New York State Radiological Society

Testimony Submitted for the Joint Legislative Public Hearing on Health

SFY 2026-2027 Budget

February 10, 2026

Honorable Chairs and Members of the Senate and Assembly Health Committees, Senate Finance Committee and Assembly Ways & Means Committee, thank you for the opportunity to submit testimony related to the New York State Radiological Society's priorities for the State Fiscal Year 2026-27 Budget Proposal.

The New York State Radiological Society represents diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists who serve patients across New York State. In addition to advocating for the above listed professions, a key component of Society's mission is to improve the access to and quality of radiologic/imaging services in all communities.

OPPOSE: Expanded Physician Assistant Scope of Practice (H/MH Article VII Part N)

The New York State Radiological Society is opposed to proposals that would weaken the current standard of physician-led care in New York State and is urging lawmakers to once again reject this proposal and prioritize patient safety by ensuring access to providers with the highest level of training and experience. This proposal would compromise quality of care and jeopardize patient safety and outcomes.

Physician assistants (PAs) are an integral part of the healthcare team. Physician supervision of PAs helps ensure patient health and safety through care coordination, assisting patients with accessing treatments, testing, and needed specialty care. Given the success of physician-led health care teams, we believe this proposal would fragment and weaken patient care.

PA training is built around a supervised, physician-led model. Proposals that eliminate physician supervision of PAs would adversely impact patients by removing the important oversight and coordination role which a trained physician plays in overseeing a patient's care. The differences in education and supervised clinical experience between physicians and PAs are substantial. Following undergraduate education, physicians' training includes four years of medical school, 3-7 years of residency and fellowship training, and 12,000-16,000 hours of supervised clinical practice. In comparison, PA training typically includes two years of physician assistant school with about 2,000 hours of clinical practice. Physician radiologists receive in-depth training in medical imaging physics, radiation safety, complex image interpretation and interventional procedures which correlate imaging results with a patient's clinical history and pathology. PAs receive generalized medical training across multiple disciplines with very limited formal coursework in radiology (see Attachment A). These differences highlight the importance of physician supervision.

Proponents of this proposal cite that it would codify certain allowances made during the COVID-19 pandemic Disaster Emergency. However, in a survey taken by the Medical Society relating to expanded scope allowances during this timeframe, 75% of the physician respondents indicated that advanced care practitioners working independently during the pandemic under the Governor's Executive Orders (waiving physician supervision requirements) had committed an error while treating a patient; 90% indicated that the error could have been prevented had there been physician oversight. This survey data reflects the realities of PA training curriculum which is built around a model of supervision by physicians.

Various studies have shown that non-physician practitioners order more diagnostic imaging than physicians for the same clinical presentation, which not only increases health care costs but also threatens patient safety by exposing them to unnecessary radiation. In a study published in the Journal of the American College of Radiology (JACR) that analyzed skeletal x-ray utilization for Medicare beneficiaries

from 2003 to 2015, ordering of diagnostic imaging increased substantially-more than 400% by non-physicians, primarily NPs and PAs during this time frame[1].

Another JACR study in 2025 shows that imaging studies interpreted by non-physician providers had significantly higher rates of repeat imaging compared with those read by radiologists: 20.4% vs. 14.6% for radiographer, 11.6% vs. 4.5% for ultrasound, and 8.8% vs. 3.8% for MRI. Repeat imaging contributes to unnecessary radiation exposure and/or increased healthcare costs[2].

Evidence from the Hattiesburg Clinic experience underscores the value of physician-led care teams in controlling costs and utilization. Their 10-year retrospective review studied nurse practitioners and physician assistants who were practicing independently alongside physicians. The study found that costs were $43 higher per patient, and as much as $119 more for complex patients who primarily saw a non-physician vs. a physician. These higher costs for patients and payers, as well as lower patient satisfaction, led the clinic to redesign their care model so that all patients now see a physician as their primary care provider and none see a non-physician exclusively[3].

AI Related Risks of Expanding Non-Physician Scope of Practice

Scope of practice proposals such as this also fail to account for the integration of artificial intelligence (AI) in medicine, and in particular, medical imaging. Physician radiologists are the only professionals rigorously trained to interpret complex medical imaging, correlating findings with clinical context to guide accurate diagnoses and treatment. As AI-assisted image interpretation becomes more prevalent, there is a growing concern that non-physician practitioners who lack comprehensive radiology training may rely on AI tools without expertise to independently assess their outputs. AI, while powerful, is not infallible – it can generate false positives, miss critical findings, or misinterpret anomalies. Without a qualified radiologist providing oversight, independent practice by PAs and other non-physician providers introduces a significant risk of inaccurate image interpretation which may lead to misdiagnoses, unnecessary procedures, or delayed treatments. Radiologists use AI, but do not rely on it for interpretation. Maintaining physician supervision of the healthcare team upholds the highest standard of diagnostic accuracy in our rapidly evolving healthcare and technological environment.

While PAs play an important role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians. Patient care would be adversely affected by removing requirements for physician supervision of PAs and this would further deepen the healthcare disparities in our state with unequal levels of care provided in communities. This proposal would be a very significant divergence from the care model that has been in place in New York since inception of PAs. For these reasons, the NYS Radiological Society strongly urges your opposition to this proposal and requests that it be rejected in the budget.

OPPOSE: Changes to the Physicians Excess Medical Malpractice Program (H/MH Article VII Part D)

The NYS Radiological Society is strongly opposed to the proposed restructuring of the Physicians Excess Medical Malpractice program that would require the 15,000 physicians currently enrolled in the program

[1] Mizrahi DJ, Duszak R Jr, et al. National Trends in the Utilization of Skeletal Radiography From 2003 to 2015. J Am Coll Radiol. 2018.

[2] Christensen E, Rula E, et al. Repeat Imaging Rates for Office-Based Imaging Studies Interpreted by Non-Physician Practitioners Compared with Radiologists. J Am Coll Radiol. 2025.

[3] Batson BN, Fitzpatrick JM, et al. "Targeting Value-based Care with Physician-led Care Teams." Journal of the Mississippi State Medical Association. January 2022.

to bear 50% of the cost of these policies. This restructuring has been included in numerous Executive Budget proposals spanning the current and prior administrations, but has thankfully been rejected by the State Legislature because of its adverse impact not only on physicians, but ultimately for patients who are the beneficiaries of this program. Unfortunately, the proposal has now returned to the Executive Budget, and we urge the Legislature to again reject it.

This incredibly short-sighted proposal would shift nearly $40 million of new costs on the backs of our community-based physicians who serve on the front lines of healthcare, many of whom are struggling to stay in practice to deliver needed care, and at a time when physicians already face staggeringly high liability premiums that have further risen by an additional 10% in the last years. It is likely that many physicians will simply forego the coverage in order to avoid the thousands to tens of thousands in new costs, per physician, this Budget proposal would impose.

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 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. In fact, New York's total medical liability payouts between are nearly twice as great as the second highest state, Pennsylvania, and far surpassing more populous states such as California and Texas. Medical liability costs hurt consumer affordability and access, as these costs contribute to New York's high premium costs, which also limit small business growth. Moreover, excessive liability costs disproportionately impact physicians working in underserved communities who have experienced heightened financial strain resulting from the pandemic. For these reasons, New York is regularly ranked worst among states in the country for physicians to practice medicine.

The Society urges the legislature to oppose stand-alone liability changes that would further drive up liability costs and, instead, would urge support for legislation that will comprehensively address New York's dysfunctional medical malpractice system which have not been made in forty years. Piecemeal changes, including this proposal, would further harm the availability of skilled physician care in New York. Meaningful reform, including consideration of instituting caps on non-economic damages in medical liability actions, would offset the staggering burdens facing physicians today.

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 absolutely essential to sustaining availability of skilled physician care in New York. For these reasons, the New York State Radiological Society urges rejection of this proposal in the budget.

OPPOSE: Elimination of Medicaid Managed Care from the IDR Process and Other IDR Changes (PPGG Article VII Part T)

The New York State Radiological Society strongly opposes the Governor's proposal to eliminate the right of physicians to bring a claim dispute to the Independent Dispute Resolution (IDR) process for Medicaid

Managed Care enrollees and additional changes that would fundamentally alter the IDR process. It is critical that the Legislature reject this expanded proposal due to the serious adverse impact that this change will have on patients' access to skilled radiology and other specialty care.

New York's surprise billing law was implemented in a manner to ensure access to a fair process to resolve payment disputes. Without the ability to access this appeal process, physicians will be forced to accept absurdly low Medicaid payment rates that do not come close to covering rapidly rising overhead costs. New York notoriously has among the lowest Medicaid physician payment rates in the country (Medicaid-to-Medicare Fee Index). At a time when New York should be prioritizing patients' access to skilled physician services, this proposal is likely to discourage physicians from providing essential emergency care, especially emergency radiology care that is critical to timely patient diagnoses and treatment.

This proposal would significantly weaken physicians' ability to negotiate fair contracts with managed care plans. By eliminating the ability to access the IDR process for managed care enrollees, the proposal would strip physicians of their primary mechanism for challenging inadequate payments, effectively granting managed care plans unchecked power to impose unsustainably low reimbursement. Without the ability to dispute, physicians would be left with little recourse, which will jeopardize the viability of community-based physician practices and threaten access to care for Medicaid patients across New York State.

This year's proposal goes significantly further by fundamentally altering the IDR framework itself in a manner that undermines independence and fairness. By removing usual and customary charges from consideration, mandating selection of payment offers benchmarked to the median in-network rate of the 50th percentile of FAIR Health allowed amount, and imposing a hard cap at the 80th percentile, the proposal transforms the IDR process from a neutral dispute resolution mechanism into a rate-setting tool. These changes would predetermine outcomes in favor of health plans and negate the purpose of an independent arbitration process.

The Executive cites concern regarding the administrative volume and inappropriate use of the IDR process as justification for this proposal. However, broad payment caps and rigid benchmarks will not distinguish between abusive billing practices and legitimate, medically necessary out-of-network care. Radiology services, particularly emergency and on-call radiology are often provided without the ability to control network participation.

The relatively small State Budget savings of this proposal is significantly outweighed by the high risk that this change would have on patient access to urgently needed skilled physician care. The Society urges lawmakers to reject this proposal in the Final State Budget for SFY 2026-27.

SUPPORT: Prior Authorization Reform (EnCon Article VII, Part HH)

The New York State Radiological Society supports the Executive's proposal to reform the prior authorization process. We recognize that utilization management is intended to serve as a safeguard within an increasingly expensive and complex health care system, and that insurers play a role in managing finite resources. At the same time, the current prior authorization framework is overly burdensome, opaque, and inefficient, creating delays in medically appropriate care without demonstrable improvements in quality or value. Thoughtful, targeted reforms are necessary to improve how the system functions for patients, physicians and health plans.

The Governor's proposal, consistent with A3789, Weprin, advances reasonable improvements by increasing transparency and predictability for prior authorization. Requiring publicly accessible formularies, extending authorization durations for chronic conditions, strengthening continuity of care protections, and disclosing reasons for denials would meaningfully reduce administrative barriers that disrupt care and strain clinical practices. Evidence shows that prior authorization consumes significant physician and staff time and frequently delays needed treatment which contribute to adverse outcomes.

These challenges can be particularly acute in diagnostic imaging, which is often the gateway to downstream care. In addition to inconveniencing patients, prior authorization delays can also stall diagnoses, treatment planning, and clinical decision-making. Treatment plans for patients with chronic conditions may rely on surveillance imaging to assess treatment efficacy. In these cases, repetitive reauthorization requirements create inefficiencies without improving care. The reforms included in this proposal modernize prior authorization practices to better support timely access to care and a more functional health care system overall.