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TESTIMONY OF ART FOUGNER, MD
PRESIDENT, MEDICAL SOCIETY OF THE STATE OF NEW YORK
at a
SENATE-ASSEMBLY HEARING
EXAMINING THE PROPOSED NY HEALTH ACT
May 28, 2019

Good morning. My name is Dr. Art Fougner. I am the Chief of Gynecological Ultrasound at Northwell Health and I am the President of the Medical Society of the State of New York.

On behalf of our over 20,000 physician, resident and student members, I wish to thank you, Assemblyman Gottfried and Senator Rivera, for organizing this hearing today to hear comments regarding the New York Health Act. I also thank you both for your continued efforts to assure necessary health insurance coverage and health care availability for all New Yorkers, as well as your interest in seeking to address the concerns of the physician community in advancing this far-reaching legislation.

To begin with, we note that the revised New York Health Act legislation introduced in February contains some improvements over earlier versions including changes to address some of the concerns raised by physicians with the potential enactment of such a far-reaching proposal. This includes inclusion of coverage for long term care, parameters to limit burdensome prior authorization requirements and some additional steps to facilitate fairer negotiations between a government bureaucracy and the physicians' delivering patient care.

As we have stated on multiple occasions, physicians across New York have divergent perspectives on the impact of a potential single-payer health care system for our patients. Some believe it would help reduce some of the many insurer-imposed administrative hassles physicians have experienced in the current for-profit insurer-controlled system, or at least create some uniformity in the hassles. Others believe it could create significant new barriers to patient care delivery by adding an enormous new fiscally controlled state government bureaucracy that would oversee care delivery and also make New York a less attractive place to practice medicine.

And many physicians believe both could happen. I have heard several physicians say to me that they support the idea of a single payor system but are concerned that, despite the best of intentions, government could "screw it up."

Certainly, I would note here that the insurance industry in many respects has spurred on this dynamic of physicians and patients wanting to support such far-reaching legislation, due to the litany of patient care hassles, such as excessive prior authorization requests and delays, drug formulary limitations and arbitrary changes, narrow networks that limit patient choice, and ruinous deductibles that leave patients significantly underinsured.

Indeed, a just-released American Medical Association (AMA) survey reported that 91% of responding physicians said that the prior authorization process delays patient access to necessary care; with more than ¼ of the respondents indicating that a PA process led to a serious adverse event. Moreover, 86% said that burdens associated with prior authorization were high or extremely high; and 88% reported that these PA requirements had increased in the last 5 years.

Our Annual meetings have seen very passionate debate among our physician delegates regarding what should be MSSNY's approach to this issue. While MSSNY continues to have a long-standing policy in support of a multi-payor insurance system to achieve universal coverage and in opposition to a single payor system, this evolving diversity of perspective has promoted MSSNY to also adopt policy to continue to study the feasibility of varying systems for achieving universal coverage including a single payor structure.

In this regard, MSSNY continues to assess the strengths and weaknesses of this and other proposals to achieve universal health insurance coverage. There are many dynamics to this issue that must considered. There are huge ramifications not only for patients considering their options for receiving needed care, but also for physicians and other health care providers deciding in which states they would like to deliver patient care. Physicians not only approach this issue as care providers, but also as providers of health insurance for their employees as well as patients themselves.

We further note that New York has done a good job in reducing the numbers of uninsured in New York (even as we continue to raise concerns about the sufficiency of that coverage). A recent report from the New York State of Health shows that the number of uninsured in New York went down from 10% in 2013 to 5% in 2017, through the variety of coverage options offered through the Exchange, such as expanded Medicaid, the Essential Plan, and subsidized health insurance coverage options.

Continued promotion and expansion of these varied programs for providing coverage is MSSNY's preferred approach. We also believe it is critical to develop programs that minimize the extensive cost sharing often thrust upon patients.

Authorization for Patient Care

With regard to specific aspects of this legislation, we appreciate that the sponsors of the legislation have amended the bill to limit pre-authorization requirements to that which is required by Medicare. While not expressly defined, we presume that means Medicare fee for service?

Even with limited prior authorization, we do have questions regarding what will be the mechanism by which a patient and/or their physician can appeal a denial of coverage by NY Health? We appreciate that the current bill references the mechanisms under existing Insurance and Public Health Laws to appeal denials of care, including the essential right to Independent External review. However, we have concerns about a government bureaucracy that is looking to save money forcing some claims into appeal, knowing that the likely result will be that most will not due to the inherent challenges in making such appeals.

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? We appreciate that the intention is not to limit physician participation, but again this is an area where the best of intentions could be set aside by a government bureaucracy looking to save money.

Payments for Patient Care

Perhaps the greatest concern expressed by physicians is determining payments for patient care delivery. We very much appreciate the comments of the sponsors that the legislation's defined standard creates a potentially court enforceable standard if it is perceived to be little. Recognizing the often difficult nature of litigation as well as the fiscal challenges New York State faces, we are not sure 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?

While we note that creating uniformity among quality reporting/payment programs are one of the key benefits identified by physicians who support this type of legislation, we also note that complying with the many facets of the Merit-Based Incentive Payment System (MIPS) value based program for Medicare has also produced a lot of consternation for physicians.

We note that the bill does not specify the timeframes for NY Health or intermediaries to make payments for health care services delivered? We appreciate that the intention is to be consistent with the Prompt Payment law, but that may need to be specified in the legislation. Moreover, should payments not follow these timeframes, what will be the recourse for inappropriately delayed payments?

We also appreciate that the collective negotiations component of the bill has been amended to match an element of the "stand-alone" collective negotiation bill that sets forth a mechanism for an independent mediator to help resolve an impasse between the negotiating physicians and the State entity.

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. Once again, liability reform IS healthcare reform.

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. Again, we very much appreciate your continued efforts to be responsive to concerns and questions raised by physicians. While there are many aspects to such a system that are appealing, we do remain concerned that your good intentions of how such a system should operate will not be how the NY Health system will ultimately operate, particularly when they must respond to situations where anticipated tax revenues may not meet spending projections. We are also concerned for the potential for future unfunded mandates and administrative burden. Finally, as events in other countries have demonstrated, a single payer for medical care implies a single decider for medical care.

Instead of a single payor system, we would urge a more targeted approach to further reducing New York's insured and underinsured. This would include proposals to increase subsidies for the purchase of comprehensive health insurance coverage, as well as enactment of several pieces of legislation that you sponsor to reduce insurer hassles such as:

- A.2393/S.3462, to permit physician collective negotiation
- A.3038/S.2847, to reduce burdensome prior authorization requirements
- A.2969/S.2849, to limit mid-year formulary changes
- A.2835/S.3463, to assure physicians have necessary due process when a health insurer refuses to permit a physician to continue to participate.
- A.5140/S.5280, to prohibit a health insurer from requiring a physician to continue to endure burdensome MOC as a condition of continuing network participation.

Other approaches include expansion of Health Savings Accounts with novel approaches to funding. This would empower the extremely cost-effective Direct Primary Care practices. This approach has also been successfully implemented in Singapore, long regarded as having an exemplary healthcare system.

Finally, I might remind this body of an informational report from 2009 developed by our Medical Society with input from Assemblyman Gottfried that called for a Public Option to be available on the NY State of Health Marketplace.

We look forward to further discussions with you on this issue.

Sincerely,

Arthur C Fougner MD

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THE LEAGUE
OF WOMEN VOTERS
of New York State

TESTIMONY REGARDING NEW YORK HEALTH BILL
SUBMITTED TO
JOINT NYS SENATE HEALTH COMMITTEE
and ASSEMBLY HEALTH COMMITTEE
PUBLIC HEARING, Albany New York
Tuesday, MAY 28, 2019, 10am
Hearing Room A
Legislative Office Bldg. 2nd fl.

Good afternoon, my name is Madeline Zevon. I am Co-Chair of the Health Care Committee of the League of Women Voters of New York State and Chair of the League of Women Voters of Westchester County, and a member of the League of Women Voters of White Plains. The League of Women Voters is a non-partisan political organization that encourages informed and active participation in government and works to increase understanding of major public policy through education and advocacy. I would like to thank the New York State Senate and Assembly Health Committee for holding today's hearing and allowing me to speak on behalf of the State League.

Access to affordable, quality health care is pivotal in determining the quality of life for New Yorkers. The League has advocated on behalf of all New Yorkers for over 20 years on the issues of health care, and has lobbied and testified on numerous bills that safeguard public access to health. The League believes that affordable, quality health care should be available to all New York State residents and that health care policies should include equitable distribution of services and the efficient and economical delivery of care.

First, I will focus on the issues of equity, and then address efficiency and cost control. Equitable distribution of services means that individuals should have access to a basic level of care regardless of income, age, health status, geographical location, or any other factor. As long as private health insurance corporations are the middleman between patients and providers, services will not be distributed in an equitable manner. Persons who are less likely to need care will have greater access to coverage, while those who are in need will go without.

The Affordable Care Act has gone far in mitigating some of the shortcomings of private-for-profit insurance, such as refusing coverage to people with pre-existing medical conditions and imposing

annual lifetime limits, What's happening now that the ACA is unfolding, there's a lot of cost shifting to the consumer with high deductibles and co-pays. Before the Affordable Care Act was passed, there were 2.9 million New Yorkers uninsured. However, even when the plan is fully implemented according to the Urban Institute of New York, there will be 1.675 million New Yorkers still uninsured. The Affordable Care Act is not a universal plan.

The League opposes a strictly private market-based model of financing the health care system. We believe that a universal single-payer system such as New York Health is a way to achieve substantial and lasting reductions in the cost of care. By consolidating responsibility and thus accountability for health care into a single-payer system, we will be better positioned to achieve quality health care for all.

In a single-payer system of publicly financed, privately delivered health care for all New York State residents, citizens will decide the level of basic care. Under this system, the long-term health of each person is valued equally. If we opt to cover effective wellness and disease prevention programs now, we will spend less in later years. It will make more sense for us as a group to pay for regular dental care now in order to avoid more costly procedures later in life.

Under the single-payer model, coverage for disease prevention and health promotion programs and services will also make good economic sense. Private health insurers are not motivated to achieve long-term benefits in health status, especially with the employer-based system. The pool of participants in a given plan is transient, individuals change plans as they change employers, and besides, it is all too easy to drop coverage if the costs get too high. The existing system is too shortsighted to make substantial commitment to prevention and wellness programs.

The League supports the standardization of basic levels of service for publicly funded health care programs as a step toward equity. Under the single-payer model, every New York resident would be eligible to enroll. There would be no premiums, deductibles, or co-payment. Coverage would be funded based on ability to pay through a progressively graduated state payroll tax and taxable non-payroll (investment) income. Federal funds now received for Medicare, Medicaid, Family Health Plus and Child Health Plus would be combined with state revenue in a New York Health Trust Fund. The "local share" of Medicaid funding--a major burden on local property taxes--would be ended. It is projected that New York State would save $11.4 billion under a single-payer system according to the RAND Corporation. All New Yorkers would be covered for all medically necessary services, including: primary preventive, specialists, hospital, mental health, reproductive health care, dental, vision, prescription drug, and medical supply costs. In January 2019 the act was amended to include long-term care - the bill is more comprehensive than most commercial health plans.

Over 2,000 New Yorkers die each year because they do not have adequate health insurance coverage according to Physicians for a National Health Program. When the ACA was fully implemented, based on the number of additionally insured, the estimate dropped to about 1500 death per year. Here in New York we have the opportunity to lead the way in implementing cost-effective, universal health care, effectively making health care a right for all New Yorkers.

Thank you for this opportunity to share our views with you.