



The New York State Society of Anesthesiologists, Inc.

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Testimony for the Joint Legislative Budget Health Hearing February 10, 2026

Honorable Chairs and Members of the Senate and Assembly Health Committees, Senate Finance Committee and Assembly Ways & Means Committee on behalf of the New York State Society of Anesthesiologists, thank you for the opportunity to submit testimony related to our priorities for the SFY 2026-2027 State Budget.

The New York State Society of Anesthesiologists, Inc. (“NYSSA”) is a medical society representing 4,400 physicians specializing in the field of anesthesia who provide care in hospitals, ambulatory surgical centers, and critical care settings across New York State. Our members evaluate patients before surgery, develop and direct anesthesia plans, manage life-threatening emergencies, and lead care teams at the most critical moments in a patient’s medical journey. NYSSA is an organization dedicated to advancing the specialty of anesthesiology and providing the safest, highest-quality patient care to the citizens of New York State.

NYSSA supports budget policies that strengthen patient access to safe, physician-led care, responsibly address workforce challenges, and reduce administrative burdens that delay treatment. We also respectfully urge caution regarding proposals that could destabilize specialty care or undermine New York’s longstanding safety standards.

Our comments center around critical areas of state Budget policy, including workforce development, prior authorization reform, physician wellness, Medicaid rates for Anesthesia care, preservation of anesthesia safety standards, and proposals affecting medical liability and the Independent Dispute Resolution Process.

Workforce Development and Access to Care

Our society stands together with the Medical Society of the State of New York (MSSNY) and other physician specialties in supporting physician-led care in office-based settings, outpatient clinics, and hospitals.

We ask that you keep in mind the unequaled risks associated with the delivery of anesthesia. When patients encounter life-threatening emergencies requiring immediate medical intervention, it is imperative we preserve equal access to the physician-led supervision and the safety standard which currently exists in the New York State Health Code (which has been in existence since 1989). The New York State Health Code requires the supervision of the nurse anesthetist by the physician anesthesiologist who must be immediately available, or the operating physician who must accept the responsibility of the nurse anesthetist.

In a recent Medical Society survey, 75 percent of responding physicians reported observing errors involving advanced practice clinicians who were practicing independently under pandemic-era Executive Orders that temporarily waived physician supervision requirements. Of those respondents, 90 percent believed the error could have been prevented with physician oversight.

Advanced practice clinicians, including CRNAs, PAs, and NPs, play important roles within healthcare teams. However, their educational pathways differ significantly from those of physicians in both length and scope of

training. Their preparation is designed within a collaborative framework that includes physician supervision and coordination. Preserving that team-based structure helps ensure that complex clinical decisions, diagnostic evaluations, and treatment adjustments benefit from the depth and breadth of physician training.

It is also important to note that the anesthesia workforce in New York has remained relatively stable in recent years, according to data from the Centers for Medicare & Medicaid Services and the American Medical Association. Unlike some other states, New York has not experienced the workforce decline that might justify lowering longstanding safety standards.

NYSSA Supports:

1. **Expansion of Residency Programs** - Increasing anesthesiology residency positions will help sustain access to surgical and critical care services across the state. Other states, including California, have implemented initiatives to expand specialty training capacity, and similar approaches should be explored here.
2. **Increased Opportunities for International Medical Graduates** - Increasing residency spots outside of CMS in rural counties of New York state would bring valuable workforce home and bring healthcare to rural areas. United States International Medical Graduates (IMGs), who have gone to medical school abroad, often cannot find residency spots when they have graduated. New York State should consider a temporary loosening for foreign graduates (non-U.S. residents) to enter the workforce for a period of time. The American Board of Anesthesiology (ABA) now has eight spots allocated per hospital as a pathway for these physicians to get their Boards. Consideration should be given to increasing the spots even more – perhaps to 12 to 14 spots.
3. **Continued Support for Student Loan Forgiveness Programs** - Loan relief remains a critical recruitment and retention tool, especially for physicians considering practice in underserved areas. The continuation of support for the DANY program is more important now than ever, considering the reductions we will see in federally subsidized student loans.
4. **Licensed Certified Anesthesiologist Assistants (CAAs) Under Physician Supervision** - NYSSA supports the licensure of Certified Anesthesiologist Assistants (CAAs) in New York, provided they practice within a physician-led model in which supervision is immediate and meaningful. Twenty-four jurisdictions currently recognize CAAs, where they function as members of the anesthesia care team under physician oversight. Establishing licensure in New York would expand access to anesthesia services, support hospital workforce stability, and generate economic activity for the state all while preserving patient safety. NYSSA supports the licensure and practice of both CAAs and CRNAs within a physician-led framework that ensures a supervising physician is immediately available. Maintaining this structure is essential to protecting New York’s longstanding safety standards in anesthesia care.
5. **Strengthening the Rural Pass-Through Program** - NYSSA encourages state leaders to advocate federally for expanding the Anesthesia Rural Pass Through program to include physicians, which would help sustain rural hospitals and expand specialty access in underserved communities. The Rural Pass Through program is where Medicare permits certain low-volume, rural hospitals to pay for the services of nurse anesthetists and anesthesiologist assistants through a Medicare Part A, cost-based, “pass-through” mechanism. The mechanism is used in lieu of a Part B payment for anesthesia services. Medicare should extend this program to all anesthesia providers, including physician anesthesiologists, who are presently excluded by law from participating. The federal government can directly improve care expansion in rural and underserved areas through addressing a significant problem in anesthesiology --strengthening the Anesthesia Rural Pass Through.

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Prior Authorization Reforms (TED Article VII Part HH)

NYSSA joins MSSNY in recognizing that the Executive Budget includes important steps to reform the prior authorization process in the FY 2026–2027 budget. While the proposal does not go as far as Assemblymember Weprin’s bill (A.3789-A), which would eliminate repeated prior authorizations for the same healthcare service, it does advance targeted reforms designed to streamline the process and reduce administrative barriers for patients and their physicians. Specifically, the proposal would:

- 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.

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 need to know that their insurance plan will continue to cover their care and treatment. *We urge that these measures be adopted by the Legislature, together with the provisions of Assemblyman Weprin’s A.3789-A.*

Support for Continued Funding of the Committee for Physicians’ Health Program

Anesthesiologists work in environments that involve direct access to powerful medications and continuous exposure to high-stress, life-critical situations. National data have long recognized that these factors can increase occupational vulnerability to substance use disorders if appropriate safeguards and support systems are not in place.

Programs such as the Committee for Physicians’ Health provide confidential, structured intervention and monitoring that protect both physicians and patients. By offering early identification, treatment referral, and ongoing oversight, CPH helps ensure that physicians who need support receive it – and that they return to practice safely. *We are grateful for the Legislature’s continued support of this program and respectfully urge that its funding be included in the final enacted Budget.*

Medicaid Payments For Anesthesia Care

Anesthesiologists provide care to all patients regardless of insurance status, geography, or socioeconomic background. In practice, this means that physician anesthesiologists perform a pre-anesthetic examination and evaluation, prescribe an anesthesia plan, personally participate in the most demanding procedures of the anesthesia plan, oversee the medical management of the patient, and if the anesthesia is delivered by a care team, remain physically present and immediately available throughout the procedure to intervene. Fair and sustainable reimbursement is essential to maintaining access to surgical and emergency services in safety-net hospitals and rural facilities.

New York’s Medicaid reimbursement for anesthesia services – currently \$10.00 per unit – falls well below national and regional benchmarks. Neighboring states such as Pennsylvania (\$15.66) and Vermont (\$18.15) reimburse substantially more, as do larger states including California (\$17.06), South Carolina (\$18.32 effective 10/1/25), and Illinois (\$15.35).

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The MCO Tax, which is projected to generate more than \$2 billion in additional Medicaid resources, presents a meaningful opportunity to strengthen physician reimbursement within the Medicaid program. *NYSSA respectfully urges that a portion of these funds be directed toward increasing Medicaid reimbursement for anesthesia services. Targeted investment in anesthesia payment rates will help sustain access to surgical and emergency care for Medicaid beneficiaries across New York.*

Preserving Safe Anesthesia Standards

As the Legislature considers workforce solutions, patient safety must remain the guiding principle. Despite advances in medicine, every surgical procedure carries inherent risk. Anesthesia care involves rapid physiologic changes and the potential for life-threatening emergencies that require immediate medical judgment and intervention.

New York has long maintained a physician-led anesthesia care model, in which anesthesiologists and nurse anesthetists work together as a coordinated team. Within this framework, the physician assumes primary responsibility for directing and overseeing the patient's medical care. This longstanding safety standard is reflected in the New York State Health Code and has contributed to the high level of anesthesia safety achieved in this state.

While nurse anesthetists are valued members of the anesthesia care team, their training is structured within a supervised model. Recent investigations in other states illustrate the risks of removing appropriate physician oversight. In 2024, federal and state regulators cited two California hospitals for allowing nurse anesthetists to practice without a physician's order and beyond the scope of their authority. The findings included serious patient harm and anesthesia-related deaths, resulting in corrective action plans and temporary suspension of surgical services as well as the closure of one hospital. These events underscore the importance of maintaining clear accountability and physician involvement in anesthesia care. Workforce expansion and patient safety are not mutually exclusive. *NYSSA supports solutions that strengthen the workforce while preserving the physician-led model that protects patients at their most vulnerable moments.*

Physicians Excess Medical Malpractice Program (H/MH Article VII Part D)

NYSSA joins MSSNY in **opposing** the proposal that would require the nearly 16,000 physicians currently enrolled in the Excess Medical Malpractice Insurance Program to bear 50 percent of the cost of their coverage.

The Excess Program provides an additional \$1 million layer of coverage for physicians with hospital privileges who maintain primary coverage at the \$1.3 million/\$3.9 million level. It was established during the liability crisis of the 1980s to ensure physician availability across all regions of the state when liability exposure significantly exceeded available coverage limits.

The proposed cost shift would impose substantial new financial burdens that would destabilize access to care in high-risk specialties and underserved communities. Similar proposals have been advanced in prior Executive Budgets and appropriately rejected by the Legislature because of their adverse impact not only on physicians, but on the patients who ultimately rely on stable hospital-based specialty care.

In the absence of comprehensive liability reform to address New York's exceptionally high malpractice costs, maintaining a fully funded Excess Program remains essential to preserving timely access to primary and specialty physician services across the state. *We respectfully urge the Legislature to reject this proposal once again.*

Upending of the IDR Process (PPGG VII, Part T)

NYSSA joins MSSNY's **opposition** to this proposal 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. We 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

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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.

The impact of this proposal extends well beyond the relatively small number of physicians who provide care on an out-of-network basis. It would also weaken the ability of physicians across the state to negotiate fair contracts with health insurers, contracts that directly affect patient access to timely care.

These negotiations determine not only reimbursement levels, but also critical terms such as payment timelines, audit practices, prior authorization requirements, and prescription drug coverage policies. If physicians lose meaningful leverage in these negotiations, the consequences will be felt by patients through increased delays, reduced access, and fewer specialty providers willing to serve certain markets.

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*

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year.

Conclusion

The members of NYSSA work tirelessly to deliver safe, high-quality anesthesia care to patients across New York, regardless of socioeconomic status or whether care is provided in an office, ambulatory surgical center, or hospital in any region of the state.

As you finalize the SFY 2026–2027 Budget, NYSSA respectfully urges the Legislature to:

- Support responsible workforce expansion while preserving longstanding safety standards;
- Advance meaningful prior authorization reform that reduces barriers to timely care;
- Maintain funding for physician wellness programs that protect both clinicians and patients;
- Strengthen Medicaid reimbursement to ensure continued access to surgical and emergency services; and
- Reject proposals that would destabilize hospital-based specialty care or undermine fair reimbursement processes.

Above all, we ask that patient safety remain the guiding principle in any policy affecting anesthesia care.

NYSSA remains committed to advancing the specialty of anesthesiology and partnering with the Legislature to strengthen access to safe, high-quality care across New York. We appreciate the opportunity to provide this testimony and look forward to continued collaboration as you finalize the SFY 2026–2027 Budget.

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