

CMGMA Legislative Update May 12, 2010

This legislative session was dominated by the State's fiscal strength (or weakness). Democrats and the Governor went head to head over taxes, budget cuts and more with one eye on the legislative session and another on the upcoming elections.

CMGMA staff read through hundreds of bills and with the CMGMA legislative committee identified priority legislation. Listed below is an overview of those legislative bills that were identified as priorities. If there is a bill that you would like more information on or if there is a bill that you are interested in that is not listed, please contact the CMGMA Executive Office at info@cmgma.org or at 860-243-3977.

Standards in MCO Contracting

In the final days of the session, the Senate passed a bill aimed at establishing standards in contracting between managed care organizations (MCOs) and physicians. Unfortunately the bill died when the House did not act on it before adjourning. The bill would have made a variety of changes to current law including: increasing the time an insurer has to pay paper claims and decreases the time it has to pay electronic claims; allowing health care providers to decline participation in a new insurance product if the product makes material changes to the provider's contract with the insurer, and requiring an insurers to adhere to nationally accepted provider network standards (Bill Analysis for Senate Bill 393).

MCO Related Legislation

While standards in MCO contracting (above) was one of the higher priorities on medicine's legislative agenda, there were several other bills that also related to MCOs. Among the bills is Public Act 10-24 which requires certain health insurers who deny coverage of a requested service because it is not (1) medically necessary or (2) a covered benefit, to notify the insured of his or her ability to contact the Office of the Healthcare Advocate if the insured believes he or she has been given erroneous information. Insurers must also provide the insured with contact information for the office. The bill also imposes a 45-day coverage determination and notice requirement on any entity that continues an individual or group health insurance policy in Connecticut. (Bill Analysis for File Copy 217). This act was signed into law by the Governor.

A bill that would have distinguished short-term health insurance policies from those having a duration of one year or more for the purpose of the Insurance Commissioner's approval of rescinding, canceling, or limiting a policy, to limit the scope of an investigation into a suspected preexisting condition and to specify requirements for insurers or health care centers that accept telephonic applications for individual health insurance coverage died.

Another bill passed into law and awaiting the Governor's signature, requires certain health insurance policies that cover intravenously and orally administered anticancer medications prescribed by a licensed practitioner with prescribing authority to cover the orally administered medication on at least as favorable a basis as the intravenously administered medication. It prohibits insurers, HMOs, medical and hospital service corporations, and fraternal benefit societies from reclassifying anticancer medications or increasing the patient's out-of-pocket costs

for the medications as a way to comply. The bill also broadens the applicability of several health insurance benefits required by law, including treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients. It does this by requiring all policies renewed, amended, or continued in Connecticut to include the benefits. Policies delivered or issued here already must include them. (Bill Analysis for File Copy 160).

Rental Network Agreements

Public Act 10-59 makes changes in the law pertaining to contracts between health care providers and contracting entities that give third parties access to the contract's terms. Specifically, the bill: 1. makes it a violation of the law an unfair or deceptive insurance practice; 2. requires a contracting entity to update routinely and at least every 90 days its list of covered entities, which must be available to providers by law; 3. establishes requirements for a covered entity that subsequently gives others access to a provider's services, rates, or fees; 4. permits a health care provider to file legal actions against contracting and covered entities; and 5. authorizes the insurance commissioner to adopt regulations relating to the law. In addition, the bill also requires a covered entity to update its list of entities to which it has granted access to providers' services, rates, or fees routinely and at least every 90 days. (Bill Analysis for File Copy 20, as amended by Senate Amendment "A").

Copays

A bill that would have prohibited co-payments, deductibles, or other out of pocket expenses for preventive care services (i.e., annual physicals, prenatal/well-child visits, immunizations, tobacco cessation, obesity weight loss programs) died in the Appropriations Committee.

Another bill that would have required any co-payment required by an individual or group health insurance policy for prescription drugs to be the same regardless of whether such drugs are obtained through a retail pharmacy or through a mail order pharmacy died on the Senate calendar.

Adverse Events Reports

A bill that amends the state's adverse event reporting law by requiring that the Department of Public Health's (DPH) annual report to the legislature on adverse events include aggregate information, for each hospital and outpatient surgical facility was passed and now awaits the Governor's signature. The bill also (1) requires the report to include contextual information about the hospital or facility and (2) allows these entities to provide informational comments relating to the adverse event reported which must be included in DPH's annual report. (Bill Analysis for File Copy 246).

The bill also prohibits a facility from taking certain actions against an employee or job applicant for actions taken to further provisions of the adverse event law. In addition, the bill requires DPH to provide patients access to information if they have filed complaints with the department alleging incompetence, negligence, fraud, or deceit by health care providers. It also requires DPH to give the patients notice about their complaint's status and disposition. It also requires mandatory mediation for all civil actions involving allegations of negligence by health care providers resulting in personal injury or wrongful death. (Id.)

The bill was also amended to require DPH's annual adverse event report to include aggregate adverse event information for each hospital or facility instead of requiring the names of the hospital or facility where the event occurred, as in the original bill. It requires DPH to prepare its report in a way that uses specific contextual information about the hospital or outpatient facility rather than to the extent practicable as in the original bill. It allows hospitals to provide additional information about the adverse event that must be included in the report. It also deletes provisions in the original bill that (1) the report include a summary of the entity's corrective action and whether DPH had reviewed its implementation and (2) imposed a civil penalty of \$ 10,000 for substantial failure to comply with the bill. It also amends the definition of “corrective action plan. (Id.)

Scope of Practice

This year’s legislative session did not produce any direct scope of practice bills, however bills were introduced that could impact certain health care providers future scope of practice.

First, a bill that would have allowed a managed care enrollee to select an APRN as a primary care provider died when the House did not pass it before adjourning. It should be noted that the Senate did pass the bill but amended it to remove this provision.

In addition, we also closely monitored Public Act 10-8, which authorizes the Connecticut State University System (CSUS) to award doctoral degrees in nursing education. There is a concern that the use of the title “doctor” by APRNs could be very misleading to the public and the program could be used as a springboard for independent practice. The bill was passed by the House and Senate and awaits the Governor’s signature.

Public Act 10-38, which also awaits the Governor’s signature, creates a new category of social workers – “master social workers”. Under the act, a licensed master social worker can practice clinical social work under the professional supervision of a licensed physician, advanced practice registered nurse (APRN), psychologist, marital and family therapist, clinical social worker, or professional counselor. “Professional supervision” is face-to-face consultation consisting of at least a monthly review, a written evaluation, and assessment by the supervisor of the master social worker's practice of clinical social work. In addition, a licensed master social worker can offer a mental health diagnosis in consultation with a licensed physician, APRN, psychologist, marital and family therapist, professional counselor, or clinical social worker. (Bill Analysis for File Copy 134). The bill also specifies that a licensed clinical social worker can perform all the functions of a licensed master social worker and practice independently, but a licensed master social worker cannot engage in independent practice, except for a limited period (see below). “Independent practice” means the practice of clinical social work without supervision. (Id.)

One bill that would have actually attempted to establish a framework for deciding scope of practice issues was not passed. The bill would have implemented the recommendations of the Legislative Program Review and Investigations Committee concerning scope of practice determinations for health care professionals. The recommendations included the creation of a standardized process with the Department of Public Health to determine scope of practice changes.

Medical Malpractice

A bill that would have eased part of the strain on the current Connecticut medical malpractice system by requiring mediation died in the Judiciary Committee but resurfaced later in the session as part of another bill and was passed. Specifically, the bill requires mandatory mediation for all civil actions seeking damages for personal injury or wrongful death, whether in tort or contract, where it is alleged that the harm resulted from a health care provider's negligence. Each action for which a valid certificate of good faith has been filed (as required by law for a negligence action against a provider) must be referred to mandatory mediation, unless the action is referred to another alternative dispute resolution program that the parties agree to. Mandatory mediation is for the purpose of reaching a prompt settlement or resolution of the action.

A bill that would have expanded professional liability insurance closed claim reporting requirements, granted the Insurance Commissioner the authority to fine entities that fail to submit reports as required and added confidentiality provisions died in the Insurance and Real Estate Committee. Provisions of the bill concerned the CMGMA Legislative Committee, which submitted testimony to the Insurance Committee. The main concern was that it defined a "closed claim" as a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer or health care provider, where all indemnity and expense payments have been made. According to the bill, a claim may be closed with or without an indemnity payment to a claimant. CMGMA interpreted this to mean that a "closed claim" could be the "write off" of a balance due from the patient and that this would then be "reportable". This, of course, is problematic for physician offices as physicians sometimes forgive balances due from patients for reasons unrelated to a professional liability issues. While CMGMA did not feel that the intent of the bill was to discourage physicians from being able to forgive balances due to a patient's financial hardship, we were worried that this would have been the effect if the bill were passed.

Gifts from Pharmaceutical Companies

A bill which would have imposed restrictions and prohibitions on pharmaceutical and medical device manufacturing companies' providing of gifts, meals, entertainment, and other payments to health care providers died when the Senate did not act on it.

Missed Doctors' Appointments

A bill that would have required physicians and medical practices to post a notice relating to missed appointment fees died. While the bill only required notices to be clearly posted regarding a physician's office cancellation, the original version of the bill only pertained to medicine not all health care offices.

Other bills that passed:

- A bill requiring insurers to disclose to certain employers upon request certain claims data passed and now awaits the Governor's signature.
- A bill requiring the Department of Social Services (DSS) to expand the HUSKY Primary Care pilot program to include primary care providers in Putnam (by July 1, 2010) and Torrington (by October 1, 2010). The bill also permits the DSS commissioner to seek a federal waiver to make these expansions. HUSKY Primary Care is the state's primary care case management program, which is an alternative care model available to HUSKY A enrollees. (Bill Analysis for File Copy 660).

Other bills that did not pass:

- Requiring the issuance of machine-readable medical benefits identification cards and scanner devices to read or access such cards.
- Requiring all employers with 50 or more employees in the state to provide their employees with paid sick leave that accrues at a rate of one hour for each 40 hours worked.
- Requiring health insurance policies to cover magnetic resonance imaging (MRI) of a woman's entire breast or breasts if (1) a mammogram shows heterogeneous or dense breast tissue based on the American College of Radiology's Breast Imaging Reporting and Database System (BI-RADS) or (2) a woman is considered at an increased breast cancer risk because of family history, her own prior breast cancer history, positive genetic testing, or other indications determined by her physician or advanced-practice registered nurse.