# The Legislative Bulletin

*A publication of the Vermont Medical Society*

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## State report on medical malpractice reforms offers exceedingly modest recommendations for improvement

Last week the Shumlin Administration filed an Act 48-mandated report on potential improvements to Vermont's medical malpractice system. The 37-page report provides lengthy analysis on the legal barriers to changing Vermont's current tort system and makes modest recommendations for improvement that largely track the past advocacy positions of the state's trial attorneys.

Act 48's inclusion of the study was heavily influenced by the findings of Dr. William Hsiao's February 2011 report to the General Assembly where he found: *"(L)astly, we estimated savings to Vermont should it move to a no-fault medical malpractice system, such as the system in New Zealand. The mechanism through which this system achieves savings is not through the elimination of malpractice insurance premiums, but through its effect on defensive medicine, which researchers estimate contributes 2-9 percent of health expenditures in the U.S."* As a consequence, the report was intended to address any findings of defensive medicine, reduce health care costs and medical errors, and protect patients' rights, and include consideration of a no-fault system and of confidential pre-suit mediation.

The report begins by stating that our medical malpractice system affects health care costs in two distinct ways. First, it affects medical malpractice premiums paid by health care providers, in turn impacting health care costs overall. Second, it may affect the way health care providers practice medicine, with a consequent impact on health care costs. It then indicates that the impact of medical liability premiums falls outside the scope of the report and there is no further analysis on efforts to address the cost of liability insurance.

**Findings of Defensive Medicine**

The report devotes several pages to examining various research studies on the issue of defensive medicine and concludes with the following statement *"On a basis of a review of the empirical studies relating to medical malpractice laws or premiums on the one hand, and health care expenditures on the other, we cannot conclude that defensive medicine motivated by fear of medical malpractice claims leads to substantial unwarranted health care costs; nor can we confidently rule out the possibility."* This statement is in sharp contrast to the aforementioned finding by Dr. Hsiao that researchers estimate defensive medicine contributes 2-9 percent of health expenditures in the U.S.

The analysis then examines physicians' self-reports to ascertain the extent and impact of defensive medicine. The report cites one study published in 2010 that found that 91 percent of physicians responding to the study believed that physicians order more tests and procedures than needed in order to protect themselves from malpractice suits, and a comparable percentage believed that protections against unwarranted malpractice suits are needed to decrease the unnecessary use of diagnostic tests. It also referred to a Vermont Medical Society survey conducted in 2005 that found most physicians reported practicing defensive medicine due to concerns about malpractice liability. Like its analysis of research studies, the report found that: *"(T)he upshot of these surveys is that the usefulness of physician survey data in predicting the impact, if any, of changes to the medical malpractice system is limited."*

**Consideration of a No-Fault System**

The report defines a "no-fault" system in connection with medical liability as one where patients who suffer injuries as a result of medical treatment are eligible for compensation

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## Provider Tax Report Submitted to Legislature

As directed by the legislature, the Department of Health Access has submitted a report on expanding the provider tax in Vermont to nineteen provider classes not currently taxed, including physicians. The 2018 state budget proposal from the administration is not expected to include a proposal to expand the provider tax to physicians. VMS' resolution opposing the provider tax that was adopted at the 2011 annual meeting was referenced in the provider tax report.

The report notes that only two states have levied provider taxes on physicians, West Virginia and Minnesota. In 2010 West Virginia eliminated most of its provider taxes, including the tax on physicians, as part of a general change to the tax code. Minnesota uses the provider tax to support the MinnesotaCare program which provides state-subsidized health care coverage for low-income individuals who are ineligible for Medicaid. Minnesota is phasing down these taxes in anticipation that individuals covered by MinnesotaCare will be transferred into Medicaid as the federal Affordable Care Act is implemented.

The report estimates that if a 1-percent tax were levied on Vermont physicians it would raise $4 million, while a 6-percent tax (the maximum amount permitted by federal law) would raise about $24 million. The physician estimate did not include hospital-owned physician practices, or physicians employed by federally qualified health centers (FQHCs) or rural Health centers (RHCs). The tax levied on physicians would be used to draw down federal Medicaid matching funds.

The report cited the resolution passed by VMS and noted VMS' concern that the tax would have a devastating impact on the state's ability to attract and retain physicians. The report also noted a number of other concerns raised by VMS, including:

- The already low reimbursement rates received by Vermont practitioners;
- The financial and administrative strain on small independent providers;
- The inability to balance bill patients to make up for lost revenue; and
- The fact that practices' insurance coverage mixes make increased Medicaid reimbursement an inadequate strategy for alleviating any new tax burden on physicians.

For more information, view the following links:

VMS resolution opposing a provider tax, adopted October 29, 2011: *http://www.vtmd.org/sites/default/files/files/2011%20Provider%20Tax.pdf*

Provider Tax report: *http://dvha.vermont.gov/budget-legislative/2health-care-related-tax-study-report-01-12-12.pdf*

## Health Care Reform: VMS testifies on physician bargaining groups and the Basic Health Plan Option

Over the past two weeks, the Vermont Medical Society has testified on a number of provisions contained in H.559 – the administration's 2012 health care reform bill. In its statements, VMS has focused on two key sections that have the potential to significantly impact Vermont physicians and their patients.

VMS has expressed strong support for section 24 of the bill that amends existing law related to health care provider bargaining groups. Under Act 48, Vermont's 2011 Health Care Reform law, the Green Mountain Care Board was charged with setting reasonable rates for health care professionals and provider bargaining groups established consistent with the existing Vermont health care provider bargaining group law found in 18 V.S.A. §9409.

The new provision adds the Secretary of Administration and the Green Mountain Care Board to the list of state officials that physician bargaining groups can negotiate with. The section also adds administrative simplification, information technology, medical malpractice reform and workforce planning to the list of areas for negotiation.

Consistent with 18 V.S.A. §9409, the Physician Policy Council (PPC) was originally established By VMS as a bargaining group comprised of medical specialties designated by the Council, authorized to negotiate with state government concerning "provider regulation, provider reimbursement, or quality of health care." The PPC was certified by the Health Care Authority as a provider bargaining group in 1994 and that certification was renewed in 2000 by the Division of Health Care Administration.

Recognizing the importance of allowing physicians to collectively discuss the issues in Act 48 with state officials, VMS members adopted a resolution last fall citing the importance of the existing bargaining group authority under health care

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## Medmal Reform

*(Cont'd from pg. 1)* regardless of whether or not the medical provider was negligent. As long as the patient can establish that the injury was caused by medical treatment, he or she is eligible to recover for that injury.

Consistent with Dr. Hsiao's recommendation, the report devotes several pages to examining New Zealand's no-fault system. It mentions that New Zealand has adopted a broad government-funded system for compensating people with personal injuries, including medical treatment injuries. The system is managed by a central agency, the Accident Compensation Corporation (ACC), and claims are handled administratively, rather than through courts. The ACC is financed through general taxes and an employer levy and benefits to successful claimants are fixed and limited.

The report then editorializes that the greatest challenge in a no-fault system would be to provide fair compensation to patients injured as a result of medical error. It explains that because a no-fault system potentially provides benefits to a much broader class of patients, it must necessarily limit the available benefits in order to be sustainable. The report concludes that *"(T)he administration has reviewed the concept of a no-fault system for medical liability. On balance, we conclude it is not the best direction for reform. A no-fault system could improve the quality of life for some doctors—a benefit that is not insubstantial, and could allow for compensation to a broader pool of injured patients than our existing system. However, on balance, we conclude that the disadvantages to a no-fault system outweigh these benefits. The disadvantages of unfair compensation to patients injured by medical negligence, increased systemic costs, or both, are quite substantial."*

In what could be characterized as a leap of faith, the report concludes that proposals for early disclosure and settlement of claims offer even greater benefits than a no-fault system. The three examples cited of such systems are the ones adopted by the University of Michigan Health System in 2001, Department of Veteran Affairs in 1995 and the University of Florida Health Science Center in 2008. The report mentions that savings attributable to the University of Michigan program occurred at the same time claims had been reduced throughout Michigan and it fails to acknowledge that the VA system is covered by the federal tort claims act.

The discussion on proposals for early disclosure and settlement concludes by stating *"(T)he challenge is to figure out how to structure the legal environment so that patients' legal remedies are not limited, but providers are incentivized to pursue full disclosure (and early settlement) practices."* The first two examples and a similar philosophy were advanced by representatives of trial attorneys during the last legislative debate on medical liability reform in 2005. It is important to note that the report's recommended framework calls for full disclosure and offer of settlement by the defendant and with the plaintiff continuing to have full subsequent access to the current tort system.

**Recommendations**

The report concludes by offering four recommendations for improvement. First, it recommends a certificate of merit be filed simultaneous with filing a malpractice claim and the plaintiff's attorney certify to receiving information from a qualified expert that described the applicable standard of care; indicated there is a reasonable likelihood that the plaintiff will be able to show that defendant failed to meet that standard of care; and there is a reasonable likelihood that the plaintiff will be able to show that the defendant's failure to meet the standard of care caused plaintiff's injury. ***Continued on page 4***

## Bill looks to eliminate immunization philosophical exemption

A bill that would eliminate a philosophical exemption from the requirement that all children attending school and child care facilities receive immunizations is currently being discussed in the Senate Health and Welfare Committee. This week Harry Chen, M.D., Commissioner of the Vermont Department of Health submitted a compromise at the request of the committee that would keep the philisophical exemption, but include an exemption form to be signed by the primary care practitioner and the parent. Dr. Chen reaffirmed VDH support for S.199 as written and clarified that the issue is not whether we require parents to immunize their child but whether we allow them in to school.

The American Academy of Pediatrics Vermont Chapter, Vermont Academy of Family Physicians and Vermont Medical Society are in strong support of this bill as written to completely remove the philisophical exemption. Please contact members of the Committee ask them to pass S.199 as written, and remove the philisophical exemption.

**Senate Health & Welfare Committee Members**

Senator Claire Ayer, Chair - cayer@leg.state.vt.us; Senator Kevin Mullin, Vice Chair - kjmbjm@aol.com; Senator Anthony Pollina - apollina@leg.state.vt.us; Senator Sally Fox - sfox@leg.state.vt.us; Senator Hinda Miller - hmiller@leg.state.vt.us

# Medmal Reform

*(Cont'd from pg. 3)* Approximately 25 states have similar requirements with the states being roughly divided between those that require the report signed by the physician expert witness and those requiring the attestation by the plaintiff's attorney. Under the report's recommendation, there would be no report of the name of the physician expert witness and their qualifications or any record validating the attorney's certification. In addition as noted below, the report defers completely to the judicial branch for the development of any possible expert witness qualifications.

Second, the report recommends that "the Advisory Committee on Vermont's Rules of Evidence may wish to consider the following with respect to expert witness qualifications in medical malpractice cases: that the expert possess a current, valid and unrestricted license to practice medicine—or have had a valid and unrestricted license within a reasonable period so that recently retired physicians who have special expertise in the area are not excluded as an expert solely by virtue of their relatively recent retirement. Further, the physician expert witness should be qualified in the area of medical practice involved in the case. And, when the physician is testifying as to standard of care, he or she should be familiar with the standard of care provided at the time of the alleged occurrence."

Since the recommendation for the adoption of an expert witness standard is only a suggestion to the judicial branch that it "may wish to consider" the standards, it's unclear if any standards will actually be developed. In addition, VMS is very concerned that physicians who have been retired from actual practice as long as three years could possibly meet the standard of "expert witness."

The third recommendation is to revitalize protected early disclosure and resolution options. As mentioned earlier, at the urging of the Vermont Trial Attorney Association (now renamed the Vermont Association for Justice), in 2006 the Legislature created the Sorry Works! pilot program to encourage the adoption of early disclosure, apology, and settlement practices by hospitals. The pilot program expired on June 30, 2009, without any actual participation.

While this recommendation represents the cornerstone of the administration's suggestions, it is difficult to understand why any hospitals would chose to participate in the pilot program since the underlying framework is exactly the same as enacted in 2006. In addition, VMS is aware of the concern expressed by some that the early disclosure could simply serve as an opportunity for informal discovery by the plaintiff's attorney in order to better prepare for future litigation.

The final recommendation tries to build off the earlier mentioned University of Florida Health Science Center program and the report recommends the adoption of a program of voluntary pre-suit mediation. Both parties would be required to provide disclosure to one another—the plaintiff of his or her medical records to the extent they are relevant, and the defendant of complete medical records associated with the incident at issue.

Under VRCP 16.3, Vermont law currently provides for mandatory mediation in the litigation process, so a confidential pre-suit mediation requirement may be unnecessary and VMS believes this type of activity may already be taking place on an informal basis.

Perhaps the most affirming statement in the report is found at the end of the section on defensive medicine where it concludes by stating: "(W)e have seen, both through anecdotal experience as well as the data above (as well as other studies) that a) physician concern and anxiety about exposure to legal malpractice claims and liability is significant and real and b) this concern impacts the job satisfaction and quality of life of physicians in Vermont and beyond."

VMS believes strongly that the above statement is true. However, unfortunately the administration's report fails to offer any meaningful recommendations for reform of our state's medical liability system to address "anxiety about exposure to legal malpractice claims." The report instead seems to only echo the past policy statements of the state's plaintiffs attorney's for building a system of early disclosure, apology, and settlement practices by the defendant and with the plaintiff continuing to have full subsequent access to the current tort system.

To read the full Medical Malpractice Reforms Report and Proposal of the Secretary of Administration, please go to *http://1.usa.gov/yPlaad.*

## Health Care Reform

*(Cont'd from pg. 2)* reform and the need for amendments. Since section 24 reflects language developed jointly by VMS and the Administration, it is expected that the updates to the providing bargaining group statute will be enacted this spring.

The Green Mountain Care Board has already announced that once the legislation passes it will spend the summer developing the necessary regulations and then begin the actual negotiations in the fall of 2012. In the meantime, VMS will begin the process of forming a new physician bargaining group that ensures appropriate specialty representation.

To view the VMS resolution on Reconvening the Vermont Medical Society Physician Policy Council, please go to: *http://www.vtmd.org/sites/default/files/files/2011%20PPC.pdf*

The other section of H.559 that VMS has focused on is found in section 34 and relates to the possible creation by the state of a Basic Health Plan. Subsection 34(b) (5) of H.559 contains a new broad grant of authority to "enable the department of Vermont Health Access to provide for the operation of a basic health plan."

Act 48 established the Vermont Health Benefit Exchange as a division of Department of Vermont Health Access (DHVA). Beginning on Jan. 1, 2014 the exchange will provide qualified health benefit plans to eligible individuals and small businesses. The commissioner of DHVA is required to make a reasonable effort to maintain contracts with at least two health insurers to provide qualified health benefit plans, in addition to the multi-state plans required by the federal Accountable Care Act (ACA).

As an alternative to using health benefit exchanges, Section 1331 of the ACA offers states the option to implement a Basic Health Program Option to adults with incomes between 133 and 200 percent of the federal poverty level (FPL). The federal government will reimburse states 95 percent of what they would have spent on premium tax credits and cost-sharing reductions had the individuals been enrolled in a qualified health plan through the state's Health Benefit Exchange. Vermont would likely treat the BHP as an extension of VHAP – one of its existing Medicaid programs. Adding additional Vermonters to the Medicaid program would make it even more difficult to reform Medicaid's below cost reimbursement system.

In its testimony, VMS has voiced its opposition to the creation of a Basic Health Program (BHP) for three reasons. First, removing the 133 percent to 200 percent of FPL population from the exchange could lead to the failure of exchange due to its low enrollment and high administrative cost. The smaller pool in the exchange would undermine the sustainability of the exchange's individual and small market and spread the exchange's fixed administrative cost over a much smaller population leading to higher premiums.

Bailit Health Purchasing states that implementing a Basic Health Program would reduce the number of people purchasing insurance in the state's Health Benefit Exchange. The projection for participation in the Exchange beginning in 2014 is 31,025 people. If the state decided to establish a Basic Health Program, enrollment in the Exchange would drop to 16,508. Bailit indicates this would present challenges for the financial viability of the Exchange because of Vermont's small market size.

In addition, in order to achieve cost saving for the state of Vermont, the BHP would likely reimburse physicians and other health professionals at the Medicaid rate. A June 2011 analysis done for the state of Vermont by Bailit states "of all the models estimated, the BHP costs the state more than it will receive from the federal government in almost all cases. Only if one assumes that the Basic Health administration can be held to 10 percent, with a patient profile and provider payments equivalent to VHAP can the state expect to realize a small savings of $315,264."

With Medicaid's below-cost reimbursement for physicians and other health professionals, the BHP policy to expand Medicaid for uninsured adults with incomes up to 200 percent of FPL would further jeopardize patient access to physicians and acerbate efforts to attract and retain the physicians needed in the future to care for an aging population.

Finally, VMS stated that enabling the department of Vermont health access to provide for the operation of a basic health plan represents an extraordinary delegation of authority by the Vermont legislature to the administration. Since there is no federal deadline for applying for the BHP, such a complete delegation of authority on a key decision is unwarranted and it would establish a new precedent in defining the appropriate roles of the legislative and executive branches of government.

The decision on the BHP is analogous to the enactment of Catamount health – legislation that reflected months of work by the General Assembly in establishing the benefit plan, cost-sharing and reimbursement rates. Section 34 would place the decision on the possible adoption of a BHP solely in the hands of the administration.

For the text of H.599, please go to: *http://www.leg.state.vt.us/docs/2012/bills/Intro/H-559.pdf*