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Q&A: Health Reform in Illinois

A Q&A with Carl Bergetz, Chief Legal Officer, Rush University System for Health

PART I

Why Is Illinois Behind in Telehealth Accessibility?

As the state of Illinois reviews the COVID-19 emergency executive orders and waivers used to facilitate a better public health response to the pandemic, Carl Bergetz, general counsel for Rush University System for Health, and an Adjunct Professor at University of Illinois College of Law, says many temporary reforms should be made permanent because our laws and regulations are outdated and out-of-step with the rest of the nation.

Q: In advocating for substantial reforms of health law and policy in Illinois, you say the state is out-of-step with the rest of the nation. How so?

A: In a variety of areas – such as telehealth and medical-malpractice law and policy – Illinois is in a minority of states that make it difficult for hospitals, doctors, and nurses to provide healthcare services in an affordable and accessible way –whether in time of normalcy or emergency.

Take telehealth for instance. Despite the fact that technology is increasingly making remote healthcare easier, as effective, and at times preferable to in-person doctor visits, Illinois's laws and regulations regarding telehealth are far out of step with the rest of the nation. Illinois is one of only a handful of states that do not mandate insurers to cover or pay for telehealth visits – known as service parity.

With the structural changes, mergers, and closures in the post-COVID hospital sector, access will become increasingly critical. Moreover, patients like it. Surveys have shown that patients would rather conduct their provider visits remotely when they can – such as for many primary care visits and for initial examination purposes. Undoubtedly, telehealth is a huge part of the future of medicine. By not having uniform coverage requirements for such services, Illinois is actually disincentivizing this forward-looking practice.

Q: What does Illinois need to do to expand accessibility to telehealth?

A: The key change is that the state insurance laws need to require both service parity and payment parity for telehealth. Service parity would at a minimum establish a uniform recognition of telehealth. But payment parity is really what is required to make telehealth viable. In Illinois, Medicaid provides limited telehealth coverage, but the insurance laws do not require private insurers to cover telehealth services at all; they are only required to meet certain minimal

requirements should they choose to provide such coverage. And they certainly aren't required to reimburse at the same or similar rates.

To make this happen in Illinois, we would need to amend the insurance code to require private carriers to reimburse treating providers for services delivered through telehealth on the same basis and at the same rates as that carrier would reimburse for the same services provided during an in-person consultation. In addition, we would want to define telehealth more broadly to allow for as many types of services as possible to be covered.

A number of other state laws would need to be modified to make telehealth more viable in Illinois – privacy law requirements would need to be modified to allow for different media for telehealth visits, and laws regarding online prescribing and other pertinent rules could be liberalized.

Q: Who stands in the way of parity laws?

A: The principal obstacle for this appears to come from private payer interests and representatives. During the special session of the General Assembly this past spring, state legislators rightly sought to codify Governor Pritzker's Executive Order mandating telehealth service parity from private carriers. This failed.

During a session at the height of the first wave of the COVID pandemic, take-out cocktail legislation passed, but the telehealth bill didn't. Luckily, the Governor's executive order is still in effect, and, in fairness, many payers agreed to service parity for a temporary period of time. However, while telehealth is critically important during a pandemic, telehealth is needed for more than just the duration of a public health emergency.

PART II

How Illinois Medical Malpractice Can Be Reformed

In the second of three Q&As on health care reform, Carl Bergetz, general counsel for Rush University System for Health and an Adjunct Professor at University of Illinois College of Law, talks about how medical malpractice law in Illinois hurts hospital finances and can sometimes hobble care.

Q: How is Illinois medical malpractice law an outlier among the laws in the nation?

A: Illinois is in the minority of states that have no limitations on non-economic jury awards in medical-malpractice cases and that have joint and several liability rules where one defendant may be responsible for the entire verdict amount, regardless of another defendants' situation. To gauge how far of an outlier Illinois' damage cap policy is, historically progressive states like Massachusetts and California implemented caps years ago and, more significantly, states neighboring Illinois – Michigan, Wisconsin, Indiana – also use caps, creating a greater risk that doctors will flee Illinois.

Without rational limits on awards, the verdicts are unfettered from reality and result in less affordable and accessible health care. In the past few years, studies have consistently shown that Illinois and Cook County are the least fair and least efficient jurisdictions in America and account for a disproportionate percentage of the highest jury verdicts and settlements na-

tionwide.

Based on reported cases, average medical-malpractice jury verdicts across Illinois have steadily increased, and in Cook County verdicts have more than doubled from around $4.6M per case during 2014-2017 to nearly $10M per case during 2017-2020. These are just averages – the threat of much larger, catastrophic verdicts is omnipresent in Illinois.

Q: What harm is done to the health care system when malpractice verdicts come in so high?

A: This medcal-malpractice crisis negatively impacts individual health care and the public health. Simply put, every dollar that goes to plaintiffs and their lawyers is a dollar that cannot support current patient care needs.

It may not be common knowledge, but the vast majority of Illinois hospitals self-insure for all these cases. That means when you read about a multi-million-dollar jury award or settlement, the money isn't coming from some distant and well-financed insurance company, but from the budget of a local hospital. Those huge

payouts divert funds from patient care, over time reducing access and increasing costs. Unfortunately, as we have seen with several hospitals in the Chicagoland area, this has resulted in the closing of units and withdrawal of service lines.

Q: But without medical malpractice claims, how can health care professionals be held accountable?

A: Claims for medical negligence do serve a purpose, and rational people wouldn't argue either against the right to such claims or for immunity in all cases. Medical negligence, as a legal principle, can help hold doctors and institutions accountable and can provide a remedy for those who may have been injured.

However, the medical-malpractice crisis in Illinois goes in the other direction, having a chilling effect on providers and their practice, imposing the threat of financial harm that could restrict access and availability of health care, pressuring providers out of the jurisdiction, and allowing for awards that are untethered from common sense. What is needed is not the elimination of the right of action, but reforms to the process that will make the system more reasonable and sustainable for providers while still providing an avenue for individuals to seek relief in meritorious cases.

Like most states in America, reforms would include placing monetary limitations on noneconomic damages, changing joint and several liability laws, and requiring the health care professional report that supports the filing of a medical negligence case to be signed versus anonymous. The fact that Illinois doesn't have these common-sense measures when most states do put us at a disadvantage, as Illinoisans face higher costs and less access because of this out-of-control system.

PART III

How Illinois Can Rationalize Its Regulatory Requirements

In the third and final Q&A on health care reform, Carl Bergetz, general counsel for Rush University System for Health and an Adjunct Professor at University of Illinois College of Law, talks about what he sees as the most onerous regulations in the state and how Illinois is positioned to be a national leader in data sharing.

Q: What regulatory requirements in Illinois, in particular, are most onerous to the health care system?

A: Overall, the hospital sector is likely the most heavily-regulated industry in the state. Multiple layers of regulatory authorities, each with their own investigatory and enforcement arms, oversee hospitals and can overlap in their review: state, county, and city departments of public health; various private accreditation entities that review many of the same standards; and federal and state payer agencies.

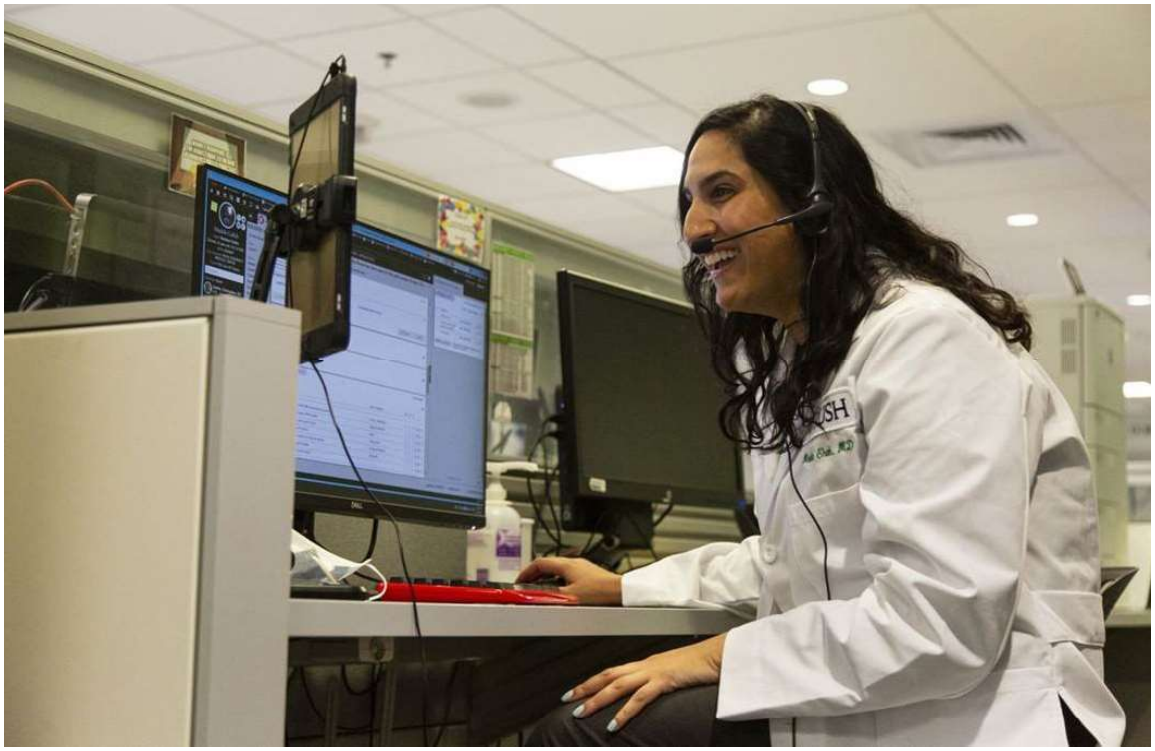
Some of the rules they police are arcane and outdated, making a host of actions that are commonplace in other industries illegal for health care providers and subjecting them to millions of dollars in penalties and fines.

For instance, the Illinois Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") have some fairly inflexible reporting and investigatory obligations. The HFSRB reporting and notification requirements require hospitals to obtain prior

authorization from the State in order to increase hospital bed capacity and/or re-allocate beds among clinical designations. While the State has an interest in knowing the number and allocation of beds within each hospital, reporting thresholds should be relaxed to accommodate the need for flexibility. Providers and hospitals are in the best place to make these decisions and have a need for agility in order to respond to circumstances within their control. The Governor recognized this need during the pandemic through an emergency order; however, we need more permanent, structural change.

Diagnosing our regulatory system as a critical problem isn't simply a matter of ideological perspective. The impact of too much regulation in health care translates into decreased affordability and access for patients and makes hospitals less agile and able to adjust and evolve, particularly in times of emergency. Doctors and nurses are pulled into regulatory investigations and accreditation reviews and out of their normal work.

The regulatory burden also places a strain on state resources and personnel, which in turn costs Illinoisans even more.



From every vantage point, the oversupply of health care regulations and oversight that has grown by accretion over the years is placing an unnecessary strain on the state, its hospitals and providers, and its people.

Q: How can data sharing be an opportunity for Illinois?

A: Unlike telehealth, medical-malpractice, and regulatory oversight where Illinois finds itself an outlier and out-of-step, data-sharing is an area where the state of Illinois is actually positioned to leap ahead of other states.

Presently, data gathering and collation in Illinois exists but is fairly static.

The data that is gathered is more historical and, thus, of limited use for practical analysis. Given the capabilities of our healthcare and academic institutions and the technology sector invcIllinois, that static situation could change quickly.

During the Covid-19 pandemic, IDPH, the Illinois Emergency Management Authority ("IEMA"), and the Chicago Department of Public Health ("CDPH") worked together with private hospitals and providers to build alternate care facilities that used electronic medical records and had robust data analytics abilities. In addition, CDPH issued medical data-sharing requirements to monitor and analyze medical and transmission information that could be analyzed to help coordinate and allocate resources, like available ICU beds and ventilators, more effectively and egciently for COVID patients.

Existing public health efforts to collect data should become more transparent and accessible to all stakeholders, even after the pandemic. The state, hospitals, and other stakeholders should coordinate on interoperability related to patient outcomes, readmission rates, social detriments of health, and increased access to patient's medical records.

Data sharing could be leveraged to allow stakeholders to implement higher quality care and operationalize better distribution of clinical resources dependent on a patient's level of acuity. De-identified data can also be analyzed to identify trends and detect possible disease outbreaks. Like all the proposals I have noted during this interview series, such data-sharing would not require much in the way of public resource expenditures if the state allowed our hospitals and technology sectors to help build that capability.

In that way, Illinois could move to the cutting edge of health policy, instead of finding itself behind the times.