Legislative Presentation to West Virginia Healthcare Human Resources Association
2011 Fall Conference – September 15-16, 2011

Good morning and thank you for inviting me to be part of your program.

As one of the West Virginia Hospital Association's chief lobbyists, most of my time is spent at the State Capitol in Charleston, so it's nice to be outside of the DOME. Although I wear a number of political hats for the Association, none gives me greater pleasure than to be part of the legislative process, and to share with you some insight into that process.

As all of you know, there is no shortage of hospital and health care issues on the state and national levels. Hospitals are dealing with: financial, operational, political and regulatory pressures that challenge caregivers every day. The main goal, of course, is to ensure that every WV resident has access to **"the right care in the right place at the right time."**

I'm here to shed light on some of these pressures and how they relate to the legislative process.

POLITICAL LANDSCAPE

- The 2011 Session concluded on March 12th, and was framed around a new "Acting" Governor AND new Senate leadership, so it was an historic session.
- We then had a SPECIAL PRIMARY ELECTION for Governor at the end of the SESSION, which added yet another dimension.
- And now, we're in the midst of another campaign, culminating in a Special General election for Governor on October 4th
- Candidates are: Acting Governor Earl Ray Tomblin (Democrat) and Morgantown businessman Bill Maloney (Republican).
- Tomblin was holding a double-digit lead in late August, but a recent poll shows him only leading by about 6 points.
- Both candidates have been running TV ads – and the campaign has become rather "aggressive" – with a televised debate held this past Tuesday.
- Tomblin is the expected favorite.
- The winner is to serve only one year as Governor – with another election in November 2012.
- 2 legislative redistricting sessions held in August.

- They were contentious in nature, especially in the House over single member districts.

- The Business Community and others pressed hard for single-member district during those discussions.

- In the end, the House bill passed with: 11 new single member districts; a split of the districts in Beckley; a 5th member added to the district in Morgantown; a breakup of the 7-member district in Kanawha County (4 members in 1 district & 3 members in another).

- The bill was VETOED by the Governor for technical flaws. SO, The Legislature met again in mid-August for a second attempt to correct errors.

- This time, the House bill passed by a more narrow margin **- 65 yeas / 37 no** – with more Democrats crossing over in favor of single-member districts.

- The Senate passed the bill by a narrow margin of **16 yeas to 15 nos** – with 8 Democrats voting no, - in favor of single member districts.

- The final bill doesn't radically change the current map for the 100-seat House, but it does contain **47 single-seat districts, up from the current 36**.

- The Governor signed the bill into law.

- Advocates of single-member districts, question whether the House plan is constitutional.

- Based on media reports, it's very likely that there will be at least one lawsuit challenging the legality of the final plan, citing lack of representation.

WASHINGTON AND HEALTH REFORM

There are many challenges facing hospitals from the national perspective. These challenges are overwhelming, **primarily led** by the implementation of national health reform, known as ***The Patient Protection and Affordable Care Act (ACA).***

There are many aspects of the ACA and so many unknowns - with rules that still need to be written. However, we do know there will be some anticipated changes in insurance coverage models, whether they are: Employer Provided Health Coverage; State Health Insurance Exchanges; or Public Programs through Medicare, Medicaid and other state sponsored programs. The overall goal of course is to expand coverage to about 32 million more Americans beginning in 2014.

What does this mean for WV? Insurance expansion means about 330,000 new lives will enter the system: Approximately 50% will be under the State Medicaid program when coverage is raised to 133% of the federal poverty level. The remaining 50% is expected to be covered under the **"to be formed"** West Virginia state health insurance exchange.

Coverage is just one aspect of reform and other areas include: health information technology; quality of care and a focus on wellness and prevention, to name a few.

WASHINGTON AND DEBT REDUCTION

In Washington, we're also following developments surrounding **The Joint Select Committee on Deficit Reduction**. This is the "super committee" authorized by the federal government's "BUDGET CONTROL ACT" from early August 2011. The bipartisan 12-member committee is charged with crafting a plan to reduce the national deficit by at least **$1.2 trillion by November 23**. If Congress fails to adopt the committee's recommendations by **December 23**, OR if the committee can't find enough savings – then automatic spending cuts totaling $1.2 trillion SPLIT between defense spending and non-defense programs…..will take effect. The IMPACT ON HOSPITALS boils down to another round of reductions in Medicare payments to hospitals over a 9 year period beginning in 2013 – to the tune of about $41 billion in cuts to hospital payments.

HEALTH REFORM/DECLINING REIMBURSEMENT/PAYMENT ISSUES

One of the more overarching challenges brought about by reform and payment issues in general, is declining and continuing reimbursement levels. In other words - payment shortfalls to hospitals by government health care programs such as Medicare on the *federal level* and Medicaid on the *state level*.

Unfortunately, it will get worse in the coming years as the federal government continues to "ratchet" back the annual increase in hospital payments to help pay for new healthcare reform initiatives.

On top of the potential reductions I just mentioned, over the next year 10 years, WV hospitals will face more than $1.3 billion in additional reductions for Medicare and Medicaid payments. This is the hospital industry's contribution to help pay for national health reform. While some of these reductions will be OFF-SET by additional covered patients through Medicaid or through health insurance exchanges, the net effect is still unknown.

HEALTH REFORM/WORKFORCE

Reform also will greatly increase the demand for caregivers and other hospital personnel, especially primary care physicians and nurses. A recent report by the Association of American Medical Colleges predicts that *"America will face a shortage of more than 90,000 physicians in the next 10 years"*. This includes ALL specialties, not only family

practice and internal medicine physicians. This will likely present a challenge to identify an adequate number of practitioners to treat the 300,000+ newly insureds in WV in a medical setting ***(versus delayed care that currently occurs in hospital emergency departments).*** Legislatively, we repeatedly emphasize with policymakers that recruitment and retention of health care workers, whether nurses, doctors, pharmacists, is critical in maintaining the viability of hospitals. After all, hospitals employ more than 39,000 compassionate care givers, and these are good paying, quality jobs with excellent benefits.

There's obviously, no 1 solution to the myriad of challenges facing hospitals. With reform implementation on the horizon, providers across the board will have to do more with less, and that's the new reality we live in today.

REVIEW OF 2011 SESSION

There's definitely a lot to watch coming out of Washington, but we also have to keep our eyes on what's happening in Charleston at the state level. Last session, to put it into perspective, there were about 2,000 bills introduced by the Legislature during the 60-day Regular Session. About 400 of those related to health care. And, when it was all said and done, only about 190 bills were passed and signed into law. Of the 190 bills that passed, there were about 40 -50 related to health care…which is again *fairly typical* for any given session.

PLAYING DEFENSE

No one session is alike, **EVEN THOUGH the same bills seem to get introduced year and after.** There are plenty of "HR AND BUSINESS OPERATIONS" bills that fall into this category, and, part of what the WVHA does as an "advocacy group" is not only "play offense" on bills, but we also play "defense." That effort typically involves HR issues in collaboration with many others in the business community.

This means, that we try to keep bills from moving out of committee and moving through the legislative process because we view them as harmful or burdensome to hospitals whether it be in the business office or clinical setting, such as repeated attempts over the years to legislate and mandate nurse staffing ratios in our hospitals. Aside from that very important clinical and operational issue, I'd like to share with you just a few of the business office related HR issues that fall on our radar each year.

WV FLEXIBLE LEAVE ACT

For the last couple of sessions we've seen the introduction of the West Virginia Flexible Leave Act. This legislation would enable employees the ability at any time and virtually without notice or proof - TO USE PAID TIME OFF for a family member's illness (spouse, child or parent). The proposed requirement would apply to all types of leave, including sick leave, vacation, ("PTO") and "compensatory time," whether provided

under company policy or collective bargaining agreement. An amendment was offered in one of the committees last session to make the Act applicable to those employers that employ more than 50 people – which is essentially what the FMLA does – so it was kind of like a "poison pill" for the bill! Still yet, the bill made it to the House Finance Committee, where we joined with others in the business community to successfully defeat the legislation.

Some general arguments to touch on: it has the potential to be extremely costly to WV employers; additionally, employers could face NEARLY unmanageable situations when faced with unexpected, unplanned employee absences. Also, only 2 other states, California and Maryland, have passed similar legislation. Still yet, the legislation will likely be re-introduced in 2012.

PERSONNEL COPIES

Over the years, we've also seen the introduction of legislation **to require employers to provide an employee with access to copies of his or her personnel file**. Various proposals have floated around that would apply to employers who have 12 or more workers and would enable an employee to "pay" to get a copy of his or her file. The fee is a $10 search fee and a .25 cent charge per page. No electronic records or files would be subject to the bill and there are exclusions for medical information in the employee's files.

One proposal included some of the following provisions: Employer has 30 days to give an employee a copy of his or her personnel file; An employee may only ask twice a year, unless terminated; AND Employers must notify employees of their right to access their file.

Among other problems, the bill creates a "cause of action" where employees still have the right to sue to see their records. Primary supporters of the legislation included members of the labor community. Some final thoughts:

- 17 other states have legislation that allows an employee the right to view their personnel file.
- 5 of these states have provisions that allow collective bargaining agreements pertaining to personnel files to supersede their legislation.
- 7 of these states have provisions that penalize the employer for not providing an employee with his or her personnel file. These range from a misdemeanor crime to civil procedures.

We'll likely see this bill in some form or another in the next legislative session.

MEAL BREAK BILL

Over the years, we've also seen the introduction of legislation **to require 20 consecutive minutes for meal breaks and rest periods of 15 minutes for each 4 hours of work**. Proposals have never moved beyond committee.

The bills did not have language that would protect provisions related to break periods and lunch periods that are already part of negotiated labor agreements. Other questions and arguments against the bill:

- How would this bill apply to workplaces such as hospitals, courtrooms, etc. where certain procedures and situations may last more than 4 hours and be beyond the control of the employer;

- Our hospitals already have meal and break period policies in place that provide for uninterrupted employee meal breaks during the course of the workday;

- Managers are responsible for coordinating and scheduling meal and break periods not the Legislature;

- If an employee elects, voluntarily, to work a flex schedule, or tele-commute, will this new law affect these situations?

These were just a few questions that fortunately prevented the bill from moving forward.

We've also seen the introduction of other HR related bills, including some of the following:

- HB 2114 - Providing an employee the right to decline to work more than forty hours in a workweek; AND
- HB 2120 - Providing overtime pay for all employees who are required to work holidays regardless if the holiday hours are in excess of a forty hour workweek

These are only a handful of bills introduced AND as experts, we'll be calling on you to help us advocate against movement of these bills in committee and the legislative process.

INTERIMS INTRODUCTION

With the 2011 session having concluded in March, the legislature has entered into what's called the "*legislative interim period.*" This is the time between sessions in which legislators gather each month in Charleston for 3 days of committee meetings to study

various issues for the upcoming 2012 session. WVHA is following the developments surrounding 2 issues of importance to the hospital community:

1. ASSIGNMENT OF BENEFITS by patients where there is no contract with the particular provider; and

2. ELIMINATION OF RATE-SETTING.

ASSIGNMENT OF BENEFITS 2011/2012

At the direction of our membership, we worked to introduce **HB 3052 during the 2011 session**. This is the so called "assignment of benefits" – to be paid directly to providers based on the patient's assignment of benefit form. There was lots of interest concerning the bill from a variety of stakeholders but there was little time for legislators to create a meaningful dialogue – so we advocated for a study resolution which was approved by the Legislature.

Currently in West Virginia if a person goes to the doctor or hospital that is out-of-network for its particular insurance company, the company sends the patient the money to pay the provider instead of sending it directly to the doctor's office or hospital.

The problem is that some insurers will not accept an assignment of benefits from non-contracted or out-of-network providers. This places an unnecessary burden on the patient, and also creates an administrative hassle for providers.

From the patient perspective, if a dispute arises regarding payment, and an assignment has been *"ignored"* by the insurer, the patient is left with the burden of disputing, investigating and possibly appealing the payment. It's simpler to take the patient out of the middle and have the trained professionals from both the insurance company and the provider resolve the payment of the bill.

From the hospital perspective, we're hearing that a lack of assignment of benefits creates an unnecessary administrative cost for them, as they must now spend valuable time and resources seeking payment from the patient. Also, BAD DEBT – **patients who have the ability to pay but don't** - is becoming a significant problem to the tune of about $429 million annually. A lot of that can be attributed to the patient caught between the provider and the insurer.

Currently, about 26 states already have "Assignment of Benefits" laws and so what we're trying to do is get WV to adopt similar laws. Our primary opposition includes the insurers who do not believe an "Assignment of Benefits" policy is needed in West Virginia and believe such a policy could increase health care costs especially if the providers "try to charge more for certain services."

Legislative discussions are expected to continue so we'll see how things unfold in anticipation of the 2012 session.

ELIMINATION OF RATE-SETTING 2011/2012

Another issue we're managing this interim is pursuit of the **elimination of rate setting under the Health Care Authority – the state's regulatory body for hospitals**. The way it works is that the Authority annually collects expense, revenue, and utilization data from hospitals and determines the average charge for **non-governmental payor patients**. It then establishes a limit on the RATE hospitals may charge these patients in the upcoming year. Some general arguments against rate-setting:

1. WV is one of only 2 states that still set rates for hospitals;
2. The current rate-setting model only factors in a small segment of our patient population – non-governmental or rather commercial insurance patients; and
3. New health reform models will provide incentives for integration of hospital services and other providers. The rate-setting program could be viewed as a barrier and disincentive for hospitals to develop integrated models of health care delivery.

The Legislature has yet to address the issue during the interim period so it's unclear how this will be shaped in anticipation of the 2012 session

LOOKING AHEAD TO 2012

Looking ahead to 2012, what other issues are on our radar? A lot of what will happen, will depend on the outcome of the governor's race - BUT from a 30,000 foot view, here's a brief rundown.

1. There are **STATE BUDGET ISSUES** which we'll follow very closely, particularly as they relate to state health care programs like Medicaid and PEIA.

Our main goal is to support adequate funding of those programs to ensure fair and increased provider payments for hospitals;

2. There will be **CONTINUED SUPPORT OF A TOBACCO TAX** as a way to help finance some of those health programs I just mentioned.

The current tax is **.55 cents** and in the past, we've joined with others in support of an increase of up to **$1.00** as a way to help finance healthcare related initiatives AND more importantly help reduce tobacco consumption which is a huge cost driver in health care.

3. In **ANOTHER AREA OF TOBACCO CONTROL** - we also intend to introduce legislation related to tobacco use by employees of health care facilities.

This would be a proposal to add a provision in the current code which would exclude: nonprofit organizations or health care facilities that discourage the use of tobacco products by the general public or provide treatment to patients with life threatening

illnesses related to the use of tobacco: **to be able to refuse hiring an employee because of tobacco use.**

4. On the business side of things, we'll continue to monitor the state's **UNEMPLOYMENT SITUATION**.

In particular, we'll engage with the business community in monitoring the management and solvency of the state's Unemployment Compensation Fund. This is to ensure that **no additional administrative burdens and costs are placed on WV businesses including hospitals** as a way to shore up funding should it be necessary.

5. We'll also be monitoring **PROFESSIONAL, CLINICAL AND OPERATIONAL** issues that typically creep into the legislative arena

Our goal here is to ensure that any dialogue in those areas also include the hospital perspective on issues such as professional licensing, health information technology, and issues related to various health boards, commission and agencies, to name a few.

MEDICAL LIABILITY

The final issue I want to mention is MEDICAL LIABILITY – more specifically: the positive impact it's had in the health care arena; AND the importance of preserving and protecting the reforms from 2001 and 2003. We believe those landmark reforms have helped ensure available and affordable professional liability for physicians and other providers.

Several years ago, West Virginia's healthcare system was in severe crisis due to the lack of affordable and/or available medical liability insurance.

Physicians were forced to either restrict the services they offered, move their medical practice out of state or quit practicing altogether. As a result, several parts of the state began experiencing the loss of specialty services, such as neurology and surgery.

Many doctors in WV were notified their malpractice insurance would not be renewed. The threat of medical liability coverage loss: further caused physicians to explore relocating outside of West Virginia, retire from practice, and/or limit the scope of their hospital privileges.

HB 601 in 2001

Faced with the possible collapse of the state's healthcare system, the Legislature passed two rounds of medical liability reform legislation, first in 2001 and then in 2003.

In 2001, after a 5 week special session, the Legislature passed *HB 601* which includes numerous components designed to help put the medical liability insurance market back on track.

This included:

1. A tax credit aimed to assist physicians with high premiums;
2. The creation of a state-run insurance program for physicians who could not obtain insurance from the private market; and
3. Several reform measures, including: prohibiting third party bad faith claims; and expansion of the juries in medical malpractice cases from six members to 12, among other items.

This bill was a significant first step toward addressing availability and affordability within the medical liability environment.

HB 2122 in 2003

A commitment to stop the erosion of the insurance market and the rising premium costs experienced by physicians and hospitals prompted the Legislature and other policymakers to move forward with further reforms.

During the 2003 Regular Session, the Legislature once again tackled the crisis with the passage of *HB 2122*. This legislation was the first comprehensive medical liability reform that had passed in WV for more than 20 years.

The legislation greatly mirrored successful reforms in California and placed West Virginia at the forefront of many states in regard to such laws.

HB 2122 included:

1. A $250,000 non-economic damages cap;
2. A $500,000 trauma cap;
3. Creation of a patient injury compensation fund;
4. More stringent medical expert witness requirements; and
5. Additionally, the legislation provided capital in the form of a loan and a mechanism for the creation of a physicians' mutual insurance company.

The results

We continue to experience the results of the 2001 and 2003 reforms. Due to these significant reforms, a stabilization of West Virginia's medical liability market is occurring.

1. Premiums have stabilized and;
2. The creation of the West Virginia Mutual Insurance Company (WVMIC) has provided measurable and necessary security for the healthcare community.

Reforms of this magnitude however, take years to be fully realized, with the frontlines over preserving and protecting these recent achievements moving beyond the legislative arena and into the court system. Hospitals and healthcare providers remain vigilant in protecting against any threats to erode the current reforms.

Other benefits of liability reform:

- Active licensed physicians in West Virginia have increased: In 2004, the state licensing Boards indicated there were 3,532 physicians actively practicing in West Virginia. By 2009, that number rose to 3730, in large part because there was a feeling of stabilization in the med mal market.

- Competition has increased in the marketplace: In 2004, the Board of Risk and Insurance Management (BRIM) was the primary insurer for physicians, with some small carriers in the mix. By 2010, thanks to the efforts of the West Virginia Department of Insurance, the WV Physician's Mutual is the primary carrier BUT there are dozens of other insurance companies competing for business - which will make the product more affordable for the West Virginia doctor.

- Medical Malpractice claims have been reduced: In 2003, there were over 300 med mal claims filed in West Virginia. By 2008, that number was reduced to fewer than 200 filed state-wide. That's a reduction of about 45 percent.

- Patient Safety has been increased: West Virginia's largest medical malpractice company informs us that over 75% of their physicians have been involved with special patient safety programs and educational classes designed specifically to make patient safety the number one priority in our state.

There are obviously a lot of health care issues "swirling" around us both nationally and statewide. And, one of the first questions people ask of me is: ***"how do I become engaged in the process and help affect change?"*** The bottom line is that as professionals with expertise…you hold more power than you think. Legislators need to turn to those who have expertise in areas like HR - AND you have the information they need to help shape policy. In an abstract sense….you too can be a "lobbyist." So thank you for inviting me to be with you this morning and I look forward to working with you during the upcoming legislative session.

Tony J. Gregory
Vice President, Legislative Affairs
West Virginia Hospital Association
100 Association Drive
Charleston, WV 25311
304-353-9719 – office
304-545-0128 – cell
304-414-0210 - fax
tgregory@wvha.org