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JOINT PUBLIC HEARING
NYS SENATE AND ASSEMBLY STANDING COMMITTEES ON HEALTH
SENATE HEALTH COMMITTEE CHAIRMAN GUSTAVO RIVERA
ASSEMBLY HEALTH COMMITTEE CHAIRMAN RICHARD GOTTFRIED

THE NEW YORK HEATLH ACT
MAY 28, 2019
10:00 A.M.

LEGISLATIVE OFFICE BUILDING
VAN BUREN HEARING ROOM A
2ND FLOOR
ALBANY, NEW YORK

SUBMITTED BY:
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President, New York American College of Emergency Physicians

Thank you for the opportunity to submit this testimony.

The New York American College of Emergency Physicians (New York ACEP) serves a membership of 3,005 emergency physicians. We strive to not only represent our physician membership but also the patients we serve every day in New York State Emergency Departments. Thank you for allowing us to comment on the proposed Single Payer Legislation in New York State. Our national organization, the American College of Emergency Physicians (ACEP) recently released a Task Force report on Health Care Financing Reform that addressed both Universal Health Care and Single Payer models. This document is a valuable resource in this discussion: https://www.nyacep.org/images/ACEP-Single-Payer-Task-Force-Final-Report.pdf.

ACEP and New York ACEP are focused on securing access to coverage for our patients and their families for all acute unscheduled care services in any health care financing model, including Single Payer.

Evaluation and comparison of health care financing models should incorporate the following "Nine Principles" when determining whether New York ACEP could support such a model:

1. Access
2. Budget
3. Choice
4. Reduce Disparities
5. Promote Competition
6. Physician Input and Support
7. Lower Administrative Costs
8. Maintain Quality and Innovation
9. Training/Technology

1. Patient Access. All United States citizens and New York residents are entitled to health care and will have immediate access to care without undue financial burden. The care available to patients in emergency departments will be equitable regardless of age, race, ethnicity, gender, geography and socio-economic factors. The Prudent Layperson Standard for access to emergency care must remain intact.

2. Financing / Budget: Health care spending in the United States currently comprises 18 percent of GDP and continues to increase. If New York moves toward a capitated/global budgeting system, adequate levels of reimbursement must be maintained for providers and facilities. New York ACEP strongly believes that universal health care reform must be fiscally responsible and realistic and should look to other countries as well as models already used in the United States for guidance. We are concerned that the tax burden placed on New York tax payers already exceeds other states thus financing a Single Payer model will need to control the use of increased taxation to subsidize the insurance plan.

3. Patient Choice: Patients should have access to different types of coverage programs and benefits, allowing them to purchase insurance products that meet their needs. However, due to the insurance tenet that coverage programs must spread risk among a large population of insureds, there will need to be an understanding that premiums will have to be adequate to cover the benefits provided. New York ACEP believes that a clear delineation of what essential benefits must be included in any health care financing plan should be considered. Likewise, there will be non-essential benefits that would have to be paid for through patient purchased supplemental plans which will need to be made available even if New York State adopts a single payer model.

4. Reduction of Disparities: The current amount and quality of health care is too varied based on social determinants of health such as income, geography, job status, age, provider and hospital access, etc. Living in a rural or urban environment should afford patients the same access to physicians, other clinical providers and facilities that are seen in suburban environments. There should also be more accurate, risk adjusted and appropriately attributed quality metrics of clinical effectiveness so that resources are given to those physicians and health care systems that ensure the best outcomes for patients.

5. Competition: All health care financing systems should promote competition to deliver better quality of care at lower cost while improving outcomes and patient/physician experience. Lack of competition does not incentivize innovation to control costs and increase efficiency.

6. Physician Leadership, Input and Buy-in: Physician support and leadership for an affordable and high-quality system is critical for its success. Emergency physicians have a unique role in the health care system and are particularly well-suited to provide perspective on the strengths and weaknesses in the current system. Due to the nature of their work, which requires them to innovate and solve problems to assure access to care for patients, they also understand the need for universal access to care.

7. Lower Administrative Costs: Health care administration is a top driver of the high cost of the United States health care system. Health care insurance and financing reform must decrease administrative drains on available resources. There are a lot of drivers of unnecessary administrative costs the task force believes can be eliminated including, duplicative unnecessary burdens on doctors, providers, insurers, etc. New York ACEP has concerns regarding undue administrative and regulatory burdens that exist in our current state administrative systems such as Medicaid. These may multiply when the entire state's population is placed under a single government run insurance plan.

8. Maintenance of Quality and Innovation: Continuing to demand quality outcomes, as well as efficiency of care is critical to the success of health care reform. Physicians, as well as private entities, should be encouraged to advance quality and drive savings in the delivery of care as well. Organization and management of the health care data also needs to be improved in ways to improve outcomes and decrease costs and redundancy. It should be recognized that costs are, in part, driven by the current medical liability system that prompts defensive medicine; hence medical liability reform should be promoted. In New York in particular, medical liability is one of the drivers of increased testing and expenditure. Any effort to control expenditure must be accompanied by liability reform.

9. Training / Technology: Any significant overhaul of New York State's health care system must address training for physicians and other health care professionals. Addressing workforce development should include research on the effects of technology such as augmented intelligence. New York ACEP believes future graduates should have more time to do research as well as incorporating GME and incurred debt into any capitated or global payment model. Efforts will need to be made to increase the number of primary care providers in New York for a single payer model to be successful. The current expense incurred by medical school graduates will need to be subsidized to encourage the training of more primary care physicians.

The ACEP task force did evaluate several models that we would like to highlight:

Canada, a single payer system, covers the entire population with a well-defined medical benefits package. Income taxes finance much of the system with only a small fraction of the population responsible for paying co-pays and premiums. Physician choice is unlimited, however primary and specialist care have lengthy waiting times at public facilities. The Canadian system does not require patients to participate in the reimbursement process. Considering the current United States system largely involves the patient; the Canadian system does not allow physicians to collect from patients in most cases. Instead, global budgets by province are set on an annual basis with volume of patients and procedures pre-determined. The Canadian single payer model presents many challenges for implementation in the United States and/or New York due to the shifting focus to quality metrics over the volume of procedures now under MACRA and MIPS.

The Maryland All-Payer Model is as a potential transition model approved by CMS as a waiver that sets rates for hospital services on a per capita basis. Maryland agreed to shift away from payment to hospitals based per inpatient admission in exchange for per capita total hospital cost growth. This model could be looked upon as a transitional approach to a "Medicare for All" or single payer system based on the results of the five-year performance period evaluation. Under this type of system, the reimbursement a provider receives for a given service is the same regardless of who pays. Although the all-payer rate setting has mainly been used for hospital inpatient and outpatient services, the possibility for increasing the quality of health care, lower costs, and meeting the nine principles outlined above is possible.

Based on the nine principles outlined above, New York ACEP is concerned that a government administered single payer insurance plan in New York will be very difficult to develop expeditiously, may incur undue cost for the state residents, decrease patient access to care, and lack fair physician reimbursement to contain cost. It may be necessary to move step wise toward universal health care rather than adopt a single payer model. We will be happy to participate and share our expertise in any phase of the discussion regarding this issue.

Thank you again for providing this opportunity to submit testimony. If you have questions, please contact New York ACEP at 585-872-2417 or nyacep@nyacep.org.