

THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

2012 Legislative Wrap-Up



Contact Us

P.O. Box 1457
Montpelier, Vermont 05601

Toll-Free: 800-640-8767
Fax: 802-223-1201

Online at: www.vtmd.org

Working for Vermont Physicians at the State House

Paul Harrington
Executive Vice President
pharrington@vtmd.org

Madeline Mongan
Deputy Exec. Vice Pres.
mmongan@vtmd.org

Stephanie Winters
Operations Director
swinters@vtmd.org

The major issue of this year's legislature was to continue implementation of Act 48 – last year's major health care reform bill – by passing H.559, which established Vermont's health benefit exchange beginning in 2014 (assuming the U.S. Supreme Court in June doesn't overturn the ACA). As passed, VMS is generally supportive of H.559. However, as outlined below, the VMS also found itself opposing a number of initiatives that it believes would have eroded the state's high-quality health care system.

On several occasions this session, VMS requested that physicians contact members of the general assembly and voice their concerns regarding legislation that would have harmed the physician/patient relationship. In every instance, VMS was able to prevent these proposals from moving forward and is extremely grateful for the many calls and emails.

In order to read the full text of the various bills, please go to:
<http://www.leg.state.vt.us/database/status/status.cfm>.

H.559 PASSES – ESTABLISHES AN ACA-MANDATED HEALTH BENEFIT EXCHANGE FOR VERMONT

The General Assembly passed H.559, legislation establishing state-specific characteristics for the federally-mandated health benefit exchanges required under the Accountable Care Act (ACA). Under the bill, individuals and employer-sponsored groups with less than 50 employees will be required to purchase their health insurance from private sector qualified health plans (QHPs) through the exchange beginning Jan. 1, 2014. Premium tax credits are available to individuals and families below 400 percent of the federal poverty level (FPL) (\$89,808 for a family of four) and above 133 percent of FPL (\$29,861 for a family of four) purchasing coverage through the exchange. In addition, individuals and families with incomes below 250-percent FPL are also eligible for cost-sharing subsidies to reduce their out-of-pocket exposure. Vermonters under 133-percent of FPL will be enrolled in Medicaid and those 65 years and older would continue to receive Medicare. Beginning in 2014, VHAP and Catamount would be repealed with individuals covered under VHAP or Catamount having income over 133-percent of FPL enrolling in the exchange.

Under the ACA, employers with 50 or more full-time equivalent employees (FTEs) are subject to a penalty of \$2,000 per employee (beyond the first 30) if they do not offer health insurance coverage and at least one employee receives subsidized coverage in the Exchange. However, there are no penalties for employers with less than 50 employees for not offering insurance coverage to their employees. The lack of a penalty for small employers led BISHCA Commissioner Steve Kimball to say that he thinks businesses with fewer than 50 employees should drop their coverage beginning in 2014 because they can save money and their employees would be eligible for the federal subsidies.

H.559, as originally introduced, contained language allowing the state to implement a Basic Health Plan option (BHP) as an alternative to the exchange for adults with income between 133 and 200 percent of FPL. In its testimony, VMS strongly opposed the creation of a BHP for two reasons. First, removing the 20,000 Vermonters earning between 133 and 200 percent of FPL from the exchange could lead to the failure of exchange due to its low enrollment. In addition, in order to achieve cost savings for the state of Vermont, the BHP would likely reimburse physicians and other health professionals at the Medicaid rate. With Medicaid's below cost reimbursement for physicians at 78 percent of Medicare, the BHP policy to expand

Continued on Page 2

H.745 – PRESCRIPTION DRUG ABUSE BILL FAILS TO PASS

Notwithstanding a great deal of consensus on numerous provisions in the bill to prevent prescription drug abuse, the House and the Senate failed to reach a compromise on H.745 and the issue of state police access to information on an online prescription drug database, thus the bill's failure.

VMS was pleased to have Commissioner of Health Harry Chen, MD, and Rep. Ann Pugh, Chair of the House Human Services Committee attend its February 11th Council meeting to discuss H.745 as introduced – particularly the provision mandating the use of the VPMS before prescribing or refilling prescriptions for a controlled substance in Schedules II, III, and IV.

The House of Representatives passed H. 745 after two provisions of particular concern to VMS were removed from the bill. VMS was successful in having a provision in the bill as introduced deleted that would have required physicians to check the VPMS every time prior to prescribing a controlled substance. In addition, VMS was able to defeat a provision that would have required physicians to provide their patients' medical records to drug diversion investigators on request when physicians believed that the records included evidence of drug diversion. If it had passed, this provision would have greatly reduced the confidentiality of patients' medical records. No court order, probable cause or warrant would have been required.

VMS generally supports the final version of the bill including:

- A requirement to show identification when picking up a prescription;
- A requirement to write out the drug dosage for controlled substances in words and numbers on the written prescription;
- A requirement to create a state-wide drug disposal program;
- A requirement that licensing boards determine when prescribers and dispensers should check the VPMS;
- A requirement that all practitioners who prescribe or dispense controlled substances register with the VPMS;
- A requirement that replacement prescriptions be identified on the face of the prescription and tracked in the database;
- The creation of a 21-person group to advise the Commissioner of Health on developing a unified pain management system and evidence-based training modules;
- Improved use of the VPMS data as recommended by the VPMS advisory committee; and
- Authorization to enter reciprocal agreements with other states to share data about prescriptions of controlled substances.

VMS intends to actively encourage the DOH to improve the functionality of the VPMS and provide Vermont physicians with information and support in registering and using the VPMS in order to help prevent prescription abuse in the state.

H.559 – PASSES

(Cont'd from pg. 1) Medicaid for uninsured adults with incomes up to 200 percent of FPL would add to the cost-shift and 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.

In response to the arguments put forward by VMS, VAHHS and FAHC against the BHP, the final bill includes language stating it is the intent of the legislature that the administration not implement a basic health plan without the approval of the general assembly. Section 24 of the bill includes VMS-recommended amendments to the health care provider bargaining group statute. The bill also includes modest medical malpractice reform through the requirement that a certificate of merit be filed by the plaintiff's attorney in conjunction with the filing of a complaint against a physician. The certificate would state that the attorney has consulted with a qualified health care provider; the qualified provider has described the applicable standard of care and indicated that the defendant failed to meet the standard of care; and there is reasonable likelihood the failure caused the plaintiff's injury (see section 24a).

The Senate added an administrative simplification provision requiring uniform prior authorization forms and reducing the time limits for prior authorization. The prior authorization provision was based on a prior authorization bill that VMS had worked to introduce in the House, H.603. The prior authorization requirement in H.559 will require insurers to use a single uniform form for prior authorization for medical procedures and tests, and will require the Department of Financial Regulation (formerly BISHCA) to work with stakeholders to develop one or more uniform forms for prescription drugs. The uniform forms will include the data elements included in national electronic standard transactions for prior authorization. Health insurers will be required to respond to completed prior authorization forms within 24 hours for urgent requests, and within 120 hours for non-urgent requests. If a plan does not respond to a request within the required time frames, the request for authorization will be deemed granted.

S.199 PASSES – BILL PRESERVES EXEMPTION FOR IMMUNIZATIONS

S.199, a bill that would have eliminated the philosophical exemption allowing parents to enroll children in public school without immunizations, passed the last day of the session with heavy amendments and in the end left the philosophical exemption intact. While the Senate voted to eliminate the philosophical exemption; the House voted 93-36 to keep it. Efforts to strengthen the bill in conference committee by giving the Commissioner of Health authority to remove the philosophical exemption if rates for MMR, DTaP, and Tdap dropped below a 90-percent threshold were unsuccessful.

In the end the bill requires parents to sign a yearly exemption form for religious or philosophical exemptions. By signing the form, parents would state that they have reviewed and understand evidence-based educational material provided by the Department of Health regarding immunizations, including: Information about the risks of adverse reactions to immunization; Understand that failure to complete the required vaccination schedule increases risk to the person and others of contracting or carrying a vaccine-preventable infectious disease; And understand that there are persons with special health needs attending schools and child care facilities who are unable to be vaccinated or who are at heightened risk of contracting a vaccine-preventable communicable disease and for whom such a disease could be life-threatening.

The bill would also require schools and child care facilities to make publicly available the aggregated immunization rates of the student body for each required vaccine and create an interim working group on protecting immunocompromised students and students with special health needs.

VMS will continue its efforts to remove the philosophical exemption - which this session included organizing a press conference to stress the importance of, and science behind, immunizations - and it was pleased to see an editorial in the April 22nd Boston Globe in support of the Society's position.

H. 777 - FAILS TO PASS - WOULD HAVE REQUIRED INSURERS TO REIMBURSE HOMEBIRTH, BUT INSURERS MAY NOT REQUIRE LIABILITY INSURANCE UNTIL 2014

The House of Representatives approved H.777 -- a bill that would by law exempt licensed midwives and certified nurse midwives from carrying medical malpractice insurance for home birth until 2014. The bill would have required insurers to reimburse licensed midwives and certified nurse midwives for homebirths, and at the same time, would not permit the insurer to require that midwives be part of the insurer's network until 2014. Because the bill was referred to the House Judiciary Committee it did not make the legislative crossover deadline, and could not be considered as a separate bill in the Senate. An attempt was made in the House to attach H.777 to an insurance bill that had already been passed by the Senate, but H.777 was found not to be germane to the insurance bill, and the legislation died.

The midwives testified that because malpractice coverage was not affordable for them, they had not been able to contract with health insurers. VMS expressed concern that this bill would not protect women and their babies who are harmed because of negligence of midwives. VMS was also concerned because Vermont is only one of a few states that has a joint and several liability rule. Most states allow juries to apportion harm among defendants. A jury in Vermont, however, may not apportion fault among defendants unless the patient has also been negligent. As a result, a plaintiff may choose to collect the entire award from any defendant. So an insured physician who provides care to a woman or infant who is transferred to a hospital in an emergency and makes a small mistake could be liable for the entire harm most of which was caused by the midwife's serious error. The House committees did not agree to language offered by VMS that would have ensured that a physician responding in an emergency would only have been liable for his or her own actions.

S.103 – PHYSICIAN ASSISTED SUICIDE BILL FAILS TO PASS

Legislation that would allow physicians to assist terminally ill patients to take their own lives failed to pass the General Assembly. VMS testified before the Senate Judiciary Committee in opposition to the bill, based on its policy of not supporting laws for or against physician-assisted suicide. VMS last formally considered physician assisted suicide in 2003, and, based on a vote of the entire membership, adopted a policy that affirms the importance of "promoting initiatives that assure all dying Vermonters receive good, comprehensive palliative care." The policy does not support laws for or against physician assisted suicide, for the reason that laws against assisted suicide could chill the use of medications needed to control symptoms and laws for assisted suicide might discourage or circumvent the provision of good palliative care.

Physicians supporting the VMS policy expressed the belief that decisions about dying should be made at the bedside by physicians with their patients. Since 2003, VMS members have been leaders in ongoing efforts to improve hospice and palliative care in Vermont. Recently Vermont has received the highest ranking in the country for hospitals with palliative care programs, with 100 percent of large and mid-size hospitals having palliative care programs compared to a national rate of 53 percent. Hospice spending for Medicare patients in Vermont, however, is reported to be well below the national average.

VMS recognizes the need to continue to work on these issues.

H.524 – OFFICE OF PROFESSIONAL REGULATION (OPR) BILL EXPANDS NATUROPATHS PRESCRIPTION AUTHORITY. VMS PROPOSED STUDY ON NATUROPATHS' EDUCATION AND CLINICAL TRAINING ADDED

H. 524 authorizes the Office of Professional Regulation (OPR) to eliminate the naturopaths' formulary, the list of drugs that naturopaths have authority to prescribe, and instead will permit naturopaths who pass a qualifying test to prescribe any prescription drug that they believe is consistent with their scope of practice. These changes to the naturopaths' prescribing authority were proposed by the Director of OPR with the concurrence of the Commissioner of Health. The current formulary would remain in effect until 2015. After 2015, naturopaths who have not passed the test would not be able to prescribe prescription drugs. VMS opposed this expansion of prescribing for naturopaths, due to concern about the potential risk to patients when dangerous drugs are prescribed by naturopaths without sufficient training. Naturopaths' education and training is very different from physicians' education and training. Their naturopathic college curricula generally appear to include only one or two courses in pharmacology that are typically taught by naturopaths. A review of their education and training done in 2007 by the Vermont Department of Health and a work group that included physicians, pharmacists, naturopaths found that naturopaths were not qualified to prescribe all prescription drugs, and proposed a limited formulary for naturopaths that would be contingent on passage of a rigorous test.

This year in the Senate, VMS, with assistance from Senators Ayer, Lyons, Mullin, Sears, Giard and Starr, was able to add a requirement that the Department of Health and the Office of Professional Regulation, in consultation with clinicians, pharmacists and pharmacologists, review and report on naturopaths' education and clinical training to determine if naturopaths receive sufficient academic training in pharmacology and sufficient clinical training to safely prescribe and administer drugs, including controlled substances, both on and off label by any route of administration. Representatives of the UVM College of Medicine and naturopathic colleges will have an opportunity to review and comment on the draft report, which will recommend limitations on the authority of naturopaths to prescribe and administer prescription drugs as necessary to ensure consistency with the naturopaths' education and clinical training and public protection. The review and report on the naturopaths' education and clinical training will be completed next January, so that limits and conditions on naturopaths' prescribing authority found to be necessary based on the review of their education and training can be established before the prescribing test is designed for the naturopaths.

VERMONT BOARD OF MEDICAL PRACTICE (VBMP) APPROVES PROPOSED RULES REQUIRING PHYSICIANS TO HAVE 30 HOURS OF AMA CATEGORY 1 CME EVERY TWO YEARS

The Vermont Board of Medical Practice (VBMP) has approved proposed rules that will require physicians to have 30 hours of AMA Category 1 CME every two years for license renewal. Of those 30 hours, 1 hour of CME must address palliative care, hospice or pain management and 1 hour of CME must address prescribing controlled substances. In connection with their license renewals, physicians will be required to certify that they have completed the CME requirements, listing the courses and hours. The VBMP will have the ability to audit licensees for compliance for four years after the certification is submitted. VMS currently tracks CME as a membership benefit. The rules include provisions for make-up plans and exceptions for physicians serving in the military. After the formal rulemaking process is completed, the CME rules are expected to be in effect for the license renewal period that begins Dec. 1, 2012, and physicians will first need to certify that they have taken the required CME when they renew their licenses in the fall of 2014. VMS is seeking comments from members on the proposed rules and will comment formally to the VBMP as the rules go through the administrative rules process.

S.209 PASSES - AUTHORIZES NATUROPATHS TO SERVE AS PATIENTS' MEDICAL HOMES

This year the General Assembly passed legislation that will require health insurers to consider naturopaths as primary care providers and medical homes under the Blueprint for Health. This legislation was supported by the Commissioner of Health and the Director of the Blueprint for Health.

VMS opposed authorizing naturopaths to serve as medical homes for patients, particularly for patients with multiple complex chronic conditions. VMS is concerned that naturopaths' training and scope of practice are not comparable to the training or typical scope of practice of physicians who are serving as medical homes. Many of the treatment modalities in naturopaths scope of practice, such as homeopathy, botanical medicine, naturopathic manipulation, diet and nutrition, Chinese medicine, hydrotherapy, and naturopathic physical medicine, have limited or no scientific evidence-based support. Additionally, naturopaths may not follow the same evidence-based guidelines that primary care physicians follow, particularly with respect to preventive care such as immunizations.

**VERMONT DEPARTMENT OF LABOR
ANNOUNCES RULEMAKING TO
PROVIDE UPDATES TO WORKERS'
COMPENSATION FEE SCHEDULE**

The VMS recently learned that the Vermont Department of Labor (VT DOL) was moving forward with phased-in revisions to its Rule 40 relating to a workers' compensation fee schedule. VMS has frequently pointed out to the VT DOL that adequate reimbursement for physicians and other healthcare professionals is an important aspect of ensuring access to appropriate medical care for injured workers and the proposed revisions should help to maintain this important workplace protection.

When Rule 40 was initially adopted in 1995, the CPT reimbursement amounts were based on the amounts paid by Blue Cross Blue Shield of Vermont (BCBSVT). The proposed revisions to Rule 40 continue this methodology by updating the payments for CPT codes in order to reflect the amounts currently paid by BCBSVT. The Rule 40 CPT amounts were last revised by the VT DOL in 2006 after an 11-year period of time had passed. These proposed revisions thus represent a CPT payment update after six years. While VMS strongly supports the payment updates, it also recommends that VT DOL consider adopting a methodology that would allow CPT reimbursement amounts to be automatically updated based on the frequency of updates used by BCBSVT.

Importantly, the proposed Rule 40 also updates the conversion factor for anesthesia services from the conversion factor of \$34.25 that was first adopted in 1995 to a new conversion factor of \$45.00 per unit. While VMS greatly appreciates the proposed increase, this proposed change represents the first payment update for anesthesia services in over 17 years. Consistent with its recommendation regarding reimbursement for CPT, VMS suggests that VT DOL adopt an approach that allows for the anesthesia conversion factor to be updated automatically in order to track the updates adopted by BCBSVT.

VMS supports the approach taken in proposed Rule 40 regarding fees for depositions, mileage and supplemental reports. Rather than fixing a set amount, the proposed rule sets reimbursement at a reasonable amount that is agreed to by the parties or as determined by the department after formal hearing. This approach, VMS believes, will more accurately reflect the true cost associated with depositions and the costs of supplemental reports and it should help to ensure the availability of these services.

**FY 2013 STATE BUDGET
INCLUDES REQUIREMENT THAT DVHA
STUDY THE IMPACT OF REVISING THE
PRIMARY CARE CASE MANAGEMENT
REIMBURSEMENT METHODOLOGY**

The FY 2013 state budget includes a requirement that the Department of Vermont Health Access study the impact of revising the primary care case management reimbursement methodology. The analysis will review the methodology for the case management fee, the impact on providers, and implications for the delivery system. The \$5 per member per month primary care case management fee has been a frequent target for proposed budget cuts, so VMS will watch this study closely, as the fee provides about \$2 million in primary care reimbursement.

**CONFERENCE ON THE IMPORTANCE
OF PHYSICIAN LEADERSHIP FOR
SUCCESSFUL HEALTH CARE REFORM
SCHEDULED TO BE HELD
ON SEPTEMBER 22ND**

The VMS Education and Research Foundation will sponsor a conference on the Importance of Physician Leadership for Successful Health Care Reform on September 22nd from 8 to 1:30 at the UVM College of Medicine. Tom Lee M.D., President, Partners Healthcare System and CEO-Partners Community HealthCare, has agreed to be the keynote speaker. Dr. Lee is a nationally recognized authority on physician leadership and reorganizing health care teams to enhance organizational performance. The conference will highlight current physician leadership initiatives across the state being supported by the VMS Foundation and others. Organizations that have expressed interest in being co-sponsors include the UVM College of Medicine, FAHC, VAHHS, Bi-State Primary Care Association, the Vermont Chapter of the American College of Physicians and the Green Mountain Care Board. The purpose of the day is to be both informative and act as a catalyst to enhance physician leadership and engagement in ensuring successful health care reform in the state.