



Connecticut State Medical Society
Legislative Session Update
April 2008

Working within a legislative session that is only twelve weeks long this year, the Connecticut State Medical Society (CSMS) has been busy addressing a wide range of issues at the State Capitol. Although much can and does change during the last month of the session, your lobbying team is pleased to provide this update to you on issues that effect physicians, patients, the healthcare system, and the practice of medicine in general. We currently are in some way involved in or monitoring over 100 pieces of legislation, several of which address or impact several issues. For that reason we provide you the following summary of significant proposed legislation or issues that effect CSMS members.

Health Insurance, Contracting, and Transparency

Although comprehensive CSMS legislation establishing transparency and standards in contracts between physicians and insurers did not receive action in its original form, many individual pieces of legislation that would accomplish many of our insurance reform goals continue to make their way through the process.

Senate Bill 273 An Act Regulating the Secondary Market in Physician Discounts-

Aimed at regulating what is known as the silent PPO market, this legislation would shine a light on and basically prevent the inappropriate and unauthorized sale and purchasing of physician networks and contract. Current estimates on the amount of lost reimbursements for physicians nationwide run as high as \$60 billion. If successful, this legislation would accomplish the following:

- Require insurers who lease, rent or grant access to a physician's services or established rates to formally state in the contract with the physician their ability to do so.
- Require insurers who do so to maintain a web site or toll free number through which a physician can obtain a listing of all third parties to which services or fees have been leased, rented or granted access.
- Defines entities who rent lease or gain access to fees and rates as *Covered Entities* and require them to pay in accordance with terms set forth in the contract between the physician and the original insurer
- Limits insurer's ability to further rent, sell or provide access to a physician's rates and fees.
- Terminates the covered entities rights to physician fees and rates if the physician terminates a contract with the original insurer
- Require all EOBs to name the entity responsible for paying the physician as well as name the entity through which the payment is made.
- Require all patient identification cards to clearly mark on the card the name and contact information of any entity responsible for processing or paying claims.

If successful, Connecticut will become one of the first states to pass legislation to stop the inappropriate use of silent PPO's.

Senate Bill 482 An Act Concerning Health Care Claims- This bill makes it an unfair and deceptive insurance practice for certain entities to offer or provide any financial or other incentive to any person (1) for denying health care claims or (2) based on the number of claims the person denies.

Senate Bill 491 An Act Concerning Medical Loss Ratio- CSMS strongly supported the original language of this legislation that would have required health insurers to spend at least eighty five cents of every premium dollar on health care services and submit annually to the Commissioner of Insurance medical loss ratio data. However, the bill has been amended and now establishes a task force to study the medical loss ratios of health insurance plans delivered, issued for delivery, renewed, amended or continued in this state. It is to include an analysis of the factors that affect such loss ratios and assessment of the impact of setting loss ratio thresholds, and shall consider both private and public organizations' health plans in such study.

House Bill 5157 An Act Concerning Medical Discount Plans – In past sessions, CSMS has successfully supported legislation to regulate medical discount plans. Prior to any form of regulation, these plans often gave the appearance of insurance coverage and the promise of access to healthcare services. A flaw in the original legislation left uncaptured independent companies hired by Medical Discount Plan Companies to market the product. This bill specifies certain operating restrictions for marketers. Additionally, it makes the medical discount organization responsible for actions of a market that are within the authority granted by the organization.

Senate Bill 280 An Act Concerning Health Insurance Coverage for bone Marrow Testing and Prosthesis, and Requiring a Health Benefit Impact Review of Health Insurance Mandates in This State. Although this legislation establishes or alters insurance coverage requirements for bone marrow testing and prosthesis, it also requires the Commissioner of the Department of Insurance to contract with an independent contractor to conduct an impact review of all benefits required to be provided by insurers in health insurance policies pursuant to chapter 700c of the general statutes in effect on October 1, 2008. The review must at a minimum include an evaluation of (1) the financial impact of such benefits, and (2) the impact of such benefits on the access and availability of insurance coverage. However, CSMS also firmly believes that any such review must also report on the impact such required coverage has on overall public health and quality of life.

The Budget

As usual, we do not expect there to be any final resolution on this year's budget adjusts **until the very end of session. However, significant changes have taken place within the** Medicaid program over the past few months and surrounding efforts to unveil new contracts with health insurers to provide services to both the HUSKY population and newly established Charter Oak Health Plan. For this reason CSMS and many human service advocates continue to remain vigilant to ensure that any final budget produces the best possible outcome. Already, CSMS and a coalition of other interest groups have successfully lobbied against a proposal to eliminate reimbursements for federally mandated interpreter services, as well as a proposal to weaken the definition of medically necessary within the Medicaid program.

On Line Profiling of Health Care Providers

CSMS has successfully lobbied to see two bills passed out of committee to expand the on-line profiling system to all health care professionals required to carry liability insurance in the State: **Senate Bill 471 An Act extending the State Physician Profile to Certain Other Health Care Providers and Senate Bill 483 An Act Promoting Patient Safety And Access to Provider Information by Extending the State Physician Profile to Certain Other Health Care Providers.** The need for inclusion of all providers in the profiling system becomes more critical as these alternative healthcare providers push to increase the scope and complexity of the services they provide to patients. Too often we hear arguments regarding the safety and/or lack of bad outcomes related to a profession seeking to expand its scope of practice without documentation or substantiation of a claim. As health care is focused on a team approach, information on all members of the health care team needs to be available in a manner that is easy to comprehend and follows the familiar format of the physician profile.

Senate Bill 462 An Act Concerning License Fees for Physicians

This CSMS legislation looks to correct and expand on legislation passed last session that allows retired physicians who provide 100 hours of pro bono services to have their annual licensure fee waived by the Department of Public Health. Unfortunately, last year's legislation limited acceptable facilities to only those considered public health facilities as defined in state statute. While current legislation expands the definition to include mobile clinics, we feel that there are many other settings and locations that should be acceptable and will encourage retired physicians to provide care to Connecticut residents.

Senate Bill 654 An Act Concerning the Availability of Prescribed Antiepileptic Drugs- CSMS continues to work with neurologists and the Epilepsy Foundation on this issue. The underlying effort is to prohibit generic to generic substitution of anti seizure medications without the knowledge of the physician and patient. Concern being that even a small change in drug consistency can trigger reactions in epileptic patients. While we continue to support legislation to accomplish the goal, we continue to seek legislation that will provide physicians and patients with the notification and yet not place an unachievable burden on pharmacists who often do not have knowledge of changes of manufacturers.