Legislative Report

June 2015

The 2015 legislative session is finally over and while the dust is still settling and a special session is looming, there are plenty of healthcare related bills that were advocated on this year. Although news of the budget and tax increases dominated was what most people were talking about during the last few days of the session, so much more was worked on over the five month long session. Below are some of the medicines top issues during this past legislative session.

Telemedicine

This year a few bills were introduced that aimed to put requirements and prohibitions on telemedicine and one passed. Among the regulations that will go into effect are that teleheath medicine may only be provided when: 1. the provider is communicating through real time, interactive, two-way communication technology or store and forward technologies; 2. has access to, or knowledge of, the patient's medical history, as provided by the patient and the patient's health record, including the patient's primary care provider's name and address; 3. gives the patient his or her provider license number and contact information; and 4. conforms to the standard of care for his or her profession and expected for in-person care as appropriate for the patient's age and presenting condition. However, when the standard of care requires the use of diagnostic testing and a physical examination, the provider may perform the testing or examination though appropriate peripheral devices (i.e., instruments he or she uses to examine a patient).

In addition, the bill also prohibits using telehealth for prescribing of controlled substances or ordering x-rays and requires insurance plans to cover telehealth services.

Hospital/Healthcare Umbrella Bill

A large bill that makes changes to certain healthcare issues that impact patients and physicians was passed. The bill establishes a statewide health information exchange, to be overseen by the Department of Social Services (DSS), and sets deadlines for hospitals, clinical laboratories, and certain providers to connect to and participate in the exchange.

With respect to hospitals and health systems, the bill: 1. places certain limits on allowable facility fees for outpatient services; 2. adds to the factors that the Department of Public Health's (DPH) Office of Health Care Access (OHCA) must consider when reviewing a certificate of need (CON) application for a hospital transfer of ownership; 3. sets certain requirements when OHCA places conditions on its approval of a CON application involving a hospital ownership transfer; 4. requires OHCA to hire an independent consultant as a post-transfer compliance reporter for three years after a hospital ownership transfer is completed; and 5. requires OHCA to conduct a cost and market impact review for hospital ownership transfers that considers factors related to the transacting parties' business and relative market positions.

Among other provisions concerning health care providers, the bill: (1) requires them to give patients certain notices of health care costs, (2) creates notice requirements when providers refer a

patient to an affiliated provider, and (3) expands what conduct by providers constitutes an unfair trade practice.

Regarding health carriers, among other things, the bill allows them to offer at least one health care plan with a tiered provider network. It also requires them to provide insureds notice about covered benefits, the network status of health care providers, and surprise bills and bill insureds at the in-network level for services if the services were emergency in nature or resulted in a surprise bill. It requires each health carrier to maintain a website and use a phone application and toll-free telephone number allowing consumers to obtain information on in- and out-of-network costs, and generally prohibits carriers from charging more than the disclosed amounts. It also sets certain limits on the out-of-pocket costs insurers can collect for facility fees.

Among other things, the bill also: 1. narrows the current exemption from the CON requirement for a group practice of eight or more physicians transferring ownership to another group practice; 2. expands the membership of the state's Health Care Cabinet, requires it to convene a working group to study rising health care costs, and expands its duties to include setting statewide health care cost growth goals and reviewing provider price and insurance reimbursement rate variations, among other things; 3. requires DPH to report to the Public Health Committee on recommendations for eliminating CON approval requirements or creating an expedited approval process for certain health care facility transactions that currently require such approval; and 4. requires the chair of the Connecticut Health and Education Facilities Authority board of directors to study and report to the Public Health Committee on financing options for community hospitals to make certain improvements, such as purchasing medical equipment or updating information technology, among other things.

For a full analysis of each of these provisions, please click on this link http://cga.ct.gov/2015/BA/2015SB-00811-R01-BA.htm

Ambulatory Surgical Tax

In the last few hours of the session, the legislature passed a budget which includes a 6% tax on ambulatory surgical center (ASC) gross receipts. The fight against this is not over though and will continue into the special session.

Facility Fee

Last year, Public Act 14-145 - An Act Concerning Fees Charged for Services Provided at Hospital Based Facilities was passed and requires certain notification and disclosure to patients of fees charged in hospital based facilities. This year under a larger health care bill, more facility fee requirements were put in place. Specifically, a billing statement that includes a facility fee must: 1. clearly identify the fee as a facility fee that is in addition to, or separate from, the provider's professional fee, if any; 2. provide the comparable Medicare facility fee reimbursement rate for the same service; 3. include a statement that the fee is intended to cover the hospital's or health system's operational expenses; 4. inform the patient that his or her financial liability might have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and 5. include notice of the patient's right to request

a reduction in the facility fee or any portion of the bill and a telephone number that the patient may use to make this request.

Acquisition of Physician Practices
A bill that would have required that physician practices receive approval from the Commissioner of the Department of Public Health and the Attorney General prior to entering into an agreement to transfer assets or operation or change of control of the practice to an insurer died when the Public Health Committee did not vote on it by its committee deadline.

Medical Assistants
A bill allowing medical assistants, under certain conditions, to administer vaccines died on the House calendar. It would have allowed them to do so only (1) under the direct supervision, control, and responsibility of a physician or advanced practice registered nurse or direct supervision of a physician assistant and (2) at the supervising practitioner's office, an outpatient clinic, or a federally qualified health center.

Extension of Health Insurance Coverage
Bills extending health insurance coverage to hearing aids and orally and intravenously administered medications were all introduced but did not pass.

Managed Care Related Issues
Once again a bill that would have established cooperative health care arrangements was introduced and supported by medicine, however it did not make it out of the committee process. In addition, a bill concerning healthcare provider network adequacy was also introduced but died when the House took no action on it. The bill would have required health care insurers to make sure that an adequate number of physicians are available to provide network enrollees complete and efficient access to health care services.

Medical Malpractice
Medicine worked throughout the session to advocate for medical malpractice reforms and to impress upon legislators that tort laws need to be strengthened not weakened. While advocating for some reforms, medicine also opposed others such as a bill that would have extended the statute of limitations for negligence actions brought by a minor. Specifically, the bill would have "allowed people who turn 18 to sue for negligence for personal injuries they suffered when they were minors and unable to sue in their own name. (This would apparently allow a person, between the ages of 18 and 19, to bring an action for an act or omission that occurred when he or she was as young as age 11.)" (File No. 659). "The bill applied to lawsuits to recover damages caused by (1) negligence, (2) reckless or wanton misconduct, or (3) malpractice of a physician, surgeon, dentist, podiatrist, chiropractor, hospital, or sanatorium. It does not apply to actions for the recovery of real property or a penalty or forfeiture" (Id.) Currently "individuals may generally sue for damages for injury to the person or to real or personal property within (1) two years from the date the injury is first sustained or discovered, or in the exercise of reasonable care, should have been discovered or (2) three years from the date of the act or omission

complained of. There are longer timeframes for certain types of injury" (Id.). We are happy to report that the bill died on the House calendar.

Definition of Surgery

The word "surgery" is used throughout the Connecticut State Statutes, however the term is not defined. Medicine working throughout the session to establish a definition of surgery that would protect physicians and patients by making sure that only those qualified to perform surgery are actually able to do so and also supported an attempt to create a task force to study the issue, however both measures failed.

Other Bills

- **Definition of Urgent Care Clinic** – This bill would have established a definition of urgent care clinics so that patients know what type of medical services are provided. Medicine advocated that any clinic that may call itself urgent care must be able to actually provide the types of services that a patient would consider urgent. The bill died in committee.
- **Childhood Vaccines** – Under a new law any person who wishes to seek a religious exemption from childhood vaccinations will have to have it acknowledged by specified legal authorities, instead of just notarized.
- **Practice of Homeopathy** - Medicine opposed a bill that would have expanded the scope of practice for naturopaths to include prescribing, dispensing, and administering certain types of drugs. Several specialty societies worked together to defeat this legislation.
- **Nutrition Advisory Council** – Medicine supported the creation of a nutrition advisory council however the bill died.
- **Off Label Prescription Drug Coverage** – Medicine advocated that any state legislation concerning off label prescription drug coverage be consistent with AMA standards, however the bill died in committee.
- **E-Cigarettes** – A bill that prohibits the use of E-Cigarettes where smoking is already banned passed both the House and the Senate.
- **Pediatric Vision Screening** – A bill that would have required primary care providers serving children, except for hospital emergency department staff, to provide an annual vision screening to children who are not yet able to enroll in kindergarten (i.e., children under age five) died on the House calendar.

As the session continues to progress we will continue to keep members update on important legislation.