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**Testimony Of
The Medical Society of the State of New York
Before the
New York State Assembly Committee on Ways & Means
New York State Senate Finance Committee
On the Governor's Proposed Budget
For State Fiscal Year 2026-2027**

I am Dr. David Jakubowicz, Director of Otolaryngology and Allergy at Essen Medical in the Bronx, and a Clinical Assistant Professor of Otorhinolaryngology at Albert Einstein College of Medicine/Montefiore. I am also the President of the Medical Society of the State of New York (MSSNY), which advocates for more than 20,000 physicians, residents and medical students practicing in regions across New York. We thank you for the opportunity to present testimony today.

MSSNY's diverse membership shares a common goal: to ensure that every New Yorker has access to high-quality, affordable, physician-led healthcare. However, the ability of physicians to deliver this care is increasingly challenged by a growing encroachment into medical decision-making from non-physician providers, health insurers, corporate pharmacy chains, private equity firms, dominant health systems, electronic health record vendors, and policymakers. While these entities may pursue well-intentioned goals of improving care or reducing costs, their actions often limit treatment options, weaken physicians' ability to advocate for their patients, and drive many doctors out of clinical practice, whether through early retirement, relocation out of state, or displacement by non-physician practitioners.

These pressures are taking a measurable toll on physicians' well-being. A [2025 national survey](#) found that physicians continue to face mounting challenges contributing to burnout, stigma, and barriers to accessing mental health care, with **55%** reporting feeling levels of debilitating stress; **54%** reported frequent feelings of burnout, and **73%** citing stigma surrounding their personal access to mental health care.

These findings underscore an urgent need for systemic reform to protect physicians' mental health and preserve a sustainable, compassionate workforce capable of meeting New Yorkers' healthcare needs.

Physicians' ability to care for their patients may be further strained by new state-level challenges stemming from recently enacted federal legislation. These changes could cause many patients to lose coverage through essential public health insurance programs such as the Child Health Insurance Program (CHIP), the Essential Plan, and Medicaid.

In many community-based practices, particularly those serving rural and urban underserved regions, a large share of patients may be covered under these public programs. A significant loss of insured patients could therefore become the final blow for already struggling practices. [The New York State Comptroller's Office](#) has warned that many rural counties already face severe access-to-care challenges; further patient coverage losses would deepen these disparities and strain the state's healthcare safety net.

Compounding these pressures, New York consistently ranks among the worst states in the nation to practice medicine. Physicians in New York face:

- [The highest medical liability costs in the country — exceeding the combined payouts of California and Florida.](#)
- High office overhead expenses and administrative burdens.
- One of the nation's heaviest tax and regulatory environments.

These factors make it increasingly difficult to attract and retain physicians, particularly in underserved areas.

Given all these challenges, we are alarmed that, while there are some modestly positive aspects in Executive Budget, there are greatly outweighed by the numerous problematic initiatives that will impose huge practice cost increases and substantially cut insurer payments – that will chase many physicians away from New York State. Instead of seeking to expand the availability of physicians, this Budget proposal seeks to replace them through inappropriate expansion in the scope of physician assistants.

All of these must be rejected - We cannot have a functioning healthcare system if we are choosing to balance the State Budget on the back of New York's dedicated physicians.

REJECT EXORBITANT COST IMPOSITIONS ON PHYSICIANS RECEIVING EXCESS MEDICAL MALPRACTICE INSURANCE COVERAGE

We urge you to again reject an incredibly short-sighted proposal within Part D of the Health/Mental Hygiene Article 7 bill (A.10007/S.9007) that would require the nearly 16,000 physicians currently enrolled in the Excess Medical Malpractice Insurance program to bear 50% of the cost of these policies. This

proposal has been advanced in multiple previous Executive Budgets but thankfully has been rejected by the State Legislature because of its adverse impact not only on physicians, but for the patients who are the ultimate beneficiaries of this program. We urge the Legislature to again reject this proposal and protect needed patient access to primary and specialty-based physician care.

This incredibly short-sighted proposal would thrust nearly \$40 million of new costs on the backs of our dedicated community-based physicians who are already struggling to keep their practices afloat for patient care, a problem that will only get worse as the provisions of HR 1 enacted by Congress last year will significantly increase the number of uninsured patients. These physicians already face staggeringly high liability premiums that have gone up by 15% in the last 4 years and face continuing cuts in reimbursement from Medicare and other payors who perpetually ratchet down reimbursement and unfairly delay and deny payments for needed patient care. This UNCONSCIONABLE cost imposition proposed in the Executive Budget will most acutely impact those specialty physicians where we are already seeing physician shortages that are adversely patient access to needed care, including reproductive healthcare services, emergency care, and surgical services.

Many of these physicians will have no choice but to move to other states with more favorable practice environments. Indeed, many have done so, with a particular adverse impact on rural areas. Many others may forego the coverage to avoid the thousands to tens of thousands of dollars of new costs, *per physician*, this Budget proposal would impose.

ESTIMATED NEW COSTS TO BE IMPOSED ON PHYSICIANS FOR EXCESS COVERAGE BASED UPON GOVERNOR'S 50% COST BUDGET PROPOSAL

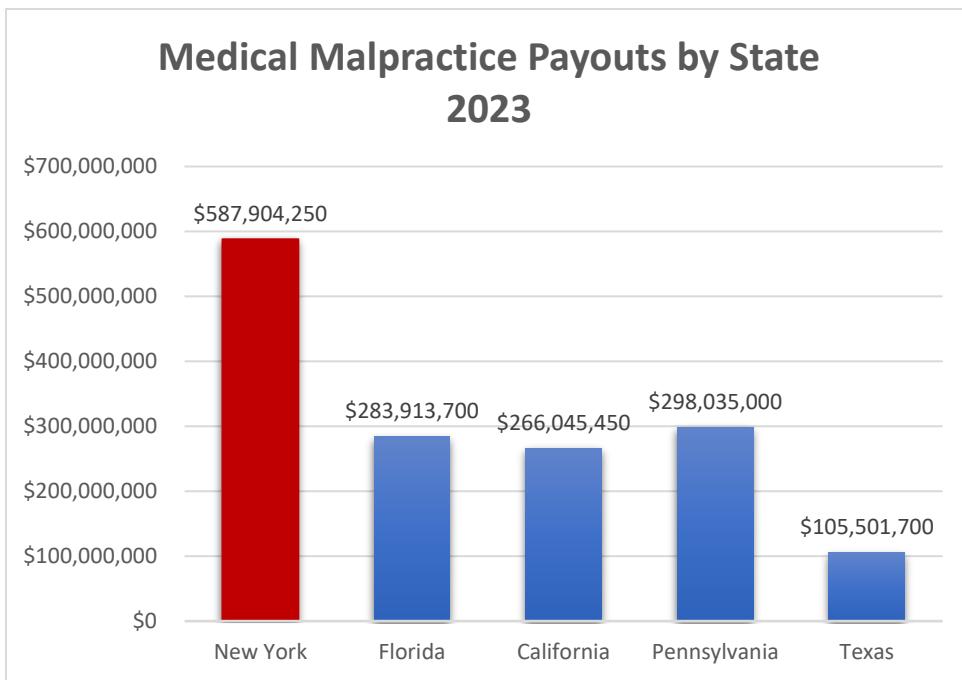
Specialty	Long Island	Bronx, Staten Island	Brooklyn, Queens	Westchester, Orange, Manhattan	Buffalo, Syracuse, Albany	Mid-Hudson Valley
ER	\$5,707	\$6,625	\$6,191	\$4,186	\$1,736	\$3,364
Cardiac Surgery	\$4,036	\$4,684	\$4,377	\$2,960	\$1,228	\$2,378
General Surgery	\$4,300	\$4,601	\$4,300	\$2,907	\$1,206	\$2,336
OB-GYN	\$17,032	\$19,769	\$18,474	\$15,181	\$5,182	\$10,038
Neurosurgery	\$28,729	\$33,347	\$31,162	\$21,069	\$8,736	\$16,931

These costs would be on top of the tens of thousands, in some cases, hundreds of thousands of dollars that physicians already pay per year for their liability insurance coverage.

The Excess Medical Malpractice Insurance Program provides an additional layer of \$1M of coverage to physicians with hospital privileges who maintain primary coverage at the \$1.3 million/\$3.9 million level. The program was created because of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had worked on for all their professional lives could be lost because of one wildly aberrant jury verdict.

This fear continues today since New York State has failed to enact meaningful liability reform to ameliorate this risk. The size of medical liability awards in New York State has continued to rise significantly and physician liability premiums remain far out of proportion compared to the rest of the country. While countless other states have passed comprehensive medical liability measures to bring these costs, New York has not. As a result, our state's medical liability payouts are double those of Pennsylvania, the next highest state, and exceed the combined totals of California and Florida. For these reasons, New York is regularly ranked among the [worst states in the country for physicians to practice medicine.](#)

Absent comprehensive liability reform to bring down New York's grossly disproportionate medical liability costs, maintaining an adequately funded Excess Medical Malpractice Insurance Program is essential to maintaining some availability of skilled physician care throughout the various regions of New York to ensure patients can receive the care they need and in a timely manner.



We again thank you for your past efforts to oppose this incredibly short-sighted proposal, but we need your help again. If this was a bad idea in previous Budget cycles, it is even more problematic now due to the increased pressures our

healthcare system is facing because of the provisions of HR 1. Please reject proposal as you work towards enacting an agreed upon Fiscal Year 2026-27 State Budget, and work for the enactment of measures that will help to reduce these overwhelming costs that are interfering with patient access to needed care.

REJECT PROPOSAL TO UPEND NEW YORK'S GROUNDBREAKING IDR PROCESS FOR RESOLVING SURPRISE MEDICAL BILLS

We strongly oppose a proposal within Part T of the PPGG Executive Budget Bill that would completely upend the rules for the determination of claims brought to New York's Independent Dispute Resolution (IDR) process for emergency and other hospital-based care provided to adult and pediatric patients by a non-participating physician. It would also eliminate the right of healthcare providers to even bring claims for IDR consideration related to care provided to enrollees of Medicaid Managed Care plans. I thank the Assembly and Senate for rejecting similar proposals in previous Budget cycles and urge that you again **OPPOSE** this short-sighted and greatly expanded proposal this year.

Physicians across the State are very concerned with the serious adverse impact that these profound changes will have on adult and pediatric patients' access to skilled specialty physician care, including access to needed and often immediate surgical care in hospitals across the State, particularly in underserved urban and rural areas. In implementing New York's successful surprise billing law, which has become a model for the nation, policymakers

sought to establish a fair dispute resolution process to resolve payment disputes that did not favor either physicians or health insurers.

The law has historically given the IDR entity the power to consider a number of factors in arriving at its decision, including the circumstances of the patient care provided, the expertise of the particular physician providing the care, and similar fees and payments charged by and paid to physicians of that particular specialty in that region. In fact, at the request of the health insurance industry, the criteria were expanded in 2023 to permit the IDR entity to factor in the median payments made by health plans to its participating physician, data which the health insurer controls.

This new Budget proposal would significantly shift the balance of this law by creating a process that puts its “thumb on the scale” in favor of the already well-heeled health insurance industry, which holds dominant market power in most regions of New York State, market power which makes it impossible for smaller community medical practices to negotiate fairly with these behemoths. It would for all intents and purposes eliminate the IDRE’s consideration of the various factors it can currently consider in arriving at a decision for which party – the health plan or the physician – should prevail.

We note that this initiative has been framed as a way to respond to the significant increase in claims brought by the IDR. We would highlight it is the inevitable result of a significant increase in wrongfully denied and underpaid claims by a well-heeled health insurance industry more interested in returning profits to shareholders than making sure patients get the care they need. One need only look to the 40% increase in overall External Appeal requests challenging health plan coverage denials and 70% increase in health plan denial overturned through External Appeal since 2019 to see the marked increase in wrongful denials by health insurers **NYSDFS: 2024 CPFED Annual Report**. We also note that the number of Internal Appeals of health plan coverage denials including successful internal appeals has also steadily increased since 2019.

The success rate for providers pursuing IDR strongly suggests that initial insurer payments are routinely far below what should be fair payment in these often emergent and urgent care instances. Research shows that qualifying payment amounts are often calculated 30-50% below historical in-network rates, in part because plans include so-called ‘ghost contracts’—rates for services that were rarely provided—in order to suppress the median.

At the same time, denial rates have steadily increased, often through automated or AI-driven utilization reviews that force clinicians into arbitration simply to receive payment for medically necessary care. Providers report

being pressured to accept deep in-network cuts or face termination, and in some cases entire contracts have been dropped, pushing large numbers of patients out-of-network overnight and destabilizing local care networks.

In other words, if insurers initially paid their providers fairly for care to patients, there would be no need for as many claims to go to IDR. Taken together, these trends point to a system where plan payment strategies, contracting leverage, and claims practices are driving disputes, threatening network stability, and ultimately putting patient access at risk. IDR is used as a last resort when routine payment and negotiation fail.

The impact of this Budget proposal goes far beyond adversely impacting the relatively small number of physicians providing care on an out-of-network basis. It would also adversely impact the ability of all physicians to attempt to negotiate a fair contract with health insurers that protects physicians' right to advocate for their patients – rights which include not only the level of payments but also rules relating to time frames for payment, audits, prior authorization, prescription drug coverage and circumstances for covering patient treatment. The one minimal right physicians have in negotiating with these healthcare behemoths is the "right to walk away" from an oppressive health plan contract with the health plan facing the risk they may have to pay above their fee schedule if their enrollee is treated by a non-participating physician in an emergency or urgent context. This Budget provision would take away even this one minimal right, again at the expense of physicians' ability to advocate for their patients.

Far from reducing health care costs, this proposal would increase them as more and more community-based medical practices find they have no choice but to become hospital employees. This would further accelerate hospital consolidation across the State and reduce competition in the delivery of healthcare services.

Of greatest concern to New York's health care system is that, without a fair appeal process to obtain fair reimbursement, many physician specialties will be discouraged from providing essential on-call emergency department care, at a time when many such departments are already frequently understaffed. With regard to Medicaid Managed Care plans, this change will also encourage these plans to significantly cut fee schedules for all of their network physicians, endangering access to care for their enrollees and further threatening the viability of many community-based physician practices. The result would be far less patient access to needed care in emergency settings all across the State.

The relatively small State Budget savings of this proposal is significantly outweighed by the risk that it will greatly harm adult and child patient access to needed emergency and post-emergency care, particularly in underserved rural and urban areas of the State. The Legislature has long recognized the importance of protecting a fair dispute resolution process to ensure needed on-call specialty care in hospital emergency departments across the State. Therefore, we urge you to reject this short-sighted proposal as you work to adopt the Budget for the 2026-27 Fiscal year.

REJECT PROPOSAL THAT WOULD REMOVE VETTING ROLE OF COUNTY MEDICAL SOCIETIES IN WORKERS COMPENSATION PARTICIPATION

We urge the Legislature to again reject a proposal contained in Part X of the Executive Budget Public Protection and General Government bill (A.10005/S.9005) that would eliminate the historical review role that county medical societies have played in recommending physicians to participate in New York's Workers' Compensation program. We thank the New York State Assembly and New York State Senate for not including this proposal in your recently adopted respective "one-House" Budget proposals and urge that you continue to work to ensure that this proposal remains out of the final adopted Budget.

We very much appreciate the goal of this measure to ease the burdens associated with participation in the Workers' Compensation program. However, this proposal does not address the fundamental challenges that have resulted in limited physician participation in this program. The reason why physicians have been reluctant to participate is the challenging process for obtaining approvals for patient care as well as the significant challenges in navigating the burdensome, often controverted, process to be fairly paid after services have been delivered to injured workers. It can take months or even years to receive payment for care that was appropriately delivered to injured workers.

Even more frustrating is that a Board decision setting forth a carrier's responsibility for making payment does not necessarily mean that payment will actually be made to the physician providing care. Certain payors, particularly municipal entity payors, regularly fail to make payments that have been deemed to be due to physicians, as a result of the lack of a meaningful enforcement mechanism.

Furthermore, our county medical societies provide an important review function in ensuring qualified physicians are participating in this essential program. The No-Fault Insurance program, which does not have a process for the approval of participating providers, has witnessed significant allegations

of fraud and abuse in the program, (as evidenced by proposals in other portions of the PPGG Budget bill to address No-Fault fraud). One such reason may be the lack of a proper vetting process for participation in that program that currently exists for Workers' Compensation but under this proposal would be eliminated. Moreover, most forms of insurance coverage, whether it be Medicare, Medicaid or commercial health insurance require a vetting process for provider participation to help ensure that patients accessing care under that program are being treated by quality providers.

Of perhaps greatest concern, permitting every physician to participate in the Workers' Compensation program by virtue of their license could impede the processing of claims by injured workers because many of these physicians may not have the deep knowledge of the Workers' Compensation treatment guideline and claim process that participating physicians must have. Having physicians poorly vetted or less knowledgeable of workers' compensation process provide care could potentially jeopardize an injured worker's legitimate claim under workers' compensation laws.

It is essential that we find solutions to the systematic challenges that deter physician participation in the Workers' Compensation program. However, eliminating the important review role played by county medical societies in the vetting process for participation does not address these challenges, and may have the effect of endangering care for injured workers. **Therefore, we respectfully request that you continue to oppose this provision and that it remains out of the State Budget.** Thank you for your consideration.

REJECT ELIMINATION OF PHYSICIAN SUPERVISION OF PHYSICIAN ASSISTANTS AND PRESERVE PHYSICIAN-LED TEAM CARE

We respectfully request the removal of a proposal in Subpart E of Part N of the Executive Budget Health & Mental Hygiene Budget bill (A.10007/S.9007) that would expand the authority of many physician assistants (PAs) to deliver care without the oversight and collaboration of a physician. We thank the State Legislature for rejecting similar proposals in previous years' State Budgets and ask you to do so again.

PAs are undoubtedly an essential source of care delivery within our health care delivery system. However, we are very concerned with the adverse patient impact of completely removing the important oversight and coordination role which a trained physician plays in overseeing a patient's care, particularly as it relates to the ordering of diagnostic tests, the evaluation of the effectiveness of various prescription medications and treatments and the ongoing assessment of the patient's response to treatment. All of these oversight functions are essential safeguards in assuring that less trained professionals do not overlook important elements of the patient's unique circumstances.

To address gaps in access to care, we believe that policymakers should begin by focusing on affirmative steps that can be taken to address the shortage of specialized physicians in various regions of the state. As a result of our challenging practice environment, New York continues to maintain the dubious distinction as one of the [worst states in the country to be a doctor](#). This is the result of New York's exorbitant liability costs, low Medicaid and other payor reimbursement, pervasive insurer hassles, and high overhead costs. This fundamentally impacts our ability to attract new physicians to New York State, and to retain the thousands we train each year.

Rather than exposing patients to diminished quality of care by expanding scope for various non-physicians, policymakers must work to improve New York's practice environment by expanding medical student loan repayment opportunities and addressing the overwhelming administrative burden on medical care delivery such as reducing excessive prior authorization and data reporting requirements which has led directly to physicians retiring early due to "burnout" or relocating to other states. Making matters worse are the plethora of other Executive Budget proposals advanced this year that seek to balance the State Budget on the backs of New York's dedicated physicians (including steep new costs for obtaining Excess Malpractice Insurance Coverage, and greatly diminished physicians rights in the State's Independent Dispute Resolution system) that will adversely impact physician care delivery and make it harder to retain their services in New York State. Improving the practice environment, not worsening it, will help to keep physicians in New York instead of losing them to other states with better practice climates.

Expanding scopes of practice will not be the panacea some assert. Multiple studies show that when non-physicians are permitted to practice independently, this difference in training presents patient safety risks and increases health care costs. One study looking at 10 years of cost data on 33,000 patients by a South Mississippi accountable care organization (ACO) ([ama-assn.org](#)) found that care provided to patients exclusively by non-physicians (PAs and NPs) was much more expensive than the care delivered by physicians. This is because these non-physician providers ordered more tests and referred more patients to specialists and hospital emergency departments than physicians did. Unnecessary tests and referrals delay care and create stress for patients. The care provided by non-physicians was also determined to have lower quality rankings. Moreover, another study ([ama-assn.org](#)) reported that NPs delivering emergency care without physician supervision or collaboration in the Veterans Health Administration (VHA) increase lengths of stay by 11% and raise 30-day preventable hospitalizations by 20% compared with emergency physicians.

Nor does scope of practice expansion actually translate to expanded access to primary care. Particularly noteworthy is a new study from Florida showing that NPs statutorily permitted to practice without physician supervision if practicing in the areas of family medicine, general pediatrics, or general internal medicine, were actually regularly practicing outside of these primary care areas. [PubMed](#)

It is impossible to state the importance of a physician's comprehensive education and training to ensure quality patient care. Most physicians must complete 4 years of medical school plus 3-7 years of residency and fellowships, including 10,000-16,000 hours of clinical training before they are permitted to treat patients independently. Various milestones must be met as part of this training to help these young physicians learn to differentiate among the many possible diagnoses for any possible patient condition. This training is unlike any other healthcare provider. This extensive training makes physicians best suited to deliver, oversee and coordinate needed primary and specialized patient care. This role cannot be replaced by a non-physician without adverse consequences to patients and unnecessarily higher costs.

Surveys on [patient sentiment](#) report that 95% of patients believe it is important that a physician be involved with their diagnosis and treatment decisions, and that 91% say that a physician's education and training are vital for optimal care.



Moreover, we note that last February the State Legislature and Governor implemented legislation enacted in 2024 to expand regulatory flexibility for PAs and to increase the services they could provide and coordinate, including ordering for durable medical equipment and collaborating with nurses on various standing order for patient treatment in hospitals. This newly enacted law must be evaluated for its effectiveness and its impact on patient safety before enacting more expansive measures that further remove the important oversight provided by

physicians. Indeed, any measure to expand scope must be time-limited in duration and its further extension conditioned on the meeting of defined specific goals of expanding access to care.

We welcome a thoughtful discussion of individual measures that would help to address gaps in patient care across the State. However, we will not in a meaningful way address the gaps in access to care we face until measures are adopted to make New York's practice environment more welcoming for physicians and other care providers.

In summary, this proposal will reduce patient safety by removing the essential coordination and oversight provided by physicians to ensure the delivery of quality patient care. We thank you for your past opposition and urge you to again oppose these provisions.

OPPOSE RE-DIRECTION OF PROFESSIONAL MEDICAL CONDUCT MONIES FOR OTHER STATE BUDGET PURPOSES

MSSNY objects to the proposed State Budget transfer of \$6 million from the professional medical conduct account to the miscellaneous Capital Projects fund, listed on p.134 of the PPGG Article 7 bill (A.10005/S.9005). The Professional Medical Conduct account is generated through receipt of \$570 of every \$600 biennial registration fee paid by a physician with an active practice license in New York State. In fact, through State Budgets enacted over the 10 years, nearly \$40 million has been transferred out of this account, often directed to the "Capital Projects Account, Health IT Capital subfund".

We question the wisdom of this re-direct of funds away from physician discipline purposes. Section 6524 (8) of the Education Law specifies that these collected registration fees are required to be deposited into the "special revenue funds-other entitled 'professional medical conduct account' for the purpose of offsetting any expenditures made pursuant to section two hundred thirty of the public health law in relation to the operation of the office of professional medical conduct within the department of health."

We are concerned that the diversion of these registration fees is having an adverse impact on the ability of the Office of Professional Medical Conduct (OPMC) to maintain sufficient staff to perform its responsibilities of investigating and removing physicians from practice who have been found to have violated professional medical conduct provisions. Therefore, we request that this provision be rejected and that these registration monies collected in the professional medical conduct account be kept for its statutorily defined purposes.

SUPPORT FOR CONTINUED FUNDING FOR MSSNY'S COMMITTEE FOR PHYSICIANS' HEALTH PROGRAM

As we highlight the growing incidence of burnout among physicians, we are appreciative of the funding in the Aid to Localities Budget (A.10003/S.9003) of MSSNY's Committee for Physicians Health (CPH) Program at its historical level of \$990,000 (identified on p. 702 as "medical society contract pursuant to Chapter 582 of the Laws of 1984"). This program is essential for assisting physicians in confronting addiction, burnout, and mental illness, and most importantly, helping them return safely to delivering patient care when they are healthy.

The program has been extended by the Legislature in 5-year increments, including an extension of the program until 2028 approved by the State Legislature in the final 2023-24 State Budget. We are also very appreciative of the efforts of the State Assembly and State Senate to ensure funding this program for the current fiscal year when it was initially proposed to be eliminated in last year's Executive Budget proposal.

As a reminder, CPH is established by state statute (Public Health Law Section 230(11)(g)), and contracts with New York's Office of Professional Medical Conduct to provide the services required by law. It is important to note that the program is NOT funded from General Appropriations but by a \$30 surcharge paid by physicians themselves in their license and biennial registration fee, which is specifically dedicated under Education Law Section 6524 (9) for this purpose.

Since the inception of this program over 40 years ago, CPH has assisted 7,600 physicians, routinely monitors the recovery of over 300 physicians, and annually reaches out to over 100 physicians thought to be suffering from alcoholism, drug abuse, and mental illness. It is clear that the work of the CPH program is not only valuable to physicians, but to all New Yorkers.

Many of these conditions treated through the CPH program were exacerbated by the pandemic, making the services provided by CPH more essential than ever. CPH provides important confidential peer-to-peer services to physicians in need of support for their health and well-being. Studies that review the long-term model effect of physician health programs show that physician recovery rates are markedly higher than the general population—even when extended into five years or more.

Again, we appreciate the funding for the CPH program in the ATL Budget bill and urge that its funding be included in the final enacted Budget.

SUPPORT PRIOR AUTHORIZATION REFORM PROPOSALS

MSSNY appreciates that the Executive Budget contains provisions (Part HH of the TED Article VII bill) to reform the prior authorization process in the final state budget for FY2026-27. The proposal is not as far-reaching as Assemblymember Weprin's bill (A.3789-A) to eliminate the scourge of repeated prior authorizations for the same healthcare service, but does take some targeted steps to help to streamline the prior authorization process and reduce barriers experienced by patients, and their physicians, by doing the following:

- Require health plan formularies be publicly available and easily accessible.
- Require health plans to provide longer authorization of treatment for a chronic condition.
- Require additional "continuity of care" coverage protections after physician leaves health plan.
- Require health plans to publicly disclose reasons for prior authorization denials.

Prior authorizations often impose overwhelming burdens that cause unnecessary delays in needed care and needless anxiety for patients already stressed by uncertainty regarding their condition. An [Annals of Internal Medicine study released in October of 2025](#) found that the prior authorization process consumed an average of 13 hours per week of physician and staff time, with 40% of physicians employing staff solely dedicated to dealing with the prior authorization process. The study also found that physicians spend nearly \$27 billion a year on time dealing with issues related to utilization management.

WHAT NEW YORK PHYSICIANS ARE SAYING ABOUT PRIOR AUTHORIZATION

PROTECT PATIENT ACCESS TO HEALTHCARE: REFORM PRIOR AUTHORIZATION!



"It has become ridiculous that as an Endocrinologist I have to justify the medications that I am choosing for my patients."

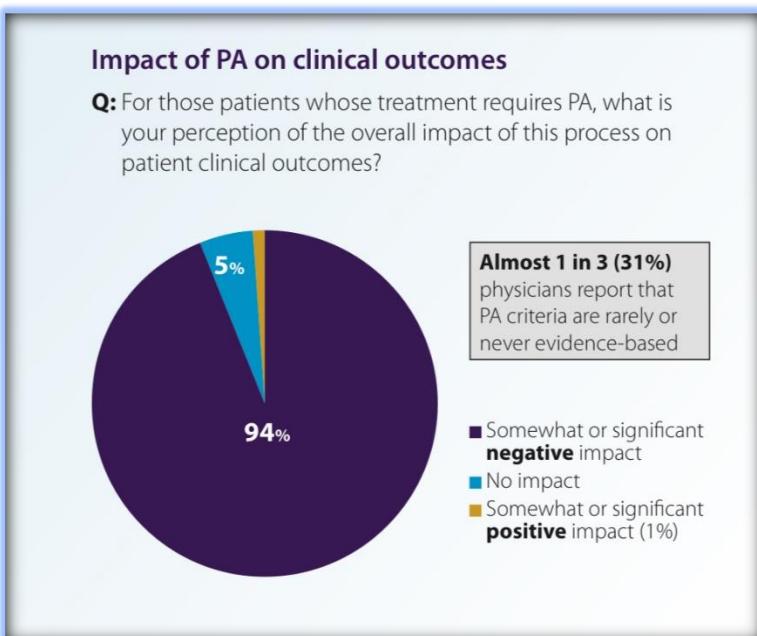
"Prior auth is completely out of control. Having to switch inhalers or BP meds annually is a potentially dangerous waste of time. We're required to do prior auth for meds less than \$30/month, or life sustaining ones such as buprenorphine."

"PA's are time consuming. I am frustrated that each insurance has their own individual formulary, drug preferences and hoops to jump through to provide care. It's no wonder so many doctors are leaving practice!"

Spotlight on New York Physicians

MSSNY MEDICAL SOCIETY OF THE STATE OF NEW YORK

patients.



need to know that their insurance plan will continue to cover their care and treatment.

Moreover, the most recent survey of physicians by the American Medical Association (AMA) reported that 93% of responding physicians said the prior authorization process delayed patient access to necessary care and 1 in 3 of respondents said that prior authorization had caused serious adverse events for

Patients with chronic conditions have complex medical needs, and their health depends on following strict treatment regimens. Timely access to medications and other treatments is critical to maintaining these regimens. Prior Authorization requirements may increase their risk of abandoning treatment or advancing progression of their disease because of these delays and can have a negative effect on their lives and health outcomes. Additionally, all patients

We urge that these measures be adopted by the Legislature, together with the provisions of Assemblyman Weprin's A.3789-A.

SUPPORT FOR CONTINUED TELEHEALTH PAYMENT PARITY

MSSNY continues its support for Telehealth insurance coverage for patients and payment parity for care delivered by physicians using Telehealth. While MSSNY agrees with the Governor's budget proposal that the current law requiring payment parity for video and audio-only medical services should be renewed, we believe it should be made permanent.

The COVID-19 pandemic ushered in big changes to how physicians consult with and treat patients, including a dramatic increase in the use of Telehealth appointments. While some physicians had already integrated Telemedicine into their practices prior to the onset of the pandemic, the pandemic forced thousands of physicians across the state to quickly increase their capacity to provide care remotely.

From the beginning of the COVID-19 crisis, steps were taken to enhance patient access to Telehealth services, with the gross disparity in payment for care delivered virtually, compared to in-office visits, finally addressed in 2022. Establishing fair payments to providers helped ensure patients had access to timely and necessary healthcare.

According to the most recent report released by the New York State Department of Health (DOH) and the New York State Department of Financial Services (DFS) from December 2023, behavioral healthcare, which includes mental health and alcohol and substance use disorder treatment, and primary care, were the two most frequently accessed services using Telehealth. The data for the report was drawn from commercial insurance and state Medicaid claims, with Medicaid beneficiaries utilizing Telehealth services marginally more than those with commercial insurance coverage. Access the [full report here](#).

Moreover, according to the Fair Health report, patients seeking mental health services were the most frequent users of Telehealth, followed by those with acute respiratory diseases, overweight and obesity conditions, noninflammatory female disorders, and endocrine and metabolic disorders, with urban New Yorkers using Telehealth more often than those in rural areas of the state.

Telehealth has become an essential tool in improving access to health care that New Yorkers across the state have come to rely on, which allows patients to engage in shared decision making with their physician. To ensure continued

equity, access and continuity of care, lawmakers must continue payment parity for commercial insurance and Medicaid.

SUPPORT OF DOCTORS ACROSS NEW YORK FUNDING

The Doctors Across New York (DANY) program was established in 2008 to assist with the recruitment and retention of physicians in areas of need across New York State that lack capacity to meet community needs by providing funding in exchange for loan repayment and practice support. Since then, DANY has become a valued tool in the recruitment and retention of physicians in underserved areas across the state.

The debt load of recently graduated medical students is staggering. According to the American Association of Medical Colleges [Medical Student Education: Debt, Costs, and Loan Repayment](#), 71% of medical students graduating in 2024 had medical school debt with an average of \$212, 341.

In 2022, the legislature approved a historic increase in funding from \$9M to \$15.86M in state funding for the DANY program and provides loan forgiveness of up to \$120,000 for individual physicians who work in underserved areas for three years. We also appreciate the recent announcement by the Governor of the launch of the Health Care Access Loan Repayment (HEALR) program, which will provide up to \$300,000 in student loan repayments per psychiatrist and \$100,000 in student loans per primary care physician for making a 4-year commitment for maintaining a personal practice panel or working at an organization that serves at least 30 percent NYS Medicaid members and/or uninsured individuals.

These student loan repayment programs are all the more important given the significant reductions in federal subsidized student loans arising from the provisions of HR 1. While there may some availability for loans to cover medical school costs from private interests, it undoubtedly will be at higher interest rates than the subsidized programs. Therefore, these programs to help repay the enormous cost of medical school education will remain essential over the next several years in order to ensure that we can fill the physician pipeline essential to ensuring patients can obtain the care they need.

MSSNY strongly supports Governor Hochul's proposed continuation of this important program in her budget for FY2027.

SUPPORT PERMITTING MEDICAL ASSISTANTS TO ADMINISTER IMMUNIZATIONS

MSSNY supports the proposal to permit immunizations by medical assistants when supervised by physicians. Finding nurses is often a challenge for primary care and pediatric practices, and particularly in the rural and underserved regions of this state, so this proposal would assist these busy practices in meeting the demand.

SUPPORT CONTINUED FUNDING FOR THE VETERANS' MENTAL HEALTH TRAINING INITIATIVE

MSSNY working together with the New York State Psychiatric Association (NYSPA), and the National Association of Social Workers - New York Chapter (NASW-NY) supports continued funding for the Veterans Mental Health Training Initiative (VMHTI). The FY 2026-2027 budgetary ask is for \$350,000 – similar to previous years' allocations – to enable their program's efforts to continue to enhance the capacity of community mental health and primary care practitioners to meet the needs of veterans and their families. MSSNY's request is for \$100,000, together with \$100,000 for NYSPA, and \$150,000 for NASW-NY.

The VMHTI has a sustained history of supporting veterans through the educating of both mental healthcare and primary care providers on veterans-specific mental health issues including, but not limited to, combat and service-related post-traumatic stress disorder, traumatic brain injuries, suicide, substance abuse, and women veterans' mental health conditions.

While veterans' mental health has seen more widespread attention in the public consciousness, the lasting effects of the War on Terror and the ever-apparent impact of the COVID-19 Pandemic has shed more light on the issues facing veterans and their families during this difficult time. The long-term effects of the pandemic have led to a greater increase in mental health and substance use symptomology, isolation, and loneliness, as well as economic stresses that disproportionately affect veterans.

The New York State Legislature has a history of supporting the VMHTI with prior funding allowing for the providing of services with immeasurable value. The Program has effectively trained over 7,100 primary care physicians and psychiatrists through NYSPA and MSSNY and over 16,800 social workers and community mental health providers through the NASW-NY programs. Importantly, the VMHTI has also pursued linkages with other veteran peer programs, including the Joseph P. Dwyer, "Peer to Peer" Program.

With continued support from the State Legislature, the VMHTI continue to serve veterans in their hours of need and continue to fight for their access to physical and mental-health services across the State. We appreciate your consideration of our request for \$350,000 in state funding for the VMHTI and we ask that you help continue their efforts in providing these critical services to veterans.

CONCLUSION

Thank you again for the opportunity to express MSSNY's perspective on behalf of the 20,000 physicians we represent. Again, there are a few Budget proposals that MSSNY supports that would expand the ability of patients to receive needed care. However, there are numerous profoundly concerning items that will reduce patient access to community-based physician care, and remove important oversight and collaboration provided by physicians that better ensures patient safety. Policymakers must prioritize expanding access to skilled primary and specialty care physicians instead of imperfect solutions that seek to replace them and proposals that would exacerbate the exodus of physicians out of community practice and out of state. I would be happy to answer any questions you may have.