New York County Medical Society

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TESTIMONY OF SCOT B. GLASBERG, MD

AT

THE JOINT PUBLIC HEARING OF

THE NEW YORK STATE ASSEMBLY COMMITTEE ON HEALTH

AND THE NEW YORK STATE SENATE COMMITTEE ON HEALTH

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BRONX, NEW YORK

Good morning. I am Doctor Scot Glasberg, a past president of The New York County Medical Society.

I want to make it clear that although the Society does *not* support the New York Health Act in its current form, we do — very much — appreciate the efforts that have already been made by Assembly Health Committee Chair Richard Gottfried and Senate Health Committee Chair Gustavo Rivera to address many concerns that we have discussed with them in a series of positive and productive meetings. For example, Mr. Gottfried and Mr. Rivera have been willing to include in the bill provisions for long–term care coverage, limits on preauthorization

requirements, and legal authorization for collective negotiation by independent physicians. All these elements are very important for physicians.

In the same spirit of working together, we wish to highlight additional areas in the Act that would benefit from specific, unambiguous language.

Economic Dimensions — Supporting Full Access to Care for New Yorkers: In recent testimony and discussions, a key question has been how the new system is to be funded. The State has never before tried the Act's new approach - paying for care out of one huge central financial repository. Issues include, How can we project future costs? What tax revenues will we need? What about new technology — or new diseases? What about new configurations that are changing the landscape, such as the "mega–complexes" recently formed by merged hospitals? What if there is an economic downturn, so that the tax base shrinks? Projections have been tentative, and there has been much controversy. And meanwhile, amid all these variables and uncertainties, there is the question of how providers will be paid. Will payments be adequate to support a full range of care settings, so that patients can choose among hospitals, free-standing clinics, group medical practices, small independent physician offices, and more? Or, if the system comes under fire, will provider payments be the first ones cut?

We as physicians do not disagree that this momentous experiment ***may*** improve our current healthcare system, which certainly is not perfect. But we have two major concerns:

1) We need to have confidence in how the basis for payment for physicians and other providers will be determined. Mr. Gottfried, you have said in meetings with us that you do not believe providers can be adequately supported at the payment level of Medicaid, or even Medicare. We agree with you. "Medicare for All" may be a catchy slogan, but it will not support a healthcare structure in New York. We urge you all to turn to the healthcare fee data base developed by the FAIR Health organization – something the state legislature has already worked with in preparing previous legislation. As you know, FAIR Health came about through actions of Andrew Cuomo, who was then New York State Attorney General, after a successful suit against healthcare insurers here in New York State. FAIR Health is an independent nonprofit organization that collects data for, and manages, the nation's largest database of privately billed health-insurance claims - plus Medicare Parts A, B and D claims data — ranging from 2013 to the present. FAIR Health provides transparency and real-life data that can be used as a basis for in-network and out–of–network medical fees. Our Society looks forward to holding further discussions with you on ways to use FAIR Health as a standard for payment.

2) We need assurance that payments for physician services will not be lowered when the State faces economic pressures. If the State takes this gamble on a new healthcare structure, healthcare providers cannot be the first ones to bear the brunt of possible economic downturns, especially as running medical practices involves fixed expenses that are continuing to rise (e.g., medical liability premiums and the costs of electronic medical records systems). The New York Health Act needs to take such costs of business into account. And, once a fee schedule is determined, yearly cost–of–living increases need to be included in the legislation as well.

Clinical Decision-Making: Clinical decision–making is the basis of quality in medical care. It is founded on the knowledge and experience of professionals with years of training. New Yorkers expect the best possible medical care, and decisions about such care must not depend solely on economics or efficiency. Within the new system outlined by the New York Health Act, the question of who will decide which procedures are medically necessary is a crucial one. New York State has long barred the corporate practice of medicine; under the law, non–physicians are not permitted to control or even influence clinical decisions. We believe this point must be supported in the system created by the Act.

In our current healthcare system, obstacles and barriers frequently are put up by insurance carriers, but at least there are multiple carriers. Even if, now, patients and physicians are

frustrated when people with little or no specialty medical experience or qualifications act as "gatekeepers" regarding crucial care decisions, at least patients do have some choice. Under the New York Health Act, it is crucial that patients not face barriers to care that have been erected by a single State decision–making entity. Clinical factors need to have been carefully considered, especially when the patient has no other place to go. Decisions must always be made by those with the proper professional qualifications, and an appeals process must always be available for the patients.

The Act as now written mentions three entities that may be involved in clinical decision-making — Care Coordinators, Health Organizations, and a Board of Trustees — but the roles of these entities and their relationship to each other are not spelled out. We believe these entities' roles should be described in detail, with written assurance that medical decisions will be shaped by the ethically protected physician/patient relationship, and not be second–guessed by non-physician administrators. To that end, we recommend that the Board of Trustees should include at least four physician members instead of the two now written in the law.

I will be glad to answer any questions about these points. Thank you for the opportunity to speak to you today and for the consideration you have shown to the medical community in the past.