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OLR ACTS AFFECTING

HEALTH CARE SERVICES

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NOTICE TO READERS

This report provides highlights of new laws (public acts) affecting health care services enacted during the 2009 regular and special sessions. Each summary indicates the public act (PA) number and effective date. The report does not cover special acts.

Not all provisions of the acts are included. Complete summaries of all 2009 public acts will be available in the fall when OLR's *Public Act Summary* book is published; most are already on OLR's webpage: http://www.cga.state.ct.us/olr/publicactsummaries.asp.

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State library, the House Clerk's Office, or the General Assembly's website: http://www.cga.state.ct.us/default.asp.

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ALZHEIMER'S RESPITE CARE

The State-Wide Respite Care Program provides respite care for people with Alzheimer's disease or related disorders, regardless of age, who are not enrolled in the Connecticut Homecare Program for Elders (CHCPE). **PA 09-75** increases, from $30,000 to $41,000, the program's annual income limit and increases the allowable asset limit from $80,000 to $109,000. Beginning July 1, 2009, the act requires the Department of Social Services (DSS) commissioner annually to increase the income and asset limits to reflect Social Security cost of living adjustments.

The act requires the commissioner to adopt regulations allowing program participants who demonstrate a need for additional services to receive up to $7,500 for respite care services. Prior law limited respite care services to $3,500 annually.

The act also adds personal care assistant (PCA) services to the list of respite care services the program provides. Respite care services provide short-term relief for family members caring for an individual with Alzheimer's or related diseases. They include homemaker services, adult day care, short-term medical facility care, home-health care, and companion services.

This takes effect July 1, 2009.

AMBULANCE TRANSPORT

PA 09-16 permits only licensed or certified ambulance and rescue services to transport patients on stretchers in motor vehicles. The Department of Public Health (DPH) licenses commercial ambulance and rescue services and issues certificates to volunteer and municipal ambulance services. By law, anyone who willfully violates an emergency medical services law can be fined up to $250, imprisoned for up to three months, or both.

The act requires any ambulance used to transport patients between hospitals to meet state regulatory requirements for basic ambulance service, including those concerning medically necessary supplies and services. These regulations require, among other things, one medical response technician and one emergency medical technician in the ambulance, the latter of whom must attend the patient at all times.

The act permits a licensed registered nurse, advanced practice registered nurse, physician assistant, or respiratory care practitioner to supplement the ambulance transport if he or she has current training and certification (1) in pediatric or adult advance life support or (2) from the American Academy of Pediatrics' neonatal resuscitation program, as

appropriate and based on the patient's condition.

This takes effect upon passage for interhospital transport; October 1, 2009 for stretcher transport.

ANATOMIC PATHOLOGY

PA 09-232 requires direct billing to the patient or insurer by a clinical laboratory performing anatomic pathology services. It prohibits any entity other than a physician, clinical laboratory, or a "referring clinical laboratory," from directly or indirectly charging, billing, or seeking payment for pathology services unless the physician or lab personally performed or directly supervised the service according to federal standards governing clinical labs. Patients and third party payors are not required to reimburse providers for charges or claims that violate the act's prohibitions.

The act allows clinical and referring labs to seek payment only from a patient, hospital, responsible insurer of a third party payor, or a government agency or the agency's public or private agent. It states that it is not to be construed to prohibit a clinical lab from billing a referring lab for specimens transferred for histologic (tissue) or cygtologic (cell) processing or for consultations.

The act defines "referring clinical laboratory" as a lab that refers a patient specimen for consultation or anatomic pathology services. The definition excludes a physician's or physician group's lab that takes a patient specimen and does not perform the professional diagnostic component of the anatomic pathology services involved. It defines "anatomic pathology services" as the gross and microscopic examination and histologic and cytologic processing of human specimens, including histopathology or surgical pathology, cytopathology, hematology, subcellular or molecular pathology, or blood banking service performed by a pathologist.

This takes effect July 1, 2009.

ASTHMATIC INHALERS AND EPIPENS

PA 09-155 requires, rather than allows, the State Education Department to adopt regulations governing medication administration by school personnel and student self-medication. It specifies that the latter must address students using asthmatic inhalers and epipens. It adds licensed athletic trainers employed by a school board to those personnel permitted to administer medication to students under the general supervision of a school nurse.

The act also requires school boards to make their plans for managing students with life-threatening food allergies publicly available on the Internet or otherwise.

This takes effect August 15, 2009.

AUTISM

PA 09-115 requires a group health insurance policy to cover the diagnosis of autism spectrum disorders and expands the requirements on insurers to cover treatment of these disorders. It requires insurers to cover behavioral therapy for a child age 14 or younger and certain prescription drugs and psychiatric and psychological services for insureds with autism. The act permits a policy to set a certain annual dollar maximum for behavioral therapy coverage.

Prior law required a group health insurance policy to cover physical, speech, and occupational therapy services provided to treat autism to the same extent that it covers them for other diseases and conditions. The act removes that limitation, but specifies different conditions for covering the therapies.

The act authorizes an insurer, HMO, hospital or medical service corporation, or fraternal benefit society to review an autism treatment plan's outpatient services in accordance with its utilization review requirements, but not more often than once every six months, unless the insured's licensed physician, psychologist, or clinical social worker agrees a more frequent review is necessary or changes the insured's treatment plan.

The act provides that it is not to be interpreted as limiting or affecting (1) other covered benefits under the policy, the state mental and nervous condition insurance law, and the birth-to three coverage law; (2) a board of education's obligation to provide services to an autistic student under an individualized education program in accordance with law; or (3) any obligation imposed on a public school by the federal Individual with Disabilities Education Act.

The act also provides that it must not be interpreted to require a group health insurance policy to reimburse special education and related services provided to an insured under state law that requires boards of education to provide special education programs and services unless state or federal law requires otherwise.

By law, each violation of the act is subject to a fine of up to $1,000. The insurance commissioner may also revoke an out-of-state insurer's license for violating the act.

This takes effect January 1, 2010.

AUTOMATIC EXTERNAL DEFIBRILLATORS

PA 09-94 requires a school board to have at each school in its jurisdiction, if funding is available, (1) an automatic external defibrillator (AED) and (2) school staff trained in its use and in cardiopulmonary resuscitation. The act allows school boards to accept donated AEDs under certain conditions. It also allows boards to accept gifts, donations, and grants for AED acquisition and staff training costs.

It also requires each school to develop emergency action response plans for the appropriate use of school personnel to respond to individuals experiencing sudden cardiac arrest or similar life-threatening emergencies.

This takes effect July 1, 2009.

PA 09-59 provides immunity in a lawsuit for damages for acts arising out of a person's or entity's negligence in providing or maintaining an AED. Existing law already provides immunity for those rendering assistance.

The act specifies that immunity does not apply to gross, willful, or wanton negligence.

This takes effect October 1, 2009.

BIRTH-TO-THREE

PA 09-3, September Special Session (§§ 44-46) increases the fee certain families must pay to participate in the Birth-to-Three program and eliminates the two months of service following enrollment that, by regulation, were previously provided without a fee. It requires the Department of Developmental Services (DDS) to increase the fees by 60%. It also requires DDS to base the fees on the state's, as well as parents', financial resources and periodically to revise its fee schedule.

The law requires DDS to charge a fee for families with gross incomes over $45,000 and permits it to charge parents with lower incomes. But it may not charge any family whose child is eligible for Medicaid. DDS maintains two sliding scale fee schedules, one for families with health insurance and one for uninsured families, based on income and family size. Fees currently range from $15 a month for a family with three or fewer children and no insurance to $310 a month for a family with six or more children and insurance whose income is over $175,000. DDS regulations require the State Interagency Birth-to-Three Coordinating Council to review and make recommendations to DDS about the fee schedule at least every three years.

The law requires group and individual health insurance policies to cover Birth-to-Three services. The act doubles the maximum annual coverage to $6,400 per child and the aggregate, lifetime benefit to

$19,200. It applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to federal law (ERISA), state insurance benefits mandates do not apply to self-insured benefits plans.

This takes effect upon passage.

CHILDREN-STATE FUNDED MEDICAL ASSISTANCE

PA 09-66 expands eligibility for state-funded medical assistance to include children under the Department of Developmental Services' (DDS) voluntary services program who are not receiving, have not yet qualified for, or are ineligible for Medicaid. It also extends these benefits to any child under the Department of Children and Families (DCF) commissioner's supervision who is ineligible for Medicaid, not just those ineligible because of institutional status. By law, children under DCF care who are not receiving or have not yet qualified for Medicaid are also eligible.

The act requires the DDS commissioner, to the extent practicable, to apply on behalf of a child, or help a child in the program qualify for, Medicaid. The law already requires the DCF commissioner to do this on behalf of children under her supervision.

This takes effect July 1, 2009.

CONNPACE PLUS

More low-income seniors and people with disabilities are eligible to participate in the federal Medicare Savings Program (MSP) under a new law (**PA 09-2**) that effectively extends the program to people with incomes as high as the ConnPACE limits ($ 25,100 for individuals and $ 33,800 for married couples in 2009). The Department of Social Services (DSS) pays for MSP participants' Medicare Part A or Part B premiums, or both. And qualifying for MSP also qualifies people for another federal program that pays some or all of their Medicare Part D drug benefit premium and any Part D "doughnut hole" charges. Participants also pay lower co-payments for each prescription.

This takes effect April 1, 2009.

CONTACT LENSES

PA 09-58 allows licensed (1) optometrists authorized to practice advanced optometric care to acquire, prescribe, dispense, and charge for contact lenses containing ocular agents-T and (2) prescribing physicians and surgeons to dispense and sell contact lenses that contain a drug. "Physician," under the act, does not include a homeopathic physician.

The act specifies that optometrists, physicians, and surgeons dispensing or selling contact lenses containing ocular agents-T or drugs do not have to meet requirements of existing law on packaging and labeling of drug containers.

This takes effect October 1, 2009.

CYSTIC FIBROSIS

PA 09-20 requires all health care institutions caring for newborn infants 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.

Under the act, the cystic fibrosis test is in addition to, but separate from, DPH's newborn screening program for genetic diseases and metabolic disorders. That program, in addition to the initial screening test, directs parents of identified infants to appropriate counseling and treatment.

This takes effect October 1, 2009.

EPIDERMOLYSIS BULLOSA

PA 09-51 requires certain insurance policies to cover wound care supplies that are medically necessary to treat epidermolysis bullosa and administered under a physician's direction.

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on and after January 1, 2010 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

Epidermolysis bullosa (EB) refers to a group of rare skin diseases characterized by recurring blisters and open sores.

This takes effect January 1, 2010.

HEALTH INFORMATION TECHNOLOGY

Existing law required DPH to contract for the development of a statewide health information technology (HIT) plan. **PA 09-232** requires DPH to submit the plan to the Public Health Committee by July 1, 2009. By law, the plan must include (1) standards and protocols for health information exchange; (2) standards to facilitate the development of a statewide, integrated electronic health information system for use by state-funded health care providers and institutions; and (3) pilot programs for health information exchange, including costs and funding sources.

This act also designates DPH as the state's lead health information exchange

organization beginning July 1, 2009. It requires DPH to seek private and federal funds, including those available through the federal American Recovery and Reinvestment Act, for the initial development of a statewide health information exchange. DPH can use any private or federal funds it receives to establish health information technology (HIT) pilot programs and grant programs. DPH must (1) assist with implementation and periodic revisions of the HIT plan after its initial submittal, including implementing an integrated statewide electronic health information infrastructure for sharing electronic health information among health care facilities, health care professionals, public and private payors, and patients and (2) develop privacy standards and protocols for sharing this information. These standards and protocols must be at least as stringent as the "standards for privacy of individually identifiable health information" established under the federal Health Insurance Portability and Accountability Act. They must require that individually identifiable health information be secure and access to it traceable by electronic audit trail.

The act also establishes a 12-member health information technology and exchange advisory committee.

This takes effect October 1, 2009.

HIV TESTING

PA 09-133 revises the law on consent for HIV-related testing. Specifically, it:

1. eliminates the requirement for separate, written or oral consent for HIV testing and instead allows general consent for the performance of medical procedures or tests to suffice;
2. reaffirms that HIV testing is voluntary and that the patient can choose not to be tested;
3. eliminates a prior requirement for extensive pre-test counseling for all HIV tests;
4. adds a requirement that an HIV test subject, when he or she receives a test result, be informed about medical services and local or community-based HIV/AIDS support services agencies; and
5. provides that a medical practitioner cannot be held liable for ordering an HIV test under general consent provisions.

This takes effect July 1, 2009.

HOSPITAL-ACQUIRED CONDITIONS

PA 09-206 prohibits hospitals and outpatient surgical facilities from seeking payment for any increased costs they incur as a direct result of a hospital-acquired condition identified as

nonpayable by Medicare according to federal law. This applies regardless of the patient's insurance status or sources of payment (including self-pay) except as otherwise provided by federal law or **PA 09-2, § 8**.

That state law requires the DSS commissioner to amend the Medicaid state plan to indicate that the approved inpatient hospital rates it pays for Medicaid-eligible patients are not applicable to hospital-acquired conditions that the Medicare program identifies as "nonpayable" (also referred to as "never events") in accordance with a 2005 federal law to ensure that hospitals are not paid for these conditions.

Under this act, "hospital" means an acute care hospital subject to the federal inpatient prospective payment system. An "outpatient surgical facility" is an entity, individual, firm, partnership, corporation, limited liability company, or association, other than a hospital, providing surgical services or diagnostic procedures for human health conditions that include use of moderate or deep sedation, moderate or deep analgesia or general anesthesia, as these levels are defined by the American Society of Anesthesiologists or by other professional or accrediting entity recognized by DPH.

This takes effect January 1, 2010.

IMAGING SERVICES

PA 09-206 prohibits specified health care providers from charging patients, insurers, or other responsible third-party payors for performing the "technical components" of CAT scans, PET scans, and MRIs if they, or someone under their direct supervision, did not actually perform the service. The prohibition applies to physicians, chiropractors, podiatrists, naturopaths, and optometrists.

Under the act, radiological facilities and imaging centers must directly bill the patient or third party payor for their services. They cannot bill the practitioner who requested the service.

This takes effect October 1, 2009.

LYME DISEASE

Beginning July 1, 2009, **PA 09-128** allows 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 (1) a clinical diagnosis is made that the patient has Lyme disease or has symptoms consistent with such a diagnosis and (2) the physician documents the diagnosis and treatment in the patient's medical record.

Also beginning July 1, 2009, the act prohibits (1) DPH from initiating disciplinary action

against a physician and (2) the Connecticut Medical Examining Board from taking disciplinary action solely because the physician prescribed, administered, or dispensed long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease. The physician must document the clinical diagnosis and treatment in the patient's record.

The act specifies that, subject to the limits on discipline of physicians treating Lyme disease established by the act, it does not limit the ability of the Connecticut Medical Examining Board to take disciplinary action for other reasons against physicians, including entering into a consent order, for violations of existing law concerning their practice of medicine.

This takes effect July 1, 2009.

MAMMOGRAPHY

PA 09-41 requires all mammography reports (i.e., written results of a mammogram) given to a patient on and after October 1, 2009 to include information about breast density based on the American College of Radiology's Breast Imaging Reporting and Data System (BIRADS). When applicable, the report must include the following notice:

"If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report."

This takes effect October 1, 2009.

PRESCRIPTION EYE DROPS

PA 09-136 prohibits certain health insurance policies that provide prescription eye drop coverage from denying coverage for prescription renewals when (1) the refill is requested by the insured less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill request does not exceed this amount.

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2010 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3)

major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

This takes effect January 1, 2010.

SUSTINET

PA 09-148 establishes 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 act specifies that these recommendations must address:

1. establishment of a public authority or other entity with the power to contract with insurers and health care providers, develop health care infrastructure ("medical homes"), set reimbursement rates, create advisory committees, and encourage the use of health information technology;
2. provisions for the phased-in offering of the SustiNet Plan to state employees and retirees, HUSKY A and B beneficiaries, people without employer sponsored insurance (ESI), people with unaffordable ESI, small and large employers, and others;
3. guidelines for development of a model benefits package; and
4. public outreach and methods of identifying uninsured citizens.

The board must establish a number of separate committees to address and make recommendations concerning health information technology, medical homes, clinical care and safety guidelines, and preventive care and improved health outcomes. The act also establishes an independent information clearinghouse to provide employers, consumers, and the general public with information about SustiNet and private health care plans.

Finally, the act creates task forces addressing obesity, tobacco usage, and the health care workforce.

This takes effect July 1, 2009, except that the sections on identifying uninsured adults and children and Medicaid and public education outreach take effect July 1, 2011, and the three task forces take effect upon passage.

PA 09-3, September Special Session (§ 43) increases membership on the SustiNet Health Partnership board of directors from nine to eleven by adding (1) an individual with expertise in either the reduction of racial, ethnic, cultural and linguistic inequities in health care or multi-cultural competency in the health care

workforce, appointed by the Healthcare Advocate and (2) an individual appointed by the Comptroller.

This takes effect upon passage.

TUBERCULOSIS TREATMENT

Under existing law, individuals with tuberculosis (TB) who require medical care provided by (1) a state chronic disease hospital, (2) a private hospital or clinic, or (3) a physician or other provider, must be seen without regard to the patient's financial condition. The cost of the care and treatment of such patients is computed based on a number of statutory provisions. The state pays these costs if DPH deems them appropriate for TB treatment.

PA-09-3, September Special Session (§§ 51-52) specifically authorizes the DPH commissioner to consider available third-party sources for payment of TB treatment when determining whether to pay for it. By law, if the patient is (1) a veteran and the TB or suspected TB for which the veteran has been hospitalized or treated is a service-connected disability entitling him to medical benefits or (2) eligible for medical benefits under the workers' compensation law or under any private or public medical insurance or payment plan, then the patient or the patient or the patient's obligor is liable for the cost of the care to the extent of such available benefits. The cost of such care must be determined according to the existing statutory process by which the comptroller annually determines the per capita per diem cost for the support of persons in humane institutions.

The act authorizes DPH and DSS to exchange patient information they hold to determine if any patient needing or receiving TB treatment is eligible for Medicaid benefits.

This takes effect upon passage.

ULTRASOUNDS

PA 09-125 prohibits anyone from performing an obstetrical ultrasound procedure unless it is (1) for a medical or diagnostic purpose and (2) ordered by a licensed health care provider acting within the scope of his or her practice.

This takes effect July 1, 2009.

UMBILICAL CORD BLOOD

PA 09-232 requires doctors and other health care providers who provide pregnancy-related care for women during their third trimester to provide the women with timely, relevant, and appropriate information about umbilical cord blood and cord blood banks. The information must be sufficient to allow women to make informed choices about banking or donating their child's cord blood.

This takes effect July 1, 2009.

VETERANS

PA 09-10 requires the Department of Mental Health and Addiction Services to work with the state Veterans' Affairs (VA) Department, not just the Department of Children and Families, to provide transitional behavioral health services for members of any reserve component of the U. S. Armed Forces (and their dependents) called to active duty in Operation Enduring Freedom (Afghanistan) or Operation Iraqi Freedom.

By law, the services are provided to veterans when no Department of Defense (DOD) coverage is available for such services or the veteran is not eligible for them. They must continue until an approved application is received from the federal VA and coverage is available.

This takes effect upon passage.

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