Vermont Medical Society Resolution
Steps for the Improvement of Vermont's Health Care System

Approved by VMS Council, October 16, 2005

WHEREAS, On October 18, 2003, the Vermont Medical Society adopted a resolution calling for the Improvement of Vermont's Health Care System. The resolution stated that:

1. The Vermont Medical Society will actively work to improve Vermont's health care system by:

- Promoting universal coverage, which ensures access;
- Eliminating the under-reimbursement of physicians and other health care practitioners and health care facilities by the Medicaid and Medicare programs;
- Maximizing the percent of health care dollars that supports direct provision of patient care;
- Supporting evidence-based medicine;
- Aligning payment policies with quality improvement;
- Encouraging a collaborative, multidisciplinary process in the treatment of chronic conditions;
- Creating a legal environment that fosters high quality patient care and relieves financial strain and administrative burden for physicians; and
- Supporting healthier lifestyles, through incentives for identified health risk avoidance.

2. The Vermont Medical Society will actively collaborate with other health care organizations, consumer groups, business groups, public and private purchasers, and state and federal agencies in order to reduce the burden of illness, injury and disability, and to improve the health and functioning of Vermonters.

3. The Vermont Medical Society will assess its progress in achieving these goals by utilizing the Institute of Medicine's six major aims for health care improvement;

WHEREAS, On June 3, 2005, the Vermont General Assembly passed H.524, Green Mountain Health, that had the goal of Vermont having an integrated health care system by 2009 which provides all Vermonters with access to affordable, high quality health care that is financed in a fair and equitable manner;

WHEREAS, On June 22, 2005, Governor Douglas issued a formal 17-page message to the Clerk of the House outlining 23 principal reasons for returning, without his signature, H.524 to the General Assembly;

WHEREAS, Governor Douglas and Legislative Committees are currently seeking proposals from organizations that identify the barriers to change and the

issues that must be addressed to advance change in a way that builds a better and more sustainable health care system in Vermont; therefore, be it

Resolved, In order to advance changes in Vermont's health care system over time that will improve the health of all Vermonters, the Vermont Medical Society recommends the following steps be adopted:

1. Promoting universal coverage, which ensures access.

All Vermonters would have health insurance coverage, by a date certain, that is at least as comprehensive as a new affordable Vermont basic benefit plan required to be offered by carriers in the individual insurance market. Existing health insurance coverage options would continue to be provided by employers, Medicaid and Medicare.

The Vermont basic benefit plan would be developed through an independent commission relying on evidence-based principles. The Commission would be appointed by the Governor and it would include physicians, health care practitioners, patients, actuaries and experts in the design of benefit plans.

The basis benefit plan would include full coverage for chronic illness care, as well as providing preventive care and protection against catastrophic illnesses. The commission would ensure that the plan is affordable for Vermonters earning the average per capita income.

Prior to the effective date of universal coverage, publicly funded premium subsidies for low-income Vermonters would be established and a publicly funded reinsurance mechanism for the basic benefit plan would be created in order to ensure affordability. In addition, new incentives would be developed to encourage employers to offer and maintain insurance coverage to their employees.

In order to qualify for federal matching funds under the Vermont Global Commitment, new premium subsidies for low-income Vermonters, a reinsurance mechanism for the basic benefit plan, and new employer financial incentives would be funded through the Office of Vermont Health Access.

Public Health related revenue sources for the new premium subsidies for low-income Vermonters, the reinsurance mechanism for the Vermont basic benefit plan, new incentives for maintaining employer-sponsored coverage, and implementation of a strategy for ending the Medicaid cost-shift would include new tax increases, such as an increased cigarette tax, and extending the sales tax to include beer, soft drinks, candy, and other high-fat foods that contribute to obesity. (See Appendix A for a list of specific public health related tax increases).

According to the IOM, uninsured Americans get about half the medical care of those with health insurance. As a result, they tend to be sicker and to die sooner. About 18,000 unnecessary deaths occur nationally each year because of lack of health insurance.

Given the growing stress being placed on Vermont's health care system, the exacerbated health problems, and the substantial societal costs that result from more than 65,000 Vermonters lacking health insurance, the Governor and the General Assembly should strive to achieve universal health coverage in Vermont, as soon as possible.

2. Considering distributive justice in the design of the basic benefit plan

The Vermont Basic Benefit Plan must recognize that health care is neither an unlimited resource nor cost free. The commission must, therefore, strive to balance the moral, ethical, and economic desires of Vermonters when determining the nature and extent of the plan's health benefits.

The principle of distributive justice requires that we seek to equitably distribute both the basic coverage and life-enhancing opportunities afforded by health care. How to accomplish this distribution is the focus of intense debate. More than ever, concerns about justice challenge the traditional role of physician as patient advocate. Physicians will need to recognize an expanded role in caring for the entire population of Vermont, which may not always be consistent with the traditional role of care for the individual patient in the office or medical setting.

The commission, with the assistance of an organization such as the Vermont Ethics Network, should engage Vermonters in a statewide discussion on the principle of distributive justice in the design of the basic benefit plan.

Part of the Oregon Basic Health Services Program prioritized those services for which the state would pay for under a waiver to Oregon's Medicaid program. The planners reasoned that by limiting the number of services normally covered under Medicaid, they would be able to extend access for many individuals who previously had no access to any services under the old Medicaid plan. Thus, instead of rationing medical care by excluding certain members of the population from having any access, Oregon attempted to ration care according to a priority list of services to which more individuals who could not afford private insurance could have access.

The Governor of Oregon appointed a commission with instruction "to report...a list of health services ranked by priority from the most important to the least important, important to the least important, representing comparative benefits of each service to the entire population served. " The commission solicited public input throughout an eighteen month process of prioritizing medical care to be funded. The list contained approximately 300 line item services that would be covered under the plan. After much public and legal debate, the Medicaid waiver was applied for in 1991 and went into effect in 1992.

3. Eliminating the under-reimbursement of health care practitioners and health care facilities by the Medicaid and Medicare programs.

In order to eliminate the Medicaid cost-shift and maintain access to health care services, the Medicaid program would be required to negotiate a new fee schedule with health care practitioner bargaining groups that would result in reasonable and fair payments for services. The Legislature would fund the Medicaid program at a level consistent with the negotiated fee schedule.

The Vermont Medicaid Program is the largest payer of health care services to Vermont residents, in 2003 accounting for 25.1% of total Vermont Health Care Expenditures. Under the current fee schedule, physicians are paid far less than the cost of providing care to Medicaid patients and, as a result, costs are shifted to the private sector. This cost-shift results in inflated premiums for employer-sponsored coverage and increases the likelihood that employers will pass these added costs on to their employees or make the decision to drop insurance coverage altogether.

Beginning July 1, 2005, Medicaid's already low reimbursement for physicians was reduced by an additional 5.3 percent (office visit codes were reduced by 4 percent and all other codes were reduced by 7.5 percent). These payment reductions took place at a time when the 2005 Medicare Trustees Report projected that physician practice cost inflation for 2006 would be 2.7 percent. Adding the lack of an annual cost of living increase to the payment cuts, the resulting 8.0 percent reduction in Medicaid reimbursement for 2006 threatens beneficiary access to both primary and specialty care services. They will result in an increasingly larger numbers of patients seeking treatment in higher-cost emergency departments.

4. Maximizing the percent of health care dollars that supports direct provision of patient care.

The VMS recommends that the state bring physicians, health care practitioners, hospitals and health plans together to reduce administrative costs by standardizing payment codes, prescription drug formularies, insurance plan designs, claims submission requirements, credentialing, reporting, and oversight practices. In addition, a review of existing regulations should be conducted and those that are redundant or out-dated should be revised or repealed.

Physicians, hospitals, and other health care professionals incur major administrative burdens that detract from their ability to provide direct patient care as a result of variations across insurers and public programs in terms of benefits covered, payment regulations, conditions of health care practitioner participation, and coverage policies.

5. Supporting evidence-based medicine and information technology.

Evidence-based medicine has been described as the integration of the best medical research evidence with clinical expertise and patient values. This best practice protocol adapts evidence-based medicine to meet the health care needs of Vermonters. While our nation's medical research is the world's best, we lack the ability to get critical clinical information in a timely manner to the physician at the point of care. It is estimated that health information technology can reduce healthcare costs up to 20% per year – by saving time and reducing duplication and waste. However, there are many financial,

staffing and technological issues that need to be addressed before there can be a successful implementation of a statewide health information system.

The VMS will continue to support the work of VPQHC and other quality improvement organizations in promoting evidence-based medicine in practice settings in order to optimize clinical outcomes and quality of life for patients. In addition, the VMS will collaborate with VAHHS in implementing system improvements to avoid medical errors and reduce waste through the Institute for Healthcare Improvement's IMPACT program and its Campaign to Save 100,000 Lives.

The VMS recommends full funding for the work of the Vermont Information Technology Leaders (VITL). The group has been directed by the Legislature to create a health information technology strategy for Vermont and to implement health information infrastructure for data sharing. VITL's initial project will be to provide medication and medical history to Vermont physicians as a first step towards a comprehensive health record system for the state of Vermont.

6. Aligning payment policies with quality improvement.

In recent years, third-party payers and policy-makers have chosen to promote programs that offer financial incentives for physicians to achieve benchmarks of performance. The VMS recommends that clear principles be adopted in order to guide the development of any pay-for-performance programs to help ensure they promote improved health care quality and patient safety in Vermont's health care system.

Pay-for-performance programs operate in a complex reimbursement environment that often creates barriers to reaching the goal of consistent, high quality care for all patients, The programs are frequently implemented without first addressing the underlying levels of inadequate reimbursement and the lack of current resources to address identified public health risks and supporting healthy behaviors.

7. Encouraging a collaborative, multidisciplinary process in the treatment of chronic conditions.

The VMS recommends that the legislature fully fund the Vermont Blueprint for Chronic Health Care Initiative to ensure that chronic diseases, such as diabetes, asthma, depression and heart disease, are treated properly and efficiently, and individuals are engaged in efforts to protect their own health.

Chronic conditions are the leading cause of illness, disability, and death in Vermont. Driven by the combination of an aging population, increased prevalence of obesity, and lifestyle habits such as poor nutrition, physical inactivity, and tobacco use, the needs of Vermonters with chronic conditions will be the primary driver of the demand for health care and the resulting costs for the foreseeable future.

Health care reform must deal with the needs and costs of Vermonters with chronic illness. This includes: changing the way that Vermont's delivery system identifies, treats and supports patients with chronic illness; addressing the root causes that are

1 increasing the number of patients with chronic illness; and changing the way third-
2 party payers reimburse physicians and other health care practitioners for the treatment
3 of chronic conditions.
4
5 The Vermont Blueprint for Health Chronic Care Initiative is a unique public-private
6 partnership that includes physicians, hospitals, and other health care practitioners, the
7 VMS and professional organizations, VPQHC, health insurance plans, consumers,
8 businesses, and state government.
9
10 The Blueprint approach calls for fundamental change in the health system at every level
11 to help patients and health care providers effectively manage chronic disease.
12 Innovations in six broad areas will be utilized as part of this effort: patient self-
13 management; provider practice; community activation and support; decision support;
14 information systems; and health system design.
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16 **8. Creating a legal environment that fosters high quality patient care and relieves**
17 **financial strain and administrative burden for physicians.**
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19 Our legal system promotes the practice of defensive medicine that contributes to the
20 high cost of health care. According to a new study of Pennsylvania physicians published
21 in the *Journal of the American Medical Association* (June 1, 2005, JAMA), researchers
22 found that to avoid a lawsuit: 93 percent reported practicing defensive medicine; 92
23 percent reported ordering unneeded tests and diagnostic procedures and making
24 unnecessary referrals; and 42 percent said "they had taken steps to restrict their practice
25 in the previous 3 years, including eliminating procedures prone to complications, such
26 as trauma surgery, and avoiding patients who had complex medical problems or were
27 perceived as litigious."

28 The Institute of Medicine's (IOM) landmark 1999 report, *To Err Is Human: Building a*
29 *Safer Health System*, stated "the focus must shift from blaming individuals for past errors
30 to a focus on preventing future errors by designing safety into the system." In order to
31 create a legal environment in Vermont that fosters high quality patient care and relieves
32 financial strain and administrative burden for physicians, the VMS recommends
33 establishing a patient safety system of adverse event reporting for root cause analysis
34 and system improvement. Under such an administrative system, any injured patient's
35 settlement would be limited to economic damages.

36 In addition, the VMS recommends adopting tort reform measures, such as caps on non-
37 economic damages, safe apology protections, pre-trial screening panels with any
38 unanimous findings being admissible as evidence, an expert witness definition, a revised
39 statute of limitations, the elimination of joint and several liability, limits on contingency
40 fees, periodic payment of awards, and the use of practice guidelines as an affirmative
41 defense.

42 The cost of medical malpractice insurance in Vermont has escalated significantly in the
43 past few years. In Vermont, from 2001 to date, rates have been approved that have
44 exceeded 53.79 and 82.52 percent, respectively, for the two largest medical malpractice

carriers doing business in the state. During this same period, physicians in some medical specialties have experienced premium increases exceeding 109 percent.

To compound the financial burden on these physicians and their practices, the State of Vermont has recently reduced the already low Medicaid payments to physicians by 5.3 percent and it issued a proposed new worker's compensation medical fee schedule that freezes physician reimbursement at the same level established 10 years ago in 1995. In addition, the Medicare Trustees are projecting cuts of 26 percent in Medicare's physician fee schedule over a six-year period. Unless Congress acts in the next few weeks, Medicare physician payment rates will be cut by 4.3 percent on January 1, 2006.

Medical liability insurance premium increases of this magnitude coupled with reimbursement cuts by public payers make it increasingly difficult to attract and retain physicians at a time when the state's population is aging and the demand for health care services is growing. According to the Health Resource Allocation Plan for the State of Vermont, 4 out of 13 Vermont Hospital Service Areas in the state already have serious shortages of primary care physicians.

9. Supporting healthier lifestyles, through incentives for identified health risk avoidance.

The VMS recommends that steps be taken to encourage beneficiaries to take responsibility for their own health and their use of the health care system, such as premium discounts of up to 15% in return for adherence to health promotion and disease prevention programs and the use of advance directives.

Recent studies indicate that the rise in treated disease prevalence is the primary factor responsible for the growth in private health care spending. The needs of Vermonters with chronic conditions will be the primary driver of the demand for health care and the resulting costs for the foreseeable future. As "baby boomers" age, the impact of chronic conditions will continue to grow.

Reducing the long-term rate of increase in the cost of health care coverage requires decreasing the prevalence of disease by lowering risk factors and supporting healthy behaviors. Many of the approaches to these tasks rely on resources other than access to traditional health care services which are under state and local control. These include, for example, public education programs, public health resources and community development and incentives for identified health risk avoidance. Since so much of chronic care involves self-care, individuals must receive training and support from the family, health care practitioners, and community.

Appendix A

Public Health related revenue sources for the new premium subsidies for low-income Vermonters, the reinsurance mechanism for the Vermont basic benefit plan, new incentives for maintaining employer-sponsored coverage, and implementation of a strategy for ending the Medicaid cost-shift, could include the following:

1 To establish parity with Maine, increase Vermont's cigarette tax from $1.19 to $2.00
2 per pack = $19.6 million in estimated new state revenue;
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4 Expand Vermont's 6 percent sales tax to include beer = $7.0 million in estimated new
5 state revenue;
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7 Expand Vermont's 6 percent sales tax to include candy = $1.7 million in estimated new
8 state revenue; and
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10 Expand Vermont's 6 percent sales tax to include soft drinks = $5.0 million in estimated
11 new state revenue;
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13 Total estimated new state revenue = $33.3 million
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15 Based on a 58.8 percent federal match rate (FMAP), and the assumption that these new
16 capitated revenue expenditures that are intended to reduce the rate of the uninsured and
17 to increase the access of quality health care would not exceed the Global Commitment
18 budget cap, total estimated new federal matching funds = $47.5 million
19
20 Total available revenue through the Global Commitment to fund:
21 Premium subsidies for low-income uninsured Vermonters;
22 Reinsurance mechanism for the Vermont basic benefit plan;
23 Incentives for maintaining employer-sponsored coverage; and
24 Increased Medicaid reimbursement = $80.8 million.