GREATER NEW YORK HOSPITAL ASSOCIATION
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January
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Senator Kristen Gonzalez
Chair, Committee on Internet and Technology
New York State Senate
Room #817
Albany, NY 12248

RE: Statement for Hearing on "Regulation of High-Risk Use of Artificial Intelligence in the Private Sector"

Dear Senator Gonzalez:

Thank you for the opportunity to submit a statement on behalf of the Greater New York Hospital Association (GNYHA), which represents more than 150 voluntary and public hospitals across New York State, regarding the intersection of artificial intelligence (AI) and health care. GNYHA commends this Committee for seeking early information related to the use of AI in health care. AI offers a world of opportunities in the health care sector.

My comments focus on the use of AI in health care, including the benefits to patient outcomes and health care costs; health insurers' use of AI in the utilization review (UR) process; and the proposed New York AI Act (A.8884/S.1169).

Since 2023, GNYHA has convened an AI Advisory Group comprised of experts from our member organizations to examine the potential benefits and challenges of integrating AI into health care. We have discussed our members' ongoing development of strategies to harness the power of AI to perform important biomedical and health services research, apply those findings to improve health outcomes, use AI to create operational efficiencies, and transform medical education.

Careful consideration must be given prior to creating new policies and regulatory standards that could either accelerate or hamper adoption of important new tools, particularly in health care settings. AI has the potential to advance medicine and improve health outcomes for millions of New Yorkers. Yet health care is a "high-risk" and consequential industry. Chief executive officers and chief information officers often play a direct role in decisions related to AI adoption within their organizations. Many institutions have

established data governance committees, some that focus specifically on AI. These committees typically oversee AI use within a hospital or health system.

AI can be used to improve patient care, business processes, documentation and revenue cycle, and research and analytics. AI is best suited for supporting clinicians and cannot ever be a substitution for a clinician: there must be a "human-in-the-loop."

In clinical applications, AI has the potential to revolutionize patient care through precision medicine, tailoring treatment based on the specific needs and genetic makeup of a patient, leading to earlier detection and enhanced care delivery. AI tools can also lighten the workload for clinicians by supporting clinical documentation, detecting diabetic retinopathy, and analyzing electrocardiograms. AI can help radiologists identify subtle abnormalities and patterns in screening mammograms and other breast imaging techniques, potentially leading to earlier and more accurate cancer detection, while also reducing workload and false positives. AI is also being used to address malnutrition, which is persistently under-diagnosed. To address this, one of our member hospital's clinical science team developed an AI model capable of tracking over 80 variables. This innovative approach resulted in a nearly threefold increase in the identification of malnourished patients, paving the way for appropriate corrective treatments. Furthermore, our members have leveraged AI to identify patients at risk of developing bed sores and pressure injuries, significantly enhancing prevention, detection, and treatment efforts. Epic, the electronic health record vendor, is used widely across the hospital membership and continues to support AI use and operations within hospital settings. Ambient listening tools have become integral to clinical care. Several members have widely adopted ambient listening among clinicians. Chatbots used for clinical documentation and patient messaging have reduced clinician burnout and supported patient satisfaction. These tools support care delivery by allowing clinicians to focus on the patient encounter, strengthening bedside interactions and supporting better health care outcomes.

Examples of AI used in hospitals for business and administrative processes include AI-embedded components within existing information technology platforms, human resource operational support, and project management. AI is also used to assist with medical coding, revenue cycle management, and prior authorization, in some cases with significant return on investment. This could be especially beneficial to safety net institutions that struggle to keep their doors open. On the research side, AI can assist with clinical trial recruitment and multimodal data analysis. This is particularly important for facilitating medical breakthroughs and scientific discovery.

AI is still in its infancy, and the potential for its usage in all aspects of our daily lives is inevitable. We must continue to support innovations. When referencing AI, a clear definition is crucial to ensuring patient safety, establishing accountability, fostering public trust, and providing the certainty necessary for responsible innovation.

As a highly regulated industry, we urge the Legislature to exercise caution on new legislation that may ultimately hinder the usage of these emerging technological innovations.

Insurers' Use of AI

We also urge regulation of insurer use of AI in the claims review process. Insurers deny our member hospitals' claims at alarming rates. New York State commercial plans reported denying approximately 25% of all inpatient hospital claims in 2024 and 2025[1]. While we understand that payers will continue to adopt technology in pursuit of administrative efficiencies, AI must not exacerbate or fortify this already untenable denial dynamic.

There are two current bills (A.8556/S.7896, Hunter/Gonzalez and A.1456 Hunter) that establish important guardrails for the claims review process. Below we identify those additional core principles for permissible and prohibited use of AI. GNYHA is eager to work with the Chairs, sponsors, and other members of the Legislature to comprehensively address the growing use of AI in this space.

Denials must not be automated. Recent media coverage and legislative reports have flagged concerns with the correlation between automation and increased denials[2]. ***It is imperative that each denial of a health care service be made by an appropriately qualified clinician, licensed in the same or similar specialty as the treating provider, who has carefully reviewed the individual patient's unique medical history and circumstances, including the treating provider's recommendation.***

Even when denials are not fully automated, AI has the potential to undermine the independent clinical review process. Based on a review of post-acute discharges and denials by three Medicare Advantage (MA) plans, the Senate Permanent Subcommittee on Investigations (Majority) recommended in 2024 that the Centers for Medicare & Medicaid Services (CMS) expand regulation to ensure that predictive technologies

[1]Based on New York State Insurance Law Section 345 Health Care Claims Reports.
[2] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims and US Senate Permanent Subcommittee on Investigations, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care," Majority Staff Report, October 17, 2024.

are not unduly influencing decisions by human reviewers and pressuring them to "rubber stamp" the recommendations of algorithms. To that end, we urge that reviewing clinicians be required to document whether they reviewed the individual insured's clinical record, and the amount of time spent doing so, prior to approving an adverse determination.

AI processes must comply with UR laws and requirements. AI should be used to support compliance with UR guardrails, and not as a tool to circumvent requirements. Regardless of whether AI is part of the UR process, UR must meet all procedural and substantive requirements. For example, CMS has explicitly cautioned MA plans that algorithms and AI must comply with all requirements applicable to the coverage determination process. Because MA regulations require medical necessity determinations to be based on an individual patient's circumstances, algorithms that base determinations on larger data sets are impermissible. Additionally, AI may not be used to shift coverage criteria over time—coverage criteria must be static and publicly accessible.[3]

State insurance law should hold all health plans to similar standards. Insurers should be required to submit AI algorithms and training data sets to the Department of Financial Services (DFS) and, at a minimum, certify that they do not rely on information or operate in ways that do not comply with UR laws, regulations, or guidance. Such submissions should occur prior to implementation, annually thereafter, and whenever algorithms or training sets are modified. Regulators must also have clear authority to audit AI used in UR, including outcomes. (We note that the National Association of Insurance Commissioners is developing a model AI Systems Evaluation Tool.)

Insurer use of AI must be transparent. Insurers should be required to disclose to regulators, insureds, and providers how they use AI in the claims review process. This should include notice when a new AI process is adopted, and annually thereafter. Insurer websites should also clearly state when AI is used for UR.

To foster transparency, all denial letters should also include a statement explaining if and how AI was used in the review process and where the insured and provider can find more information about the specific AI employed. Denial notices should also include the name or other unique identifier and credentials of the reviewing physician, and an explanation of the physician's review of the individual insured's medical

[3] Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F), February 6, 2024.

record and circumstances. In addition to strengthening accountability in general, this will provide insight into the number of cases being reviewed by an individual clinician on a given day, and whether the staffing model fosters a culture of individualized clinical review by human reviewers.

Further, to facilitate an understanding of the applicable review standards and expected outcomes, detailed information about the algorithm, including its criteria and training data sets, must be available to providers upon request.

Overall, greater transparency and disclosures are required to ensure that DFS, health care providers, and patients fully understand how these tools are being used and to help prevent direct or indirect harm to insured individuals.

Third-party vendors must be held to the same standards. It is imperative that third-party vendors comply with all regulatory requirements governing the use of AI in UR. Vendors with which insurers contract and/or to which they delegate UR functions include, but are not limited to, UR agents, behavioral health management companies, and pharmacy benefit managers. The core principles for permissible AI use are no less salient because, for example, behavioral health services are carved out to a vendor rather than administered by the insurer directly.

The New York AI Act (A.8884/S.1169)

The New York AI Act would require hospitals to comply with extensive and time-consuming obligations as developers of AI systems, deployers of AI systems, or both. While GNYHA supports the Legislature's goal of promoting safe AI integration in health care, we oppose this bill because it imposes burdensome requirements on hospitals that already operate under strong regulatory oversight and enforcement.

The bill requires end users to be informed at least five business days before the use of an AI system to support a consequential decision, including use in health care. The notice must appear in clear, conspicuous, consumer-friendly language. This requirement presents significant operational challenges and risks disruption to clinical operations. Some of our hospital members use more than 100 AI tools across patient care, administrative functions, documentation, revenue cycle support, and research. In some cases, existing technology gains AI functionality because of a non-hospital vendor update without advance notice given to hospitals. Requiring hospitals to identify, track, and notify all end users of each AI use, with the option for patients to decline such use, is not feasible because AI is becoming so ubiquitous.

The bill also establishes detailed high-risk reporting and audit obligations for deployers at a relatively frequent cadence. These requirements are extensive. The bill further requires hospitals to develop risk management policies and programs and submit them to the New York State Attorney General, if requested. These provisions would impose additional administrative burdens while not necessarily improving oversight outcomes. Hospitals already assess AI performance and identify risks through established internal governance structures and monitor AI performance post-deployment through staff observations and a "human-in-the-loop." Hospital data governance practices also support oversight. GNYHA does support transparency from non-hospital vendors, such as risk management policies. However, applying lengthy and burdensome requirements that hospitals must comply with would likely widen the existing technology gap. Institutions that lack the financial and operational support needed to integrate AI systems may delay or forgo AI adoption due to regulatory burdens, in addition to any existing financial barriers to acquiring AI technology. This would stymy technological innovation and adoption of AI tools aimed at improving hospital operations and patient care.

Conclusion

GNYHA strongly urges the New York State Senate to proceed cautiously with regulations that encompass AI in health care, as hospitals are already highly regulated by multiple layers of government in ways that already cover the use of AI. At the same time, we share the concerns of legislators that private vendors should disclose their data-sharing practices to protect patients and consumers.

New York is home to academic medical institutions that lead in research and training scores of doctors who will work in hospitals across the nation. New York and the Empire State Development have long invested in life sciences to encourage groundbreaking innovation. Policymakers can help health care organizations integrate AI in ways that support quality and safety and position New York as the leader of AI in health care with State incentives and long-term investment strategies. State support would accelerate implementation, especially in safety net institutions, promote learning and innovation, and allow all health care organizations to advance care delivery and improve patient outcomes.

Thank you for the opportunity to provide these comments. GNYHA is committed to working with policymakers so that New Yorkers can benefit from AI applications in health care. Please feel free to contact me at edupree@gnyha.org with any questions or concerns.

Sincerely,

Erin DuPree, MD

Senior Vice President and Physician Executive, Quality and Clinical Initiatives