West Virginia State Medical Association
2010 Legislative Policy Statements

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West Virginia State Medical Association

Protecting Medical Liability Reform Laws

POSITION: ***The WVSMA <u>strongly</u> maintains the need to preserve the integrity of the Medical Professional Liability Act and to protect against any threats to erode the current statute.***

ISSUE: In recent years West Virginia's healthcare system has been in severe crisis. The lack of affordable and/or available medical liability insurance forced many physicians to either restrict the services they offer, move their medical practice out of state or quit practicing altogether. The Legislature has made great strides in passing new laws designed to stabilize the medical liability system and preserve patient access to care. The efforts are paying off but it is critical that we stay the course.

The medical liability crisis of recent years has two distinct components: insurance *availability* and *affordability*.

The cost of medical liability insurance had grown to exorbitant levels in recent years. As a result, some physicians attempted to reduce their premium costs by limiting the services they provide to only those procedures that are lower risk, or by closing their practice and either moving out of state or quitting the practice of medicine altogether.

Many physicians were also experiencing a lack of insurance availability. Several years ago, the few carriers that were willing to offer medical liability insurance tightened their underwriting. In 2001, the largest carrier in the state stopped writing insurance altogether. For many physicians, insurance was not available at any cost.

Faced with the reality that West Virginia's healthcare system was on the verge of collapse and with concerns over patients' access to care being severely jeopardized, the Legislature responded by passing two rounds of medical liability reform legislation.

First in 2001, after a five week special session, the Legislature passed HB 601. The bill included numerous components and measures to help put the medical liability insurance market back on track. Those components were: a tax credit aimed to assist physicians with their rising premiums, and the creation of a state-run insurance program for physicians who could not obtain medical liability insurance from the private market. The bill also included several medical liability reform measures including: prohibiting third-party bad faith claims; requiring notice of claims and a certificate of merit thirty days prior to the filing of a medical malpractice claim; expansion of the juries in medical liability cases from six members to twelve, among other items.

This legislation was a good first step toward addressing the healthcare crisis. However, it did not curtail the continued erosion of the insurance market and the rising premium costs.

In the 2003 regular session the Legislature once again addressed the crisis with the passage of HB 2122. This legislation was the first comprehensive medical liability reform that had passed in West Virginia in over 20 years. The legislation greatly mirrored the successful reforms passed in California two decades ago and placed West Virginia at the forefront of many states in regard to such reform laws. The new law included a $250,000 non-economic damages cap, a $500,000 trauma cap, collateral source offset, elimination of joint liability, creation of a patient injury compensation fund, and more stringent medical expert witness requirements. Additionally, and critically important, the legislation provided the revenue and mechanism for the creation of a physicians' mutual insurance company.

Due to these significant reforms a stabilization of West Virginia's medical liability market is occurring.

- In 2008, (the most recent data available) medical malpractice premiums in West Virginia continued to demonstrate highly favorable results culminating in the lowest overall loss ratio on record.
- A review of Medical Liability Fund data by the Insurance Commissioner indicated the number of filed actions in West Virginia generally continued to decline in 2008.
- Since 2002 the pre-trial screening process has resulted in a sharp and maintained rise in the percentage of dismissals. Additionally, since 2002, we have seen a sharp drop in the percentage of claims settled.
- Overall, since 2002, the number of claims filed annually has declined by about 50%.
- Recruitment efforts are paying off. New physician licenses issued by the Board of Medicine have continued to rise over the past four years, and in 2008 the WV Board of Medicine saw the largest number of new licenses issued in the last two decades.
- The WV Mutual Insurance Company, which was created by the legislation and given a $30M startup funding from the state (of which $24 million was a loan), is now the largest medical liability insurance carrier in WV. It is in good financial condition, has reduced rates over the past years and has paid the State loan in its entirety.
- The WV Mutual Insurance company has instituted an overall rate reduction of 25% - 45% since 2006. For 2010 the Mutual has instituted a 12 % renewal credit for policy holders renewing their coverage.
- WV is no longer designated a "crisis" state by the American Medical Association.

West Virginia still has a long way to go. Reforms of this magnitude take years to be fully realized. <u>We must stay the course.</u>

West Virginia State Medical Association

Completing the Healthcare Provider Tax Phase-Out

POSITION: ***The WVSMA strongly supports the continued phase-out of the healthcare provider tax with no interruption or slowdown.***

ISSUE: The healthcare provider tax was imposed in 1993 as the Legislature's solution to generate additional funding for Medicaid. It was considered an unfair burden by physicians and other healthcare providers and repeal of the law has been fervently sought since its inception.

Physicians (MD's and DO's) were taxed at a rate of 2% of gross revenues. All the following individual healthcare practitioners were taxed at the rate of 1.75% of their gross revenue: Chiropractors, Dentists, Nurses, Opticians, Optometrists, Podiatrists, Psychologists, and Therapists.

In 2001 the Legislature passed a bill initiating the repeal of this tax on all individual practitioners through a ten-year phase out. As a result, on July 1, 2009 the tax on physicians was reduced to 0.2 percent. Under the current timetable the tax will be eliminated for physicians and the other healthcare practitioners on July 1, 2010.

Physicians and other healthcare practitioners pay this tax in addition to paying their personal income tax, and other state business taxes, as well as municipal taxes that must be paid as any other business would. Only physicians and individual healthcare practitioners are required to pay this tax on their gross revenue without consideration for the cost of providing services.

The vast majority of West Virginia's counties are federally designated as "health professional shortage areas." This unfair tax has over the years encumbered the recruitment and retention of healthcare professionals in our state particularly physicians.

The WVSMA thanks the legislature for their foresight in the passage of this phase-out and for their fortitude in continuing down the path of repeal. We strongly recommend that no interruptions or slowdowns are implemented to obstruct the ultimate phase-out of this onerous tax.

WEST VIRGINIA State Medical Association

Addressing the Impact of Federal Healthcare Reform on Medicaid

POSITION: ***With the prospect of federal healthcare reform looming, and since the leading proposals call for a significant expansion of Medicaid eligibility, the WVSMA strongly supports fully funding the West Virginia Medicaid program to provide appropriate reimbursement to healthcare providers for their services. Adequate funding of the program is essential to ensure that Medicaid recipients enjoy continued access to medical care.***

ISSUE: The major healthcare reform bills call for a significant expansion of the Medicaid program to cover a larger population of low wage earners. West Virginia will face a particularly large increase in its Medicaid program because the state has a large number of low wage earners, and its current Medicaid eligibility criteria are stricter than those of most other states.

WEST VIRGINIA'S CURRENT MEDICAID PROGRAM

West Virginia's current Medicaid program enrolls disabled people, pregnant women who earn 150 percent or less of the Federal Poverty Level (FPL), and parents who earn a maximum of 33 percent of the FPL. The following table illustrates the current federal poverty guidelines. Based on these guidelines, a family of three must have annual wages of no more than $6,042.30 to be eligible for West Virginia Medicaid. The program currently covers 392,600 people, or about 20 percent of the state population. Of these, 107,300 are eligible because of disability.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia*

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

**Table from Department of Health and Human Services*

IMPACT OF LEADING FEDERAL REFORM PROPOSALS

The leading healthcare reform proposals call for a substantial expansion of the states' Medicaid programs. The House bill calls for expanding Medicaid to 150 percent of the FPL, and the Senate bill would expand coverage to 133 percent of the FPL. Thus, as the table below shows, under the House bill, Medicaid would cover a family of three with wages up to $27,465, and, additionally extend coverage to single adults with income up to $16,245 and childless couples with incomes of up to $21,855.

Eligibility Cutoffs for WV Medicaid			
Persons in family	**Current eligibility: 33% FPL**	**Proposed eligibility: 133% FPL**	**Proposed eligibility: 150% FPL**
1	N/A*	$14,404	$16,245
2	**	$19,378	$21,885
3	$6,042	$24,352	$27,645
4	$7,277	$29,327	$33,075
5	$8,511	$33,527	$38,685
6	$9,745	$39,275	$44,295
7	$10,979	$44,249	$49,905
8	$12,213	$49,223	$55,515

** Current eligibility is limited to families in which at least one person is a dependent child.*
*** This figure does not apply to childless couples, for whom Medicaid is currently unavailable.*

In West Virginia, expanded eligibility will lead to a substantial increase in Medicaid enrollees that is disproportionately large compared with other states since the state's current eligibility cutoff of 33 percent of FPL is among the lowest in the nation. Since WV Medicaid currently covers 392,600 people, and the U.S. Census Bureau reports that 544,000 West Virginians live at or below 150 percent FPL (25.5 percent of the state population), the expansion could mean 151,400 new enrollees, a 38.6 percent increase.

Expanding Medicaid coverage for many low-income people who might otherwise have no medical coverage could have a perverse effect of limiting access to care. Throughout the nation, many physicians have had to refuse to accept Medicaid patients or limit the number they can accept because of the program's inadequate reimbursements. Only about 40 percent of physicians accept all new Medicaid patients, and 28 percent do not accept any Medicaid patients, according to a national study of more than 4,700 physicians that was completed in September 2009. Another recent national study of over 100,000 physician groups found that large physician groups (more than 26 members) and those that served a high volume of patients were more likely to accept Medicaid patients. We know in West Virginia that the vast majority of physician practices are individual or small group practices. The number of physicians who accept Medicaid has been dropping dramatically in some areas as the Medicaid population grows. For example, in Texas, physician participation has declined from about 65% in 2002 to only 42% in 2008.

How much will the expansion cost West Virginians? The House bill stipulates that the federal government will fully finance the Medicaid expansion from 2012, when it first is scheduled to take effect, until 2015, and then states will contribute nine percent thereafter. Currently, the federal government's contribution to each state's Medicaid program is a minimum of 50 percent; in West Virginia, the federal government contributes 73 percent of the total. In fiscal year 2007, WV Medicaid cost nearly $2.2 billion, and West Virginia spent over $591 million on the program. If the program expands to cover 150 percent FPL, and the costs increase proportionately to the resulting Medicaid population increase (38.6 percent, as explained above), the new total cost will be over $3 billion. When West Virginia begins contributing 9 percent of the total cost of the expansion, the new additional cost will be $74 million, a more than 12.5 percent increase above current levels. The leading reform proposal in the Senate calls for a smaller expansion of Medicaid but requires a larger state contribution.

In addition to limiting Medicaid recipients' access to care, and costing state taxpayers over $70 million, the proposed expansion could erode employer-based private insurance because of cost shifting. Government payers like Medicaid account for a large segment of the patient population in West Virginia. For example, 70 percent of hospital revenue comes from government programs like Medicaid. When Medicaid does not pay its full share of costs, healthcare providers must shift the non-reimbursed cost of serving government covered patients to private sector payers. Simply put, through this cost shift, the private sector businesses subsidize public program beneficiaries. Under-funding government programs creates a hidden tax that inflates prices and forces employers to pay more than their fair share for healthcare and results in the loss of insurance coverage as businesses cut back benefits in an effort to save money.

Such a shift often makes private insurance too expensive for businesses to provide full or even partial insurance coverage to their employees. It also makes insurance too expensive for individuals to purchase. Underinsured or uninsured workers compromise the state's economic well-being when they incur uncompensated care.

To help ensure continued access to medical care and to reduce cost-shifting to the private sector, the WVSMA supports responsible initiatives that help secure funding to sustain the Medicaid budget and provide appropriate reimbursements to providers. Such initiatives will improve access to healthcare services for the State's most at-risk populations.

WEST VIRGINIA State Medical Association

Supporting State Health Care Reform Initiatives

POSITION: ***The WVSMA supports efforts to achieve healthcare reform in West Virginia.***

ISSUE: West Virginia, like the rest of the nation, is faced with the serious threat of rising costs in health insurance, decreasing availability of insurance and concerns with chronically ill patients and a progressively unhealthy population.

In 2009 the Legislature and the Governor took a good first step toward addressing the issue by establishing the Governor's Office of Health Enhancement and Lifestyle Planning (GO HELP). Additionally the legislature passed legislation directing the Insurance Commissioner to convene a committee to draft legislation establishing a credentialing verification organization.

Though the federal government is currently engaged in the development of health system reform there are a number of important initiatives that West Virginia should simultaneously pursue. The WVSMA recommends continued work in the following areas:

Patient-Centered Medical Home Pilots
In order to appropriately address the chronic healthcare needs of our patients and preserve the provision of care in the primary care setting a move toward the patient-centered medical home is necessary. The fundamental principle that a medical home is "physician" lead can not be underscored enough.

Practitioner Credentialing
Enabling the credentialing of health care providers in a timely and less burdensome fashion is imperative to recruitment efforts. The creation of a central verification organization (CVO) and the implantation of shorter timeframes for credentialing will reduce the administrative burdens on physician practices and hospitals and enable providers to begin caring for patients sooner. Additionally the CVO should reduce the overlap of work that currently exists with each entity re-verifying the same provider's information.

Wellness and Prevention
As West Virginia leads the nation in unhealthy behaviors (tobacco use) and lifestyles (obesity) it is critical that a core component of any healthcare reform address these issues. Tobacco cessation, nutrition and labeling, school and community based initiatives among other are all vital elements of healthcare reform.

Health Information Technology
Encouraging the use and supporting the expansion of electronic medical records and other health information technologies will help to provide probably the most critical reform to West Virginia's healthcare system. Funding mechanisms for initial start up and ongoing technological support must be integrated into the plan.

Research and Education
Critical to success is a process which helps to answer the question of whether the reforms are what the public needs or better yet are tailored in a fashion which will lead to successful outcomes. Additionally, as we have seen with past failed initiatives, if there is not sufficient training, education and support of the providers who are expected to carry out the programs then we can only expect them to not reach the desired outcomes.

The recommendations outlined above will lead our state toward a healthier population while controlling the rising expenditures in health care spending.

West Virginia State Medical Association

Modifying the Open Hospitals Proceedings Act

POSITION: ***The WVSMA supports legislation clarifying medical staff committees are not governing bodies under the Open hospitals Proceedings Act, the executive session topics enumerated in the Act are inadequate and at the least should be expanded, and that action on those topics should be permitted in executive session if the Act is to apply to any medical staff bodies.***

ISSUE: While hospitals must be accountable to the public, the nature of healthcare has evolved to where a hospital's public mission may be adversely affected by certain aspects of open proceedings. Of greatest privacy concern to hospitals and physicians are issues of professional credentialing, peer review and discussions related to the sensitive and confidential nature of medical liability cases, among other areas related to the delivery of care, patient safety and operations.

The West Virginia Supreme Court of Appeals in 2007 ruled that one hospital's Medical Staff Executive Committee is a "governing body" for purposes of the Open Hospital Proceedings Act (OHP Act) and therefore its meetings must be conducted in compliance with the Act. The Act requires that public notice of meetings be published and that meetings be held open to the public to attend except for enumerated topics that may be addressed in executive session. However, no action on any matter may be taken in executive session.

More specifically, the ruling held that a hospital may have more than one "governing body" for purposes of the OHP Act. The Court's ruling reversed a Kanawha County Circuit Court ruling that the Board of Trustees of the hospital is the sole "governing body" of the hospital. The decision has a broad effect on all nonprofit and government-run hospitals throughout West Virginia. Under this decision, arguably all groups "that make recommendations to a hospital on policy or administration" fall within the definition of a "governing body" for purposes of the Act.

In so ruling, the Court overlooked the fact that for all other purposes, including West Virginia hospital law other than the OHP Act and hospital licensure regulations, hospitals clearly—and logically—have a single governing body, in most cases that being the hospital's board of trustees. The Court chose to take an expansive view of the language of the Act even though West Virginia was already in a small minority of states in posing any open meetings requirements on private hospitals, be they for-profit or nonprofit.

The WVSMA joins with the WV Hospital Association in the position that no medical staff committees should be considered governing bodies under the OHP Act, that the executive session topics enumerated in the Act are inadequate and at the least should be expanded, and that action on those topics should be permitted in executive session if the Act is to apply to any medical staff bodies. The OHP Act should be amended to clarify that for nonprofit corporations, the board of directors or board of trustees is the sole "governing body" of the hospital. This will ensure that Medical Staff meetings continue to be an effective means to conduct essential hospital business by promoting open discussion and willing participation by medical staff.

WEST VIRGINIA State Medical Association

Strengthening Tobacco Control and Clean Indoor Air Initiatives

POSITION: ***The WVSMA supports policies that protect public health by discouraging tobacco use and promoting clean indoor air. Such policies include significantly increasing the tobacco excise tax, allocating sufficient funding for education programs designed to reduce or eliminate tobacco use and exposure to secondhand smoke, and supporting counties' indoor air regulations.***

ISSUE: The WVSMA seeks to reduce or eliminate tobacco use by West Virginia citizens, especially children, and to eliminate the exposure to secondhand tobacco smoke, which is the third leading cause of preventable death among nonsmokers.

FACTS ABOUT TOBACCO USE[1]

Morbidity/Mortality: Tobacco use is the number one preventable cause of death and disease in the United States. In West Virginia the statistics are particularly dire. The state's smoking-attributable death rate is the second worst in the nation, with nearly 4,000 deaths annually. Smoking accounts for one in five adult deaths, and an estimated 128,000 WV kids now alive will die from smoking.

Prevalence: Among the states, West Virginia ranks worst in the nation for smoking rates of adults and youth. We rank first in smoking among pregnant during pregnancy and second overall in women smokers. Further, West Virginia has the highest rate of smokeless tobacco use in the nation. The usage rates among West Virginia's youth are particularly disturbing. One in three high school students currently use tobacco and one in five males use smokeless tobacco; of those, one in four began using before age 11.

Second-hand Smoke: The deleterious effects of tobacco use affect not only smokers but also the public at large. Scientific studies clearly show that secondhand cigarette smoke is a hazardous, cancer-causing air pollutant. Exposure to secondhand smoke causes increased risk for disease and death in healthy nonsmokers and is the third leading cause of preventable death among nonsmokers.

Costs: The prevalence of tobacco use in West Virginia translates to an enormous economic toll. The state spends over $1 billion a year on the direct health care costs of smoking, and another $1 billion on occupational costs due to smoking, according to the West Virginia Bureau for Public Health. Further, West Virginia ranks 40th in the nation (ranked in ascending order) for smoking-attributable Medicaid cost per capita, according to the CDC.

POLICY RECOMMENDATIONS

1. Increase the Tobacco Excise Tax

[1] The data in this section were provided by the Centers for Disease Control, Campaign for Tobacco-Free Kids, West Virginia Division of Tobacco Prevention, and Coalition for a Tobacco-Free West Virginia.

Increasing the price of tobacco products is the single most effective strategy for reducing tobacco use, especially among youth. One way to increase the price is through excise taxes. The WVSMA joins with the Coalition for a Tobacco-Free WV in supporting a significant increase in the excise tax on cigarettes and an equivalent increase in the excise tax on the wholesale price of all other tobacco products. This will provide not only one of the best mechanisms for reducing youth tobacco use, but also has the potential to bring in substantial revenue to the State.

- West Virginia's cigarette excise tax was increased last in 2003, from 17 cents to 55 cents per pack, which was the first increase in 25 years.
- This tax rate still places West Virginia well below the national average of $1.34 per pack.
- West Virginia nationally ranks 43rd among states on the rate of cigarette excise taxes, although our smoking rates are the highest in the nation.
- Of our five contiguous states, Ohio, Pennsylvania, Maryland, and even Kentucky all have higher cigarette taxes.
- The excise tax on tobacco products other than cigarettes remains at 7 percent.
- Revenue from tobacco taxes are among the most predictable, steady and reliable revenue sources that states receive. Gradual reductions to state tobacco tax revenues from ongoing smoking declines are dwarfed by the massive reductions in public and private sector smoking-caused costs.

2. Provide State Funding for Education Programs

The WVSMA supports legislation to allocate sufficient funding for education programs designed to reduce or eliminate tobacco use and exposure to secondhand tobacco smoke.

The Centers for Disease Control and Prevention (CDC) recommends a **minimum** tobacco prevention funding level for each state. CDC recently upgraded its recommendation for West Virginia from **$14.1 M to $28 M.**

The WVSMA joins with the Coalition for a Tobacco-Free WV in strongly recommending implementing a statewide, comprehensive approach to tobacco use prevention containing the following elements:

• *Community-based programs* that will promote the tobacco-free social norm and change public attitudes and behaviors about tobacco use, and monitor retailer compliance with youth access laws.

• *Youth-based programs* that include school programs and community oriented youth programs that provide education to empower youth to serve as agents of change and advocates for tobacco-free communities.

• *Counter Marketing* campaign that educates about the dangers of second-hand smoke, warns youth about being targets of the tobacco industry and encourages tobacco cessation for both youth and adults.

• *Cessation programs* that increase availability and affordability of cessation aids and programs and provide training to health care providers and other health professionals involved in cessation counseling and treatment.

• *Statistical surveillance and evaluation* to ensure that the elements of the comprehensive program are working effectively.

The CDC recommends that a successful tobacco prevention program must be comprehensive; well-funded; sustained over a long period of time; operate free and clear of political and tobacco industry influence; and address high-risk and diverse populations. West Virginia is *not* meeting these standards.

3. Protect County Clean Indoor Air Policies.

Local boards of health, municipalities, various public agencies and private establishments in West Virginia have acted to protect the public health from secondhand smoke by restricting smoking in enclosed places. Fifty-four counties have adopted clean indoor air regulations, and they have won widespread support from the public.

The WVSMA joins with the Coalition for a Tobacco-Free WV in support of policies that provide the maximum possible protection from secondhand smoke in all places open to the public and in all places of employment. Such policies should be accompanied by consistent public education campaigns addressing the harmful nature of secondhand smoke, and emphasizing the benefits of smoke-free environments and workplaces. The policies should pay particular attention to protecting children by providing that outdoor sports arenas, playgrounds, special events, festivals and performances are smoke-free.

WEST VIRGINIA State Medical Association

Reversing West Virginia's Poor Perinatal Health

POSITION: ***The WVSMA supports initiatives to improve the health of pregnant women and children in West Virginia.***

ISSUE: The health of West Virginia's babies has a tremendous impact on the state's economy, workforce development and family well-being. Twelve years ago, West Virginia birth statistics were much brighter than today. The State's rates for pre-term birth, primary C-sections, vaginal births after cesarean section (VBAC), and low birth weight infants were all more positive for healthy outcomes.

While there are solutions to our child health problems, West Virginia has made little progress over the past decade in improving infant mortality. The number of low birth weight babies has increased and more babies are spending the first weeks of life in neonatal intensive care. Actually, WV's three Neonatal Intensive Care Units (NICU) have been at 100 percent capacity for the past several years, causing havoc for our community hospitals and physicians seeking referrals for high risk care of mothers and infants. Each of the past several years over one hundred infants and or mothers were referred to out-of-state NICUs because a bed could not be found in West Virginia.

If we want to improve the health and well-being of our children we must begin long before birth. Better health for our children will be the result of better health for pregnant women and infants. About 21,000 babies are born in West Virginia each year. This is a relatively small number - a workable number.

West Virginia women under the age of twenty years have the worse pregnancy outcomes and newborn outcomes of any age group of women except for women over forty years of age. It appears that most of the poor outcomes among women under twenty could be prevented by behavioral changes of the pregnant woman. These behavioral factors need to be influenced with appropriate educational information for both males and females, prior to the woman ever becoming pregnant.

Recent studies have also determined that drug use during pregnancy is a significant issue that needs addressed. During the summer of 2009 the Perinatal Partnership initiated a study to determine the magnitude of drug use during pregnancy in West Virginia. The study involved testing the umbilical cords of babies born in eight different hospitals located throughout the state. The study revealed that one in five babies born had been exposed to alcohol, controlled and illicit substances while *in utero*.

If West Virginia could achieve improvements fewer babies would be lost and more dollars would be saved. The State of West Virginia has a vested interest in improving perinatal health. We would see a large financial impact because PEIA, Maternal, Child and Family Health, and Medicaid provide coverage for over 56% of the pregnant women and newborn infants in our state. The State also supports three medical schools and numerous medical residency programs, and therefore can impact the quality and the cost of that care.

In recognition of this, the West Virginia Perinatal Partnership, a partnership of more than 30 health care providers, educators, business organizations and non-profits including the WVSMA, began working together in 2006 to study and identify the causes of poor birth outcomes and ways to improve them. Key policy solutions were identified through a research and survey process that was published in a document called "*The Blueprint to Improve West Virginia's Perinatal Health.*"

The Legislature, over the past few years, has addressed some of these important perinatal policy issues identified including the passage of SB 234 establishing a Maternal Mortality Review Team under the Office of the State Medical Examiner which is enabling a process to identify and study the causes of maternal deaths; funding lactation consultant training through the WIC program to help support mothers in the breastfeeding of their babies; and the passage of SB 307 creation of a uniform maternal risk screening tool to simplify and standardize the process for flagging high-risk pregnancies.

The WVSMA, along with the WV Perinatal Partnership, supports the following recommendations to further the efforts on improving perinatal wellness:

- Continue funding the breastfeeding training program established in 2007 so to increase the number of West Virginia physicians, hospital nurses, and lactation consultants who can improve breastfeeding success among women and their infants. The legislative funding has allowed for over 130 professionals to receive extensive training and certification that has allowed them to help mothers succeed with breastfeeding.

- As determined by the Advantia study presented to the Legislature in the 2009 interim, in counties with the most favorable outcomes, the teachers believed their health curriculum's emphasis on "perinatal aspects" contributed to favorable outcome measures, therefore all West Virginia teachers credentialed in Health Education and Family and Consumer Science Education should receive professional development based on the most recent scientific research specific to planning for a healthy pregnancy and baby; increase the availability and accessibility of school-based health center services and community health center services for school-aged children throughout the state; and conduct further research to determine the access to adequate perinatal health, life skills and wellness education within the schools of the counties identified in the study as having the poorest maternal and newborn outcomes.

- Work to assure adequate funding is directed toward smoking cessation and education programs to help reduce the incidence of smoking during pregnancy and smoking in the homes of children. West Virginia has the highest rate of women smoking during pregnancy, which contributes significantly to low birth weight, poor maternal health, and other early childhood problems.

WEST VIRGINIA State Medical Association

- Allocate more resources to support programs that aid in the identification of and provide treatment for substance abuse during pregnancy and provide funding for additional research to further study the magnitude of the problem and identify risk factors and populations at greatest risk of substance abuse.

By working together, we can make sure that the 21,000 babies born each year in West Virginia and their mothers have the best healthcare possible to assure a healthy beginning.

West Virginia State Medical Association

Combating Poor Oral Health

POSITION: ***The WVSMA supports efforts to make policy changes which foster improved oral health for West Virginia's children and families.***

ISSUE: West Virginia is a leader nationwide in the percentage of our citizens with tooth loss and decay. By the time of high school graduation, over 80 percent of West Virginia youth have had dental decay; over 60 percent have had dental decay by age 8 and over 30 percent of West Virginia children suffer from untreated decay. Over 45 percent of West Virginia adults, aged 65 and older, have lost *all* their natural teeth.

Dental disease is the single most prevalent chronic childhood disease and correlates directly to other health concerns. With today's tools and technologies, oral disease is almost 100% preventable. Prevention is cost effective, with the potential to save millions of dollars.

Poor oral health has a direct correlation to poor overall health and left untreated it can contribute to a lifetime of poor health including diabetes and heart disease which are serious and growing problems in West Virginia.

Here are a few facts:

- Bad gums could be as strong a risk factor for heart attacks as smoking cigarettes.
- A new study of fatty deposits lodged in the carotid arteries of stroke sufferers shows that 70% contain bacteria and 40% of the bacteria comes from the mouth.
- Men with periodontal disease have a stronger propensity for cardio-vascular disease and diabetics with gum disease are three times more likely to have heart attacks than those without gum disease.
- Women with gum disease are seven to eight times more likely to give birth prematurely to low birth-weight babies.
- Bacteria in plaque are linked to lung infections in people with chronic lung diseases such as chronic obstructive pulmonary disease.

Poor oral health in children affects their quality of life and school performance. Untreated oral disease in adults affects employability and the ability to eat, sleep and function. Sugary soft drinks are one of the leading causes of tooth decay in children and adults.

The WVSMA supports the following recommendations to address poor oral health:

- Establish the Office of Oral Health within the Bureau for Public Health
- Encourage school aged children to have dental exams at appropriate intervals.
- Prohibit sale of sugary snacks and beverages in schools.

Ensuring good oral health is a blend of community responsibility and personal action. Much more needs to be done for oral health education in West Virginia. To promote the health of West Virginians, save health care dollars, improve learning and worker productivity, West Virginia should pursue policies that will address and improve oral health. The WVSMA supports efforts to make policy changes that foster improved oral health for West Virginia's children and families.

WEST VIRGINIA State Medical Association

Encouraging Routine Voluntary Screening for HIV

POSITION: ***The WVSMA recommends the West Virginia HIV testing laws be updated and modified to require simple consent for routine voluntary HIV testing.***

ISSUE: Human immunodeficiency virus (HIV) testing is entering a new era in this country as lawmakers, health care and insurance executives, and public health officials are making changes in their respective fields to ensure that more people will know their HIV status. Knowing their status is an important consideration for maintaining health and reducing the spread of the virus.

HIV infection and acquired immunodeficiency syndrome (AIDS) remain leading causes of illness and death in the United States. In its most recent report, the CDC estimates that over 1 million Americans are living with HIV and at least one quarter do not know they are infected with HIV.

Why is Testing Important?

People who are infected with HIV, but not aware of it are not able to take advantage of the therapies that can keep them healthy and extend their lives, nor do they have the knowledge to protect their sex or drug-use partners from becoming infected. Knowing whether one is positive or negative for HIV confers great benefits in healthy decision making.

Cohort studies have demonstrated that many infected persons decrease behaviors that help transmit infection to sex or needle-sharing partners once they are aware of their positive HIV status. HIV-infected persons who are unaware of their infection do not reduce risk behaviors. Because medical treatment that lowers HIV viral load might also reduce risk for transmission to others, early referral to medical care could prevent HIV transmission in communities while reducing a person's risk for HIV-related illness and death.

Of particular importance is the early detection of HIV infected pregnant women, since treatments are available to greatly reduce the risk of transmission of the disease to the infant.

CDC Recommends Routine Voluntary Testing

In 2006, the CDC revised their recommendations for HIV testing of adults, adolescents and pregnant women in healthcare settings. The objectives of these recommendations are to increase HIV screening of patients, by urging routine voluntary screening of all persons in the healthcare setting; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce transmission of HIV from pregnant women to their babies.

West Virginia's law, enacted early in the epidemic, required informed or written consent before a test could be conducted; this was supported at the time by physicians and other healthcare providers because there were concerns for confidentiality and there were no available treatments for the disease.

Now there are strong HIPAA protections and there are excellent antiretroviral drugs which can prolong a person's life expectancy and quality of life for many years. Our law inadvertently places barriers to routine voluntary testing and is unwieldy and out of realm in today's treatment of this chronic infectious disease.

- HIV screening is an integral part of a comprehensive wellness and prevention strategy. A person's awareness of his or her HIV status leads to earlier treatment, better survival rates, and preventing transmission. In a 2005 meta analysis of sexual behaviors, persons who knew their HIV status were 68% less likely to engage in unprotected intercourse with uninfected partners.

- According to the CDC, "HIV infection is consistent with all generally accepted criteria that justify routine screening:
  1) HIV infection is a serious health disorder that can be diagnosed before symptoms develop;
  2) HIV can be detected by reliable, inexpensive, and noninvasive screening tests;
  3) Infected patients have years of life to gain if treatment is initiated early, before symptoms develop; and
  4) The costs of screening are reasonable in relation to the anticipated benefits.

HIV screening is on a par with other screenings that can lead to prevention, treatment and survival. Physicians routinely screen for cholesterol, diabetes, and breast cancer and sexually transmitted diseases because intervention saves lives.

This change in West Virginia law will trigger a cultural shift among physicians and other providers and the general population that will ensure that HIV screening becomes truly routine.

Routine screening is NOT "mandatory" testing. A routine test is provided to the patient after the patient is informed that the test will be conducted and the patient chooses not to opt out of (or decline) the test. Routine testing is never done against the patient's will.

The essence of this important law change is to give priority to identifying West Virginians who are unaware of their HIV status and get them into care and treatment and prevention while sustaining the fundamental voluntary nature of HIV screening.

Protecting Patients from Non-physician Practitioner Scope of Practice Expansion

POSITION: ***The WVSMA opposes the scope of practice expansion of non-physician practitioners without the appropriate education, training and supervision. Safety and protection of the patient is of utmost importance.***

ISSUE: Every year, in nearly every state, non-physician practitioners lobby for expansion of scope of practice to gain prescriptive and independent practice rights that were once the sole domain of physicians. The WVSMA recognizes the inevitability of scope of practice overlap. While some scope expansions are appropriate and beneficial to patients, many are unwarranted intrusions into the physician practice of medicine. The health and safety of patients are threatened when non-physician practitioners are permitted to perform services that are not commensurate with their education, training and experience.

Some non-physician health care provider groups have become increasingly aggressive in efforts to expand their scope of practice to include treatments, procedures, and authority inconsistent with their education and training. These providers seek to expand their scopes of practice through legislative, regulatory, and administrative means. Debates over scope of practice issues have serious implications for patient care. If scope of practice expansions are inconsistent with the education and training a provider group receives, or are not coupled with safeguards, such as practice protocol arrangements with a physician who provides oversight of the care provided, the safety and quality of health care delivered to patients is compromised.

Non-physician provider groups also frequently circumvent the legislative process by expanding their scopes of practice via the rulemaking authority of their state regulatory boards. Commonly seen scope of practice expansions include independent prescriptive authority, independent practice, diagnostic and/or surgical authority, and other care privileges for which a non-physician provider may not be educated or trained to safely and effectively provide.

Undoubtedly, there is a place for non-physician practitioners in the delivery of healthcare. With appropriate education, training, and licensing, non-physician practitioners provide extremely beneficial healthcare services. However, problems arise when such non-physician practitioners seek practice expansions which are not commensurate to their education and training, and may adversely affect a patient's health or safety.

Determining whether a specific healthcare profession is capable of providing the proposed care in a safe and effective manner is of paramount interest and should be done in a deliberate manner not under political pressure.

Another factor to consider is as non-physician provider groups seek to expand the care they deliver into the traditional practice of medicine, patients may become

confused as to the credentials of their health care providers. Many non-physician provider groups now advocate a "clinical doctorate" degree as the minimum qualification for entry-level practice, enabling these providers to be called "doctor" in the health care setting. A recent national survey demonstrated confusion among patients as to the qualifications of their health care providers.

The WVSMA recognizes that in some cases modifications of practice acts are merely the formalization of changes already occurring in education and practice within the profession. But, absent those factors, such scope expansions are nothing more than attempts by non-physicians to practice medicine without having successfully completed the rigorous training and licensure requirements required of physicians.

Non-physician practitioners contend that they deliver high quality care, and can efficiently deliver additional care to patient populations that have little or no access to physicians. Physician workforce shortage issues provide a unique opportunity for non-physician practitioners to assert themselves as the "solution" to the access to care dilemma facing this country. As a result, policy-makers tend to perceive these debates to be about "turf," as opposed to patient safety and quality of care.

Scope of practice expansions by non-physician practitioners pose several concerns and considerations:

- What is the historical basis for the profession, especially the evolution of the profession that is advocating a scope of practice change?
- Is public health or safety put at risk by the practice expansions of non-physicians?
- Are scope expansion decisions at the state level based primarily on political pressures rather than good medicine?
- Do current and predicted physician workforce shortages and distribution inequalities mean that non-physician practitioners will *truly* become more prevalent in the routine delivery of health care services in those underserved areas?
- What is the relationship of education and training of practitioners to scope of practice and what is the evidence related to how the new or revised scope of practice will benefit the public?
- What is the capacity of the regulatory agency involved to effectively manage modifications to scope of practice changes?

The West Virginia State Medical Association does support collaborative arrangements with nurse practitioners, physician assistants, pharmacists and radiologist assistants. Through such collaboration, patient access and quality care can be achieved without threatening patient safety. However, protection of the patient is of the utmost importance. Expanding the scope of practice without adequate medical training and appropriate physician supervision is unacceptable.

WEST VIRGINIA State Medical Association

Strengthening the All-Terrain Vehicle Safety Law

POSITION: ***The WVSMA strongly supports strengthening West Virginia's All-Terrain Vehicle safety law.***

ISSUE: Though the Legislature passed All-Terrain Vehicle (ATV) Child Safety law in 2004, much more needs to be done to protect the health and safety of our citizens.

The Good News
In 2004 the West Virginia Legislature passed legislation that requires ATV riders under the age of eighteen (18) to wear helmets. This is significant. The law forbids underage riders from carrying guest passengers. Additionally, the law mandated a training course be established for child ATV users and provided law enforcement with the ability to hold adults responsible, under certain circumstances, for their negligence in empowering underage children to unlawfully operate an ATV.

The Bad News
Instead of implementing safety standards limiting ATV use on roadways, the 2004 legislation effectively legalized ATVs to travel unimpeded on well over 20,000 miles of paved roads with no center lines *even though* the manufacturers, the Consumer Product Safety Commission, the EPA and the Federal Motor Vehicle Safety-US DOT, recognize that these vehicles are *inappropriate and unsafe for highway use*, particularly on paved surfaces.

Even with the passage of the 2004 legislation, the number of ATV deaths continues to dramatically rise. Research by Jim Helmcamp, PhD, MS, Director of WVU Injury Control Research Center, printed in the July- October 2007 issue of the West Virginia Medical Journal revealed the following: In 2005 there was a record number of 39 deaths from ATV accidents. Then in 2006 that record was beat again with 52 people perishing from ATV accidents, including a 2 year-old boy. Data through November, 2007 concludes that 44 deaths occurred.

Though the manufacturers specify age requirements for persons who operate certain sized ATV's, with this new law *children can ignore the age requirement* relative to the size of the machine because the law establishes none. Additionally there is nothing to restrict young ATV riders from using the machines on many highway venues or from their being a guest passenger on those same highways. **Mixing automobiles and ATV's on our state's roads is a deadly combination.**

The legislation enabled adults to carry other adult passengers on an ATV on public paved roads. By allowing this, the West Virginia Legislature has established that an ATV is "roadworthy" although the federal agencies indicate otherwise. There is no helmet requirement for adults who operate their otherwise

non-road worthy vehicles on our State's roads, and an adult can double a child passenger on an ATV, placing them in extraordinary, unnecessary, life threatening danger.

The West Virginia Legislature has taken a step toward ATV safety, but much more needs to be done to improve the state's ATV safety laws.

The WVSMA strongly supports legislation with the following components:

- Removing non road-worthy vehicles from our public roadways.
- Expanding the mandatory helmet law to cover persons of *all* ages.
- Strengthening the requirement for ATV safety instruction to require hands-on safety courses.
- Prohibiting passengers with the exception of machines which manufacturers have designed for passengers.

WEST VIRGINIA State Medical Association

Protecting the Motorcycle Helmet Law

POSITION: ***The WVSMA strongly supports maintaining West Virginia's motorcycle helmet law for motorcycle operators and riders of all ages.***

ISSUE: In recent years, efforts have been made by various groups to repeal our critically important motorcycle helmet law. Such an action by the Legislature would be highly irresponsible. Helmets are the best-evaluated way to reduce motorcycle accident deaths and injuries. Helmets are 29-35 percent effective at preventing motorcycle deaths and substantially more effective against deaths from traumatic brain injury. A study conducted at the University of Southern California, which analyzed 3,600 motorcycle traffic crash reports, concluded that wearing helmets was the single most important factor in surviving motorcycle crashes.

The National Highway Safety Administration (NHTSA) estimates that helmets saved 1,316 motorcyclist's lives nationally in 2004 and that 670 more could have been saved if all motorcyclists had worn helmets. *(Motorcycle Safety Facts, 2004 data)*

Helmets reduce the probability and severity of head injuries, thus they reduce the cost of medical treatment. The NHTSA statistics for average hospital charges per case by Head Injury Status showed that "Head Injuries" cost $27,000 in comparison to "Non Head Injuries" at $12,000. Additionally, their statistics revealed that motorcycle helmet use saved $1.3 billion dollars in 2002 alone. An additional $853 million would have been saved if all motorcyclists had worn helmets.

With less injuries come shorter length of stay in the hospital and a reduction in the necessity for special medical treatments (including ventilation, intubations, and follow-up care). Critically important is that helmets reduce the probability of long-term disability.

The WVSMA strongly supports the retention of our State's current mandated helmet use law for all motorcycle operators and riders of all ages.

WEST VIRGINIA State Medical Association

Addressing Substance Abuse: Balancing Treatment and Prevention

POSITION: ***The WVSMA supports policies that discourage diversion of prescription drugs and that facilitate treatment opportunities for individuals suffering from substance use disorders. Such policies must be balanced with policies that promote the physicians' ability to provide comprehensive and compassionate care, and an individual's ability to access appropriate treatment.***

ISSUE: Substance use disorders are a significant problem in the United States and in West Virginia. Substance use disorders and associated co-morbidities effects more of our citizens than any other health care concern we are faced with today. Experts estimate that prevalence of addiction in the general population is between 10 to 12 percent. The following examples illustrate the significance of this issue nationally and in particular West Virginia:

- In the 10 years (1997-2007) the per capita retail purchases of Methadone, Hydrocodone and Oxycodone in the United States increased 13-fold, 4-fold and 9-fold respectively.
- Nationally, unintentional drug poisoning deaths increased 68% during 1999-2004.
- The drug of choice for adolescences Age 12 – 18 is no longer Marijuana, but prescription drugs from family, friends and others.
- 4.6% of individuals 18 – 25 used pain relievers for non-medical reasons.
- A 2009 report from the WV Perinatal Partnership showed that one in five babies born in the state suffered exposure to drugs or alcohol while *in utero*.
- A 2007 Centers for Disease Control report indicated that the state experienced a 550 percent increase in drug overdose mortality during the years 1999-2004, and the rate has continued to increase in subsequent years. This increase was the largest in the nation.
- According to the U.S. Drug Enforcement Administration, West Virginia leads the nation in methadone-related deaths per capita, and it has the fastest-growing rate of methadone overdoses.

Substance abuse is a complex problem that has societal, public health, and public safety ramifications that cross all socioeconomic and demographic boundaries. In West Virginia it is estimated that substance abuse costs more than $1.8 billion in 2006 and of that $470 million was in direct costs.[1] Recent news reports have highlighted the growing problem with prescription drug diversion. This is an epidemic affecting not only adults but our children and teens.

Although the WVSMA recognizes the importance of policies that prevent substance abuse and prescription drug diversion through law enforcement mechanisms, we also recognize that physicians have a responsibility to provide appropriate treatment to patients, and policies should not interfere with their ability to practice good medicine. The American Medical Association reports that

[1] WV Partnership to promote Community Well-Being report "Governor's Comprehensive Strategic Plan to Address Substance Abuse in WV"

there is some evidence to suggest that prescription drug monitoring programs, like the controlled substances database currently administered by the WV Board of Pharmacy, reduce the amount of opioid prescriptions for pain management. Physicians and other prescribers of controlled substances must adequately balance treating pain against overprescribing. Under-treatment of pain is not only detrimental to patients but can result in civil liability and professional sanctions.

Policies should not focus on requiring physicians to be watch dogs for potential drug abusers because this could deter patients from seeking help or treatment. This is particularly critical for pregnant patients who may delay seeking prenatal care and ultimately cause more detrimental effect on the baby as result of the concern of being reported by their treating physician. Confidentiality rules should be respected because they facilitate the trusting patient-doctor relationship that is essential to effective diagnosis and treatment.

To foster a balanced approach, in 2001 the AMA, together with 21 other health organizations and the DEA, noted in a joint statement of accountability that "both healthcare professionals, and law enforcement and regulatory personnel, share responsibility for ensuring that prescription pain medications are available to the patients who need them and for preventing these drugs from becoming a source of harm or abuse," and that "preventing drug abuse is an important societal goal, but there is consensus, by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve."

West Virginia, like most other states in the nation, mandates the maintenance of a controlled substances database by the Board of Pharmacy. The goal of the program is to reduce the improper use, or diversion, of controlled substances by providing information to those individuals treating or investigating a specific person with a potential problem. The law was written tightly in regard to those who have access to the information in the database to ensure citizens' constitutional rights to privacy are protected. Since its creation in 2002 many groups have sought access to the database for different purposes. It is the strong position of the WVSMA that database access must continue to be tightly limited. One exception is that of the Medical Examiner's Office which does not have clear direct access to the information.

The WVSMA supports the following recommendations to begin to address prescription drug diversion and substance use disorders in West Virginia:

- Appropriately fund and encourage development of treatment, education, prevention and intervention programs in the state. The Governor's Comprehensive Strategic plan to Address Substance Abuse in WV estimates an investment equal to 5 percent of the direct costs of substance abuse be allocated the fund programs and projects, infrastructure, assessment research and evaluation this equates to $23.5 million annually.
- Encourage the use of the Board of Pharmacy's controlled substances database by prescribers and dispensers of medication and encourage better coordination among them to foster better care and treatment of patients

through educational programs coordinated by the Boards of Pharmacy, Medicine and the WVSMA.

- Modify the law to allow better access to the controlled substances database by the Medical Examiner's Office to help facilitate investigations into deaths performed by this office.
- Add the drug Ultram (Tramadol) to the list of Schedule IV controlled substances.
- Encourage the expansion of education on prescription drug abuse and substance use disorders in the curriculum of the schools of medicine, nursing, pharmacy and dentistry.
- Encourage the education on prescription drug abuse and substance use disorders into the already existing mainstream medicine, leading to further education of the patients they serve.

Addressing addiction, prescription drug diversion and substance use disorders in general takes a multifaceted, multidisciplinary approach. The issues surrounding these problems are complex and not solely attributable to any one factor. In order to make a real impact, policies and approaches must be broadly encompassing, comprehensive and persistent over time