prohibit the use of so-called “conversion therapy” (A. 3977/S.263).
- MSSNY supports background checks for firearm purchases, advocates for firearm safety education in all settings and will also advocate for expansion and implementation of technologies to improve gun safety.
- MSSNY will conduct a survey of its membership to ascertain its attitudes toward the issue of death and dying.
- MSSNY supports insurance coverage for PSA testing.

Notes

Charles Rothberg, MD President
Thomas J. Madejski, MD President-Elect
Arthur C. Fougner, MD Vice President
Malcolm D. Reid, MD, MPP Immediate Past President
Gregory L. Pinto, MD Commissioner, Governmental Relations
Thomas T. Lee, MD Assistant Commissioner, Governmental Relations
Paul A. Pipia, MD Chair, Legislation and Physician Advocacy Committee
Brian P. Murray, MD Vice-Chair, Legislation and Physician Advocacy Committee
Phillip A. Schuh, CPA Executive Vice-President
Morris M. Auster, Esq. Senior Vice-President and Chief Legislative Counsel
Patricia Clancy Senior Vice-President, Public Health & Education & Managing Director
John P. Belmont Vice-President, Legislative & Regulatory Affairs

Division of Governmental Affairs
99 Washington Avenue, Suite 408
Albany, New York 12210
Phone: 518-465-8085
albany@mssny.org