September 11, 2018

Honorable Richard Gottfried  
Chair, NYS Assembly Health Committee  
250 Broadway, Suite 2232  
New York, NY 10007

Dear Assemblyman Gottfried:

Thank you again for taking the time to have a thoughtful dialogue with myself and other MSSNY and New York County Medical Society physician leaders regarding questions and concerns about various aspects of your legislation (A.4738-A) that would create a single payer system in New York State. As we discussed, we would appreciate if you would be able to provide a written reply to many of our discussion points so that they may be shared with other physicians who have raised similar questions about this legislation.

Authorization for Patient Care

While we are pleased that the bill states that among its goals are “simplification” and “transparency”, and excludes “prior authorization” from “care coordination”, the bill is silent as to how prior authorization will be used by the NY Health entity. As you may know, a recent AMA study concluded that 92% of physicians reported that insurer prior authorization hassles caused unnecessary delays to patient care. Physicians remain concerned that the excessive hassles they currently experience with private and public insurance carrier imposed prior authorization processes will simply just be replicated by a governmental entity which will likely face strong taxpayer driven pressure to contain costs. What will be the rules for how prior authorization will be imposed?

What will be the mechanism by which a patient can appeal a denial of coverage by NY Health? We note that the bill calls for NYHealth to follow the utilization review and coverage requirements that are currently applicable to managed care organizations, but wouldn’t this bill make those laws moot?

Physician Participation with NY Health

The bill is not clear as to whether there will be network limitations on physician participation in NY Health. It is noted that physicians qualified to participate under Medicaid, CHIP and Medicare will be deemed to qualify in NY Health, and that provider participation shall not be limited by “economic purposes”, but is there a possibility that NY Health could still limit the number of participating physicians based upon the faulty premise that narrow networks reduce cost?

Will a physician not participating with NY Health be prohibited from treating a NYHealth enrolled patient on a private pay basis? Could NY Health provide a subsidy to enable that patient to have some coverage for seeing a non-enrolled physician?

Payments for Patient Care

What will be the process for determining how payments for services will be “reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service”?
• Will meaningful outreach to various health care provider associations for their input be required, as they are currently in Workers Compensation and Medicare?
• Will there be a Board charged with assessing the reasonableness of such fee schedule?

While the bill importantly notes that payments will be on a “fee for service” basis, it also conditions that this will only be the case “until another payment methodology is established”. What will be the process for establishing these “alternative payment methodologies”? Once established, which body will be responsible for interpreting the submissions to determine whether the health care provider has met the conditions required as part of these APMs?

How will the NY Health system respond to situations where anticipated tax revenues are not meeting spending projections?

We note that the bill does not specify the timeframes for NY Health or intermediaries to make payments for health care services delivered? What will be the recourse for inappropriately delayed payments?

The “collective negotiation” provision is an important element to this bill. However, what is the incentive for the government to negotiate fairly with the health care providers’ representative? Should there be an “appeal mechanism” in situations where the physician collective reasonably believes that NY Health is not negotiating in good faith?

Miscellaneous Questions
Would auto accident injuries be covered under NY Health? The definition of “benefits” appears to include coverage injuries arising from auto accidents, but it would also not repeal auto insurers’ requirements to cover these health care costs as well.

Will this prohibit self-insured employers from offering health insurance benefits to their employees? How would this impact upon patients who receive retiree health care coverage from their former employer?

How would a patient enrolled in NY Health have coverage for care when they receive care in another state (i.e.”snowbirds”)?

Would a patient’s personal Health Savings Accounts (HSAs) still be permitted to be used to cover health care costs?

Would physician, hospital and other health care employers be subject to the proposed employer tax when the likelihood is that, at least for many, their payments for care will be substantially reduced under NY Health?

We would further note that, given the projected need for extensive new resources to help pay for this program, it would appear that there is a need to reduce some of the unnecessary costs embedded in our health care system. One such example are so-called “defensive medicine” costs, which generally refer to additional diagnostic tests of marginal utility that a health care practitioner feels compelled to perform in order to help defend against a possible future lawsuit. Providing meaningful control of New York’s enormous liability costs and liability exposure would help to reduce these defensive medicine costs.

Thank you again for taking the time to have this thoughtful discussion regarding some of what likely will be the “real world” issues such a program would face. We look forward to further discussions with you on this issue.

Sincerely,

THOMAS MADEJSKI, MD
MSSNY President
October 15, 2018

To: Thomas J. Madejski, MD, President

From: Richard N. Gottfried and Gustavo Rivera

Re: MSSNY questions about the New York Health Act

Thank you for your letter of September 11, providing questions about the New York Health Act, following up on our earlier meeting.

We greatly appreciate having MSSNY’s concerns about the bill. We firmly believe that the NYHA is in the best interests of physicians, as well as patients. We would not want it to be any other way. Yet we are very cognizant of the fact that neither of us is a physician. It is essential to have focused and candid input from physicians if we are to make sure that the bill reflects those goals as fully as possible. We need that input not only to win your support for the bill – which we certainly seek – but to get it right.

As the next step in our dialogue, attached are the questions presented in your letter followed by our response to each question.

Before we re-introduce the bill for the 2019 legislative session, we will be making changes in response to concerns and input from various parties. We look forward to continuing our discussion with you.
MSSNY questions from 9-11-2018 letter, on NYHA in italics.
Answers inserted in bold.

Authorization for Patient Care

While we are pleased that the bill states that among its goals are “simplification” and “transparency”, and excludes “prior authorization” from “care coordination”, the bill is silent as to how prior authorization will be used by the NY Health entity. As you may know, a recent AMA study concluded that 92% of physicians reported that insurer prior authorization hassles caused unnecessary delays to patient care. Physicians remain concerned that the excessive hassles they currently experience with private and public insurance carrier imposed prior authorization processes will simply just be replicated by a governmental entity which will likely face strong taxpayer driven pressure to contain costs. What will be the rules for how prior authorization will be imposed?

As now written, the bill does not explicitly speak about prior authorization, except to say that care coordination does not include prior authorization. Making rules on this would be up to the NYH system, with decision-making by a board including stakeholders and consultation with stakeholders. However, the bill does say that Medicare eligibles would be entitled to all benefits and rights that they have under Medicare, so they would be entitled to the services covered by traditional Medicare with no prior authorization beyond what traditional Medicare has. And the bill says that the system is to be run as one uniform system, so this protection would apply to all NYH enrollees.

We will consider amending the bill to make explicit that the system will have no prior authorization requirement that is more restrictive than what applies to traditional Medicare, for all NYH services. We look forward to discussing the particulars of this with you.

What will be the mechanism by which a patient can appeal a denial of coverage by NY Health? We note that the bill calls for NYHealth to follow the utilization review and coverage requirements that are currently applicable to managed care organizations, but wouldn’t this bill make those laws moot?

The bill says that the provisions of the Insurance Law and Public Health Law that don’t conflict with the NYHA provisions will continue to apply. The bill specifically provides that NYH shall be deemed to be a “health care plan” for purposes of utilization review and external appeal under PHL Art. 49; §5101, subd. 7. This provision makes sure that NYH will be covered by that provision’s definition of a “health care plan,” so Art. 49 will clearly apply to NYH.

Physician Participation with NY Health
The bill is not clear as to whether there will be network limitations on physician participation in NY Health. It is noted that physicians qualified to participate under Medicaid, CHIP and Medicare will be deemed to qualify in NY Health, and that provider participation shall not be limited by “economic purposes”, but is there a possibility that NY Health could still limit the number of participating physicians based upon the faulty premise that narrow networks reduce cost?

The permitted criteria for recognizing a health care provider as “participating” explicitly excludes “economic purposes” and is limited to grounds relating to good professional practice. A provider who qualifies has a legal right to be a “participating provider,” and a patient has a legal right to have the plan pay for services by that provider (§5105, subd. 1). I believe it is clear, but we could make it more explicit, that assertions like “we don’t need more of X” or “a narrow network reduces cost” are plainly prohibited by the “economic purposes” exclusion.

Will a physician not participating with NY Health be prohibited from treating a NY-Health enrolled patient on a private pay basis? Could NY Health provide a subsidy to enable that patient to have some coverage for seeing a non-enrolled physician?

The prohibition against soliciting or accepting payment other than what is provided by the program applies to a service that is provided “under the program,” but only to such services (§5105 (4) (d)). “Under the program” does not mean the service is within the NYH scope of benefits. It means NYH is paying for it in a particular case. This is a ban on balance billing.

A particular service for a given patient would be either paid for entirely by NYH or not paid for at all by NYH. If the patient pays for the service out of pocket, then the service is not “under the program,” and the provider may not be paid by NYH for that service.

Payments for Patient Care

What will be the process for determining how payments for services will be “reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service”?

Will meaningful outreach to various health care provider associations for their input be required, as they are currently in Workers Compensation and Medicare?

Will there be a Board charged with assessing the reasonableness of such fee schedule?

While the bill importantly notes that payments will be on a “fee for service” basis, it also conditions that this will only be the case “until another payment methodology is established”. What will be the process for establishing these “alternative payment
methodologies"? Once established, which body will be responsible for interpreting the submissions to determine whether the health care provider has met the conditions required as part of these APMs?

A key provision of the bill (§5105(4)) states:

“All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service.”

Actual payment methodologies and rates would be determined by the commissioner and the NYH board (which includes provider representatives), with consultation with a broad range of interested parties including providers (§5107 [5]). These criteria could be enforced legally in court. The bill also includes provision for collective negotiation with provider organizations. The Legislature would have an interest in making sure provider payments meet these criteria because it will have a direct effect on the quality of care that legislators, their families, their constituents, etc. receive.

The NYH program would be in charge of processing claims and payment, whether under a fee-for-service system or other models, such as value-based payments, capitation, etc. This function could be performed – under NYH policies and rules – by a contractor (as with traditional Medicare).

How will the NY Health system respond to situations where anticipated tax revenues are not meeting spending projections?

The plan has authority to maintain a reserve fund, which could cover such contingencies. Ultimately, if necessary, the Governor and Legislature could provide for raising increased revenue.

We note that the bill does not specify the timeframes for NY Health or intermediaries to make payments for health care services delivered? What will be the recourse for inappropriately delayed payments?

The legislative intent is that the prompt pay requirements of the Insurance Law would apply. This could be made explicit in the bill. Under procedures described above, NYH could adopt better provisions.

The “collective negotiation” provision is an important element to this bill. However, what is the incentive for the government to negotiate fairly with the health care providers’ representative? Should there be an “appeal mechanism” in situations where the physician collective reasonably believes that NY Health is not negotiating in good faith?

In addition to the procedures described above, we are considering including some version of the impasse provisions in the free-standing collective negotiation bill.
Some modification would be called for because the Commissioner is an interested party, not neutral.

**Miscellaneous Questions**

Would auto accident injuries be covered under NY Health? The definition of “benefits” appears to include coverage injuries arising from auto accidents, but it would also not repeal auto insurers’ requirements to cover these health care costs as well.

If Insurance Law Art. 51 applies to a particular instance, that would preclude NYH coverage. This should probably be re-considered in the same context as considering the status of Workers Comp coverage.

Will this prohibit self-insured employers from offering health insurance benefits to their employees? How would this impact upon patients who receive retiree health care coverage from their former employer?

Because of federal law, NY cannot preclude employers from offering self-insured plans. However, any employer continuing to offer a self-insured plan and its employees would still have to pay NYH taxes, and the employees would have better coverage available to them under NYH at no extra cost. It is hard to imagine that any employer would continue to offer a self-insured plan.

Retirees living in NYS would receive better coverage under NYH than they now receive. The bill provides for future development of a proposal for dealing with retirees who lived in NY and then move out of state.

How would a patient enrolled in NY Health have coverage for care when they receive care in another state (i.e. "snowbirds")?

The bill explicitly provides for NYH to pay for care received out of state by a NY resident who is temporarily out of state or when care is provided out of state for clinical reasons (e.g., if the nearest hospital is on the other side of the state line).

Would a patient’s personal Health Savings Accounts (HSAs) still be permitted to be used to cover health care costs?

People with HAS balances would not need to use them to pay for health care, because it would be covered by NYH. Funds in an HSA, like any funds, could be used to pay for health care services, but not if the service is provided “under the program” (in which case supplemental payments would be barred).

Would physician, hospital and other health care employers be subject to the proposed employer tax when the likelihood is that, at least for many, their payments for care will be substantially reduced under NY Health?
Physicians would benefit because the time and administrative costs they spend with multiple complex billing systems and fighting with insurance companies would be dramatically reduced, and their income would benefit because there would be no New Yorkers who can’t afford their out-of-pocket share of a bill, and provider payments that today do not cover costs (whether commercial, Medicaid or Medicare) would be legally required to meet the standard of reasonableness and adequacy mentioned above. The NYH taxes would be graduated based on ability to pay, so if, for some reason, an individual’s income goes down, their NYH tax would go down.

If a physician has low- or middle-income employees for whom the physician provides health coverage, there would be substantial savings because the NYHA payroll tax would be substantially less than the current premium. If the physician is not now providing health coverage, the NYHA would mean no longer losing a good employee who leaves for a job that provides coverage.

We would further note that, given the projected need for extensive new resources to help pay for this program, it would appear that there is a need to reduce some of the unnecessary costs embedded in our health care system. One such example are [sic] so-called “defensive medicine” costs, which generally refer to additional diagnostic tests of marginal utility that a health care practitioner feels compelled to perform in order to help defend against a possible future lawsuit. Providing meaningful control of New York’s enormous liability costs and liability exposure would help to reduce these defensive medicine costs.

As you know, I believe any change in the professional liability system requires the governor to bring together representatives of health care providers, patients, lawyers and others and (perhaps not literally) lock them in a room and make them come up with proposals they can all live with. As we have discussed, a system in which patients do not have to worry about deductibles, out-of-network costs, and other expenses – including the cost of care to remedy a bad outcome – would help reduce liability disputes and costs.