

CMGMA Legislative Report July 12, 2011

The 2011 legislative session ended and despite being dominated by the state's economic woes and Governor Malloy's ongoing negotiations with the unions, several pieces of health care legislation were acted on. Following is a brief report of those issues. If you have any questions about any issue in this report or if there is another issue that you would like more information on, please contact the CMGMA office at 860-243-3977.

Medical Liability

Medicine continued its advocacy long after the regular session ended, lobbying the Governor to veto Public Act 11-77 – An Act Concerning Offers of Compromise. Unfortunately, the Governor signed the act into law.

Currently an offer to compromise is a written pretrial offer by the plaintiff to settle a civil lawsuit for a specific amount of money. If the defendant rejects the offer and the plaintiff's recovery is equal to or above it, the defendant must pay 8% interest on the judgment plus court-assigned attorney's fees of up to \$ 350. In some circumstances the interest is applied retroactive to the date the complaint was filed. (Bill Summary Public Act 11-77). In medical malpractice actions, the bill changes the timing and eliminates plaintiff's obligation to provide the defendant with information before filing the offer. Currently, at least 60 days prior to filing an offer to compromise, the plaintiff must (1) state with specificity the damages on which the lawsuit is based, (2) provide a release for medical records, and (3) disclose all experts who will testify concerning the prevailing professional standard of care. The plaintiff must file a certification with the court indicating it has provided defendant with all documentations supporting the damages claim. (Id.)

Changes made in the act put physicians in the position of making difficult decisions on how to proceed in medical liability cases without critical information.

Fortunately another medical malpractice related bill that would have loosened requirements for certificates of merit died during the session. The bill would have expanded the types of health care providers who may provide a prelitigation opinion letter concerning evidence of medical negligence in a medical malpractice lawsuit or apportionment complaint. It would have also eliminated the requirement that the opinion letter include a detailed basis for the formation of the opinion, instead requiring that it state one or more specific breaches of the prevailing professional standard of care.

Cosmetic Tax

On May 4, 2011, Governor Malloy signed Connecticut's biennial budget bill, Public Act 11-6, into law. The Act contains numerous tax changes including a new tax on cosmetic medical procedures. Effective July 1, 2011, cosmetic medical procedures, excluding reconstructive surgery, will be taxed at 6.35%. Medicine fought against this tax arguing that the bill did not specify how the tax would be collected and that collecting the tax would likely cause violations of patient confidentiality. In addition, medicine argued that the bill would result in patients seeking cosmetic services outside of Connecticut. Joining medicine in its objection to the bill was Department of Revenue Services Commissioner Kevin Sullivan who contacted the Governor directly. However, in this year's tough economic climate, the tax was ultimately passed and physician offices performing cosmetic medical procedures should prepare to begin collecting the tax.

Certificate of Need (CON)

Public Act 11-183 – An Act Requiring Certificate of Need Approval for the Termination of Inpatient and Outpatient Services by a Hospital requires any hospital seeking to terminate current inpatient or outpatient services to file a certificate of need (CON) application with the Office of Health Care Access (OHCA) division of the Department of Public Health (DPH). The act awaits the Governor’s signature. The bill also requires, under certain conditions, a CON for termination of surgical services by an outpatient surgical facility or a facility providing such services as part of the outpatient surgery department of a short-term acute care general hospital. Generally, the law requires CON authorization when a health care facility proposes: (1) establishing new facilities or services, (2) changing ownership, (3) purchasing or acquiring certain equipment, or (4) terminating certain services.

In addition, PA 11-242 – An Act Concerning Various Revisions to Public Health Statutes requires hospitals and institutions operated by the state to get a CON before terminating inpatient or outpatient services eligible for reimbursement under Medicare or Medicaid. The act also (1) adds podiatrists owning and controlling an outpatient surgical facility to an existing CON exemption concerning transfer or change of ownership and (2) makes changes concerning CON filing and notice procedures. The act currently awaits the Governor’s signature.

Lastly, Public Act 11-10 – An Act Concerning Exemptions from the Certificate of Need Process for Researchers Utilizing Certain Technologies that have no Impact on Human Health was signed into law by the Governor. The act exempts from CON review the acquisition of any equipment by a person used exclusively for scientific research on non-humans.

Reporting Requirements

A bill that would have expanded hospital data reporting requirements and applied them to outpatient surgical facilities died when it was not passed by the Senate. Current law requires acute care and children's hospitals to submit to the Office of Health Care Access (OHCA-a division of the Department of Public Health) discharge data and any other data it requests to fulfill its responsibilities. The bill would have required hospitals and outpatient surgical facilities to also submit inpatient and outpatient data.

SustiNet

A bill implementing the SustiNet plan was introduced and in its original form would have authorized Connecticut to create large pools of health care users, such as state workers and people covered by Medicaid and HUSKY programs, to leverage savings on care. In addition each patient’s care would be centralized and coordinated under one physician. Before approving the bill, the Public Health Committee deleted a provision that would have protected physicians, providing care under SustiNet, from malpractice lawsuits as long as they followed SustiNet procedures. It was argued that this provision would set up a double standard for medical malpractice suits –one for SustiNet and another for everyone else. Medicine considered the inclusion of the malpractice provision to be critical and therefore was unable to continue to support the bill.

In the last few weeks of the session, the Malloy administration and Democratic leaders struck a deal to move the SustiNet bill forward, however the bill had been watered down to allow municipalities and a small group of not-for-profit organizations to buy into the state employee’s health plan, but leaves out private sector employees. In addition, Medicaid, the state employee’s health plan and the retiree health plan will not be merged into a large purchasing pool.

Ultimately, the bill died in the final days of the session b/c it got mixed up w the union negotiations & state employees impression that they would get Sustinet.

Rate Approval

Public Act 11-170 – An Act Concerning the Rate Approval Process for Certain Health Care Insurance Policies was vetoed by the Governor. The act, which was supported by medicine, would have established a new rate approval process with more transparency, however it was vetoed by the Governor. In his veto message the Governor stated that such a process is unnecessary under PPACA and the ensuing HHS regulations.

Most Favored Nation Clauses

MCO contracts often contain provisions that are incredibly unfair to patients and physicians. One such provision is a most favored nation clause. Such clauses require providers to allow health care plans to match any lower reimbursement rate from another insurer. The plan does not have to beat the lower reimbursement, just match it. Such clauses discourage a competitive market and are unfair. Public Act 11-132 – An Act Concerning Most Favored Nation Clauses in Health Care Provider Contracts, which was signed into law by the Governor, remedies this by prohibiting MCOs from including a most favored nation clause in its contracts.

Scope of Practice Determinations

Public Act 11-209 – An Act Concerning the Department of Public Health’s Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions awaits the Governor’s signature. This act establishes a formal process for the submission and review of requests from health care professions seeking to revise their existing scope of practice or to establish a new scope of practice. Under the bill, scope of practice review committees will review and evaluate scope of practice requests and provide written assessments to the Public Health Committee, including any legislative recommendations.

APRNs as Primary Care Providers

Public Act 11-199 – An Act Concerning the Listing of Advanced Practice Registered Nurses in Managed Care Organization Provider Listings, and Primary Care Provider Designations currently awaits the Governor’s signature. Medicine advocated against this bill as it requires a MCO’s annual list of participating providers to include, under a separate category or heading, participating advanced practice registered nurses (APRNs). In addition, the act will allow an enrollee of a managed care plan that requires selection of a primary care provider to instead choose a participating, in-network APRN.

Merging OHA and DCP

Medicine opposed a proposed “cost-saving” bill that would put the Office of the Healthcare Advocate (OHA) totally under the Department of Consumer Protection’s (DCP) authority (not just for administrative purposes only). Under a proposal put forth by the Governor, the DCP commissioner will appoint the healthcare advocate and the healthcare advocate's authority to direct the office will be removed.

Our interest in OHA is largely based on its advocacy for patients. The insurance process is often a difficult and bureaucratic nightmare especially for those who do not know the “system”. Merging OHA with DCP limits its independence and authority. In the end, OHA was not merged with DCP but with the Department of Public Health.

Preauthorization Standards

A bill that would have established uniform standards for health care providers and health insurers for the preauthorization, precertification and predetermination of an admission, service, procedure or extension of stay was not acted on by the Insurance and Real Estate Committee. The current system of different criteria and standards among the multiple health insurers make it a guessing game trying to figure out which criteria need to be met to get treatment authorized. This is quite labor intensive for staff and frustrating for physicians and patients who are at the mercy of individual health insurance plans each requiring different criteria to be met.

Cooperative Health Care Arrangements

Medicine once again advocated for a bill that would have required managed care companies to negotiate in good faith with parties that have entered into an Attorney General-approved cooperative agreement. This bill died when it was referred by the House to the Insurance and Real Estate Committee which took no action on it; however it passed significant hurdles by getting through the Judiciary and Appropriations Committee. The insurance industry will continue to lobby against the bill however it is slowly gaining momentum and will be back in future sessions.

Standards in Contracting

A big victory for medicine came in the form of standards in contracting. While Public Act 11-58 was not signed into law by the Governor due to scheduling conflicts, it will still become law. The act includes timely payments for electronic claims; network adequacy provisions; a ban on future product clauses; and standards for denying previously authorized services.

Preventive Care

Medicine advocated for a bill that that would have prohibited managed care companies from imposing a copayment, deductible or other out-of-pocket expense for preventive care services. This would have included charges for annual physicals and periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations such as annual physicals; routine prenatal and well-child care; child and adult immunizations; tobacco cessation programs; and obesity weight-loss programs. The bill died when it was referred by the Senate to the Appropriations Committee.

Also failing to win legislative approval was a bill that would have promoted health behavior wellness, maintenance or improvement program participation by requiring insurers to offer such programs, and to require an incentive or reward for such participation.

