Busy Legislative Session Leaves Many Issues Unresolved

The 2009 legislative session got off to a busy start with hundreds, if not thousands, of bills being introduced. The budget and universal healthcare were two of the hottest topics at the Capitol this year and the budget continues to dominate the headlines as Democratic leadership and the Governor's office have been unable to come to a budget compromise. Most of the disagreement between the two sides revolves around spending cuts and borrowing. Among the budget cuts being proposed by the Governor is the drastic change to the definition of medical necessity within the Medicaid and Husky A programs, cutting other Medicaid benefits, subjecting mental health related drugs to the State's preferred list, cutting funding for Lifestar helicopters and the closing of Riverview Hospital. Medicine continues to lobby Democratic leadership and the Governor's office on these issues.

Listed below are other bills acted upon this session that will impact physicians and their patients. Some have been signed by the Governor; others have not. If you have any questions about any of the issues listed below or any other issue that you may have read or heard about that is not listed below, please contact Phyllis Darby at the CAFP Executive Office at 860-243-3977.

Standards in Contracting with MCOs

A bill that will help to level the playing field in physician and MCO contract negotiations has passed both the House and the Senate and now awaits the Governor's signature. **This is a major victory for medicine** which has lobbied for years to strengthen the physician's negotiating position.

Public Act 09-204 broadens the type of fee information a contracting health organization must give to health care providers with whom they contract. It also requires the organization to give providers Internet, electronic, or digital access to policies and procedures regarding:

- payments to providers;
- providers' duties and requirements under the participating provider contract;
- inquiries and appeals from providers;
- contact information;
- a description of the rights of a provider, enrollee and enrollee's dependents with respect to an appeal; and
- the Health Care Procedure Coding System (HCPCS) codes applicable to or requested by such provider for other services for which the provider actually bills or intends to bill, provided such codes are within the provider's specialty or subspecialty.

In addition, the bill prohibits contracting health organizations from making material changes to a provider's fee schedule except as specified below:

- once a year if it gives providers at least 90 days' advance notice by mail, electronic mail, or fax of the changes; and
- at any time if it gives providers at least 30 days' advance notice by mail, electronic mail, or fax of any changes that are based on certain circumstances the bill specifies, such as (a) to comply with changes to national best practice protocols made by the National Quality Forum or other national accrediting or standard-setting organization, or (b) to be consistent with changes made in Medicare pertaining to billing or medical management practices.

The bill also prohibits a contracting health organization from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than 18 months after the date of the receipt of a clean claim, unless:

- the organization has a documented basis to believe that the claim was fraudulently submitted by such provider;
- the provider did not bill appropriately for the claim based on the documentation or evidence of what medical service was actually provided;
- the organization already paid the provider for the claim;
- the organization paid a claim that should have been or was paid by a federal or state program; or
- the provider received payment from a different insurer, payer, or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy.

Lastly, the bill gives a provider that receives a payment from another source one year after the date of the cancellation, denial, or return of full or partial payment to resubmit an adjusted secondary payer claim with the organization on a secondary payer basis, regardless of the organization's timely filing requirements. (Public Act 09-204 OLR Analysis).

This bill is considered a huge victory for medicine and will hopefully have a significant impact on physician/MCO contracting.

Universal Healthcare

In Connecticut two universal healthcare related bills dominated the headlines and legislative attention this year. The bill which medicine supported was the SustiNet bill which in its original version would have created a new state health care program to extend insurance coverage to the state's uninsured. In the final days of the session, the bill was stripped of its original language and replaced with language establishing a nine-member SustiNet Health Partnership Board of Directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the “SustiNet Plan,” a self-insured health care delivery plan. The bill also created task forces addressing obesity, tobacco usage, and the health care workforce.

The bill was passed by both the House and the Senate, as was the “pooling” bill described below. However, Governor Rell vetoed both bills on July 8, and there was no word as yet whether the Democrats will attempt to override the veto.

The other universal healthcare related bill was referred to as the “pooling” bill and was supported by the Democrats and the Speaker of the House. The bill was passed by both the House and the Senate and also awaits the Governor’s signature. The bill takes the state from a fully insured plan to a self insured plan and requires the comptroller to offer employee and retiree coverage under the self-insured state plan to nonstate public employers, municipal-related and nonprofit employers, and small employers beginning January 1, 2011. Republicans argue

that this very risky especially when the plan is opened up to municipalities, small businesses and not for profits whose claims experience cannot be accurately predicted.

There were two reasons for the vetoes; one was the high cots involved; the other that they were the first steps towards universal healthcare, an idea not completely supported by the Governor.

Gifts from Pharmaceutical Companies

A bill prohibiting pharmaceutical and medical device companies that do business with the state from giving certain health care providers cash, gifts, or other things of value **died** when the House and Senate failed to act on it by the end of the legislative session.

Cancelled Doctor's Appointments

A bill that would have prohibited a physician or medical practice from charging a patient a fee for a missed appointment unless the physicians or practice posted a notice of such a fee **died** when the House took no action on it.

APRN Scope of Practice

APRNs came back this session once again looking for independent practice. Medicine objected to this expansion of their scope of practice and argued that the education and training of an APRN is adequate for collaborative practice not independent practice. The bill **died** when the Public Health Committee did not vote on it by its Committee deadline. **Despite the failure of the bill this year, Medicine expects that this APRN issue will be back in future sessions.**

Other

- A bill establishing a health benefit review program within the Insurance Department to evaluate the social and financial impacts of mandated health benefits **passed and was signed into law by the Governor on June 30.**

- A bill requiring certain health insurance policies to include: 1. coverage for prosthetic devices, and repairs and replacements to them, subject to specified conditions; 2. specified coverage for human leukocyte antigen testing; 3. a "reasonably designed" health behavior wellness, maintenance, or improvement program that gives participants one or more of the following: (a) a reward; (b) health spending account contribution; (c) premium reduction; or (d) reduced copayment, coinsurance, or deductible; and (4) coverage for licensed physician- or advanced practice registered nurse-prescribed wigs for a person with hair loss caused by a diagnosed medical condition other than androgen tic alopecia **passed and awaits the Governor's signature.** See the CAFP website: www.ctafp.org for a complete list of items covered under this bill.

- A bill broadening what a group health insurance policy must cover regarding autism spectrum disorders was **signed into law by the Governor**. It requires a policy to cover the diagnosis and treatment of autism spectrum disorders, including behavioral therapy for a child age 14 or younger and certain prescription drugs and psychiatric and psychological services for insureds with autism.

- An act prohibiting insurers or other entities in the individual health insurance market from using as an underwriting factor a person's history of taking a prescription drug for

anxiety for six months or less **was signed into law by the Governor**. This bill does allow the use of such history if it arises directly from a medical diagnosis of an underlying condition.

- A bill prohibiting anyone from performing an obstetrical ultrasound procedure unless it is for a medical or diagnostic purpose and ordered by a licensed healthcare provider **was signed into law by the Governor**

- The **Governor signed into law** a bill that would allow a licensed physician to prescribe, administer, or dispense long-term antibiotic therapy to a patient for a therapeutic purpose that eliminates the infection or controls the patient's symptoms if a clinical diagnosis is made that the patient has Lyme disease or has symptoms consistent with such a diagnosis and the physician documents the diagnosis and treatment in the patient's medical record.

- Effective October 1, 2009, all health care institutions caring for newborn infants will be required to test them for cystic fibrosis, unless, as allowed by law, their parents object on religious grounds. It requires the testing to be done as soon as is medically appropriate. **This has been signed into law**.