

Legislative Report

June 2007

With the regular and special legislative sessions having just ended, the dust has still not settled from the chaos of the closing days of the 2007 legislative session. Issues such as universal health care, scope of practice, managed care contracting and much more made this a very busy session for medicine.

One of the most popular issues at the Capitol this year was universal health care and no less than a dozen proposals were introduced on the issue. One bill got particular attention because one of its provisions called for a 3% tax on physician revenue. As expected, medicine opposed this provision and physicians came out in full force at the public hearing to make our voice heard. Physicians persuasively argued that “taxing doctors for doing our work makes no more sense than taxing teachers to fund public education, taxing firemen for fighting fires, or taxing policemen or lawyers or pharmacists or anyone else for what they do.”

Due to the active and outspoken criticism of the 3% tax, it was removed from the bill before being voted on by the Insurance and Real Estate Committee. A similar tax that was labeled the “vanity tax” and called for a tax on all cosmetic procedures remained in the bill, but medicine was able to have it amended out of the bill when the bill reached the Finance Committee. In addition, medicine’s active lobbying also led to the removal of two other provisions that would have negatively impacted medicine. The first would have required that all health care providers accept and provide services to HUSKY A and B recipients as well a Medicaid-Fee-for-Service patients. The second potentially harmful provision would have capped physicians from charging more than 200% of Medicare for any service.

In the end, the legislature failed to pass any Universal Health Care, but this is an issue that is sure to return next year. In addition to universal health care, several other issues also kept medicine busy this session. Listed below is a brief report of those issues.

APRN Independent Practice Bill – Died when the APRNs could not make their case that independent practice was needed because physicians were refusing to collaborate with APRNs. This issue will probably resurface again next year.

Physician Assistant Supervision - A bill that eases the requirements of physicians supervising physician assistants was passed. The bill eliminates (1) the requirement that licensed physicians who supervise physician assistants (PAs) register with the Department of Public Health (DPH) and (2) their \$37.50 registration fee. The bill also states that each PA practicing in the state or participating in a resident PA program must continue to have a clearly identified supervising physician who has the final responsibility for the care of patients and the PAs performance. It also eliminates a requirement that a supervising physician notify DPH in writing within 30 days of terminating a physician-PA relationship.

The bill also specifies that licensed PAs who are part of the Connecticut Disaster Medical Assistance Team, the Medical Reserve Corps, or the Connecticut Urban Search and Rescue Team provide patient services under the supervision, control, responsibility, and direction of a licensed physician.

Mandatory Eye Exams – A bill that was put forth by the optometrists that would have mandated that all children have a full eye exam performed by an optometrist or ophthalmologist before entering public school died in committee.

Healthcare Professional Assistance Program – A bill that allows state or local health care professional societies and organizations to establish a single assistance program to serve all health care professionals passed. The assistance program must have one or more medical review committees. A “medical review committee” is a committee that reviews and monitors participation by health care professionals in the assistance program. The program must provide a variety of educational, rehabilitative, and supportive services to health care professionals with a chemical dependency, emotional or behavioral disorder, or physical or mental illness. It must include mandatory, periodic evaluations of each participant's ability to practice with skill and safety and without posing a threat to the health and safety of any person or patient in the health care setting.

Tolling of the Statute of Limitations – A bill that would have allowed 18-year-olds with childhood injuries caused by another person's negligence to file suit in their own name for money damages when the state's statute of limitations would otherwise bar this died.

EMR - A bill that would have required all hospitals and physicians to use EMR died in the Insurance and Real Estate Committee.

Insurance Related Bills – Bills that would have provided for better disclosure in contracting terms, reimbursement, etc. and would attempt to make collective negotiations with MCOs a possibility died.

Emergency Contraceptives – All hospitals in Connecticut will be required to provide rape victims with emergency contraception, even Catholic Hospitals. The controversial bill was passed by an overwhelming majority and signed into law by the Governor. The drug, which has become known as Plan B, is administered within 72 hours after sex to prevent pregnancy.

Palliative Marijuana - A bill allowing a physician to certify an adult patient's use of marijuana after determining that the patient has a debilitating condition and could potentially benefit from the palliative use of marijuana was vetoed by the Governor. The bill which has been worked on for the past two to three years by several legislators would have established a procedure for certifying patients and allows people suffering from these conditions and their primary caregivers to possess a quantity of marijuana that the bill sets to treat the conditions. The bill also would have required patients and their primary caregivers to register with the Department of Consumer Protection (DCP) and authorized the department to impose a \$25 registration fee. The fees would have been deposited in a separate, non-lapsing Palliative Marijuana Administration Account.

Licensure Fees - A bill that allows a physician who (1) practices for no fee for at least 100 hours a year at a public health facility and (2) does not otherwise practice medicine, to renew a license without charge was signed by the Governor and goes into effect October 1, 2007. Current law defines a “public health facility” as a hospital, community health center, group home, school, preschool operated by a local board of education or a Head Start program, rest home, health care facility for the handicapped, nursing home, residential care home, mental health facility, home

health care agency, homemaker-home health aide agency, substance-abuse treatment facility, infirmary operated by an educational institution, and an intermediate-care facility for the mentally retarded.

Medical Necessity - Signed into law is a bill that prohibits insurers, HMOs, and other entities from issuing individual and group health insurance policies that do not contain a statutory definition of “medically necessary” or “medical necessity.” The bill limits the medical necessity definition requirements to health insurance policies covering (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accidents only, (5) limited benefits, and (6) hospital or medical services, including those issued by HMOs. For those insurers and HMOs that have entered into a federal court-approved class action settlement with physicians, which includes abiding by a similar definition of “medical necessity,” the bill’s prohibition does not apply until the settlement’s expiration date.

The bill also extends timeframes for appealing to the insurance commissioner (i.e., external appeal) after a person has exhausted a managed care organization’s (MCO), health insurer’s, or utilization review company’s internal grievance procedures. Under current law, after receiving a final written claim denial based on a lack of medical necessity or determination not to certify an admission, service, procedure, or extension of hospital stay, a person, or a medical provider acting with consent on his or her behalf, has 30 days to file an appeal with the commissioner. The bill extends this time period to 60 days. It also makes a conforming change.

Lead Screening

A bill was passed in the special session that requires primary care providers (e. g., physicians and advanced practice registered nurses) other than hospital emergency departments, to screen annually for lead every child between nine and 35 months old. The screening must be done according to the recommendations of the Childhood Lead Poisoning Prevention Screening Advisory committee. These recommendations call for blood lead screening (capillary) tests at age 12 months and 24 months with follow-up venous blood tests if the initial screening shows an elevated blood lead level.

These providers must also screen (1) all children between 36 and 72 months old who have never been screened and (2) any child under 72 months if the provider determines screening is clinically indicated under the Lead Screening Advisory Committee’s recommendations, which call for screening children who exhibit developmental delays. The committee also recommends blood lead testing of any children who have unexplained seizures, neurologic symptoms, hyperactivity, behavior disorders, growth failure, abdominal pain or other symptoms consistent with elevated lead levels or a recent history of ingesting foreign objects.

The bill also requires primary care providers also to conduct annual lead risk assessments for children ages three up to six. Providers can assess younger children if they determine it is needed. Assessments must be conducted according to the Lead Screening Advisory Committee’s recommendations. These recommendations call for questioning parents or guardians about the child’s housing (age and location) and family history of elevated blood lead levels. The bill exempts children whose parents object to blood tests on religious grounds from these screening requirements.

By law, health care institutions and clinical laboratories must notify the DPH commissioner and appropriate local health official within 48 hours of receiving or completing a report on a person

with a lead level of 10 or more $\hat{\text{A}}\mu\text{g/dL}$ of blood or other abnormal bodily lead level. The bill requires them also to report the results within 48 hours to the health care provider who ordered the test. It requires this health care provider to make reasonable efforts to notify parents or guardians of the test result for a child under age three. The provider must do this within 72 hours of learning the test results.

The bill requires individual and group health insurance policies to cover the bill's lead screening and risk assessments mandates. The requirement applies to Connecticut policies delivered, issued for delivery, amended, renewed, or continued on or after January 1, 2009.

Budget

Preliminary budget reports indicate, that of the \$470 million new dollars allocated to increase access to health care, \$27 million will be allocated for a 50% increase to physician Medicaid reimbursement rates in both the first and second year of the budget and \$10 million will be used to increase rates in the Medicaid HMO system.