



2009 Chapter-Supported State Legislation

Government Relations Division • 2021 Massachusetts Avenue, NW • Washington, DC 20036

The AAFP Commission on Governmental Advocacy (CGA) is pleased to bring you the 2009 edition of Chapter-Supported State Legislation.

Constituent chapters are encouraged to submit—at any time throughout the year—legislation that is likely to be of interest and relevance to other states. Chapters can help facilitate the selection and review process by providing background or supporting documents, including issue briefs, fiscal notes, etc. Legislation and accompanying materials should be submitted electronically directly to AAFP state government relations staff.

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The legislation is reviewed by members of the CGA Subcommittee on State Government Affairs using the following criteria:

- Does the legislation impact family medicine?
- Is an innovative approach used to address the issue?
- Does the legislation represent a practical approach?

Chapters should keep in mind that the AAFP is not in the position of advocating the enactment of items presented in the SSL volumes. The legislation contained in this publication is offered as an aid to chapters interested in drafting legislation in a specific area and can be looked upon as a guide to areas of broad current interest to family medicine.

The legislation presented is either the enacted form or the most recent revision. Final legislation may have been amended and, therefore, differ from the original filing. AAFP state government relations staff are ready and able to gather earlier versions of each bill for chapters upon request.

Rather than provide chapters one large document, legislation and supporting materials are provided separately. Documents are labeled by year, state, chamber, bill number and document type if applicable (e.g. “Fiscal Note”).

The document “2009 AAFP CSSL Summary” provides a quick summary of each bill’s aims, current status and supporting documents.

We hope this resource proves to be a useful tool in your ongoing advocacy efforts.

American Academy of Family Physicians 2009 Chapter-Supported/Suggested State Legislation

2009 State Legislation

California AB 1201

In addition to creating the Healthy Families Program to provide health benefits to eligible children pursuant to the State Children's Health Insurance Program (SCHIP), AB 1201 requires all health insurers, including the Healthy Families Program, that provide coverage for childhood and adolescent immunizations to reimburse physicians or physician groups in an amount not less than the actual cost of acquiring and administering the vaccine. The legislation also prohibits including a dollar limit provision in policies or charging a deductible, copayment, coinsurance or any other cost-sharing mechanism for the immunization or related procedures.

The bill prohibits contracts between health care service plans and physicians or physician groups from including a provision requiring physicians or physician groups to assume the financial risk for the acquisition costs of immunizations for children, regardless of whether those immunizations are part of the current contract.

Supporting Documents

- AB 1201 Committee Analysis 1
- AB 1201 Committee Analysis 2
- AB 1201 Immunization Access Fact Sheet
- AB 1201 Immunization Payment Fact Sheet

STATUS: PENDING

Indiana HB 1138

HB 1138 establishes the primary care physician loan forgiveness program to provide annual student loan forgiveness payments to qualified primary care physicians the state. To qualify for the program, individuals must:

- (1) be a resident of Indiana;
- (2) be a licensed physician under IC 25-22.5;
- (3) practice as a primary care physician (includes family medicine, pediatrics, obstetrics and gynecology, and internal medicine);
- (4) conduct the majority of the individual's medical practice in Indiana;
- (5) have an outstanding student loan balance at the beginning of the calendar year; and
- (6) be approved by the commission.

Supporting Documents

- HB 1138 Fiscal Note

STATUS: NOT ENACTED

Indiana SB 216

SB 216 requires the state department of health to conduct a study to determine:

- (1) the number of health clinics in the state;
- (2) the number of health clinics that are regulated by the state;
- (3) the adequacy of the state regulations for health clinics; and
- (4) whether any additional standards are necessary.

The legislation includes the following in its definition of “health clinic:”

- (1) a retail merchant that includes a health care clinic located on the premises that offers episodic health care for patients; and
- (2) a clinic that provides health care to individuals without an appointment, including those operating under a hospital licensed under IC 16-21. The term does not include a physician’s office that predominately provides health care to patients who schedule an appointment with a physician.

Supporting Documents

- SB 216 Fiscal Note

STATUS: NOT ENACTED

North Carolina S 877

S 877 requires all contracts between an insurer and a health care provider to contain a “notice contract” provision listing the contact information for the person to whom all correspondence, including proposed amendments and other notices, shall be provided. All proposed contract amendments must be dated, labeled “Amendment,” signed by the insurer, and sent to the designated individual with the proposed effective date.

Health care providers receiving a proposed amendment shall have at least 60 days from the date of receipt to object in writing. If the provider does not object within 60 days, the amendment will take effect on the given date. If the provider objects to the proposed amendment, it will not take effect and the insurer is permitted to terminate the contract after 60 days of receiving written notice from the provider.

The bill also requires insurers to provide a copy of its policies and procedures to a health care provider prior to execution of a new or amended contract and annually to all contracted providers. These policies and procedures cannot conflict or override any term of a contract, including fee schedules, and in the case of a conflict, the contract language shall prevail.

Supporting Documents

- NC S 877 Fiscal Note

STATUS: ENACTED

Nebraska LB 396

LB 396 establishes a medical home pilot program for Nebraska Medicaid recipients. The bill limits medical home provision to primary care physicians, defined as general medicine, family medicine, pediatrics and internal medicine. The program is scheduled to run from January 1, 2012 to June 1, 2014 and conform to broad goals outlined in the bill as well as guidelines drafted by the Medical Home Advisory Council created by 396.

Supporting Documents

- LB 396 Fiscal Note
- LB 396 Intent Statement
- LB 396 Committee Statement

STATUS: ENACTED

New York A 158B

A 158B authorizes the commissioner of health to certify certain clinics and clinicians as health care homes with the intent to improve health outcomes and efficiency through patient care continuity and coordination of health services. Participating providers will be eligible for enhanced payments for services provided to enrollees of: Medicaid fee-for-service; Medicaid managed care; Family Health Plus organizations; and Child Health Plus.

The legislation also requires the commissioner of health to develop and implement standards of certification for patient-centered medical homes (PCMHs), taking into consideration the standards developed by the national accrediting and professional organizations and consulting with national and local organizations. Subject to the availability of funding, the commissioner is authorized to pay enhanced rates of payment to clinics and clinicians that are certified PCMHs and to pay additional amounts for those that meet specific process or outcome standards specified by the commissioner.

The bill also allows the commissioner of health to establish an Adirondack medical home multipayor demonstration project, which will encourage cooperative, collaborative and integrative arrangements between payors and providers of health care services. To the extent that such arrangements might be anti-competitive, state action immunity is provided under the state and federal anti-trust laws. Participation in the Adirondack medical home multipayer demonstration program shall be on a voluntary basis.

Supporting Documents

- NY A 158B Summary

STATUS: ENACTED

New York A 4301

A 4301 allows health care providers practicing within the service area of a health care plan to meet and communicate for the purpose of collectively negotiating:

- (a) the details of the utilization review plan;
- (b) coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage;
- (c) the definition of medical necessity;
- (d) the clinical practice guidelines used to make medical necessity and utilization review determinations;
- (e) preventive care and other medical management practices;
- (f) drug formularies and standards and procedures for prescribing off-formulary drugs;
- (g) respective physician liability for the treatment or lack of treatment of covered persons;
- (h) the details of health care plan risk transfer arrangements with providers;
- (i) plan administrative procedures, including methods and timing of health care provider payment for services;
- (j) procedures to be utilized to resolve disputes between the health care plan and health care providers;
- (k) patient referral procedures including, but not limited to, those applicable to out-of-pocket network referrals;
- (l) the formulation and application of health care provider reimbursement procedures;

- (m) quality assurance programs;
- (n) the process for rendering utilization review determinations; and
- (o) health care provider selection and termination criteria used by the health care plan.

The bill specifies that collective negotiation rights granted by this title must conform to the following requirements:

- (a) health care providers may communicate with other health care providers regarding the contractual terms and conditions to be negotiated with a health care plan;
- (b) health care providers may communicate with health care providers' representatives;
- (c) a health care providers' representative is the only party authorized to negotiate with health care plans on behalf of the health care providers as a group;
- (d) a health care provider can be bound by the terms and conditions negotiated by the health care providers' representatives; and
- (e) in communicating or negotiating with the health care providers' representative, a health care plan is entitled to contract with or offer different contract terms and conditions to individual competing health care providers.

The legislation also requires that before engaging in collective negotiations with a health care plan on behalf of health care providers, a provider's representative must file with the commissioner.

Supporting Documents

- NY A 4301 Summary

STATUS: PENDING

Ohio HB 198

HB 198 aims to create a patient-centered medical home demonstration project. Of note in this bill are the opening lines of the medical home section: "The demonstration project shall be operated to evaluate the medical home model of care, as that model of care is defined by the American academy of family physicians." The legislation aims to create a medical home pilot program in the Dayton, Ohio metropolitan area. The bill does not attempt to define the medical home, but rather states that physician practices must, "be capable of adapting the practice during the demonstration project in such a manner that it is fully compliant with the minimum standards for a patient-centered medical home, as those standards are determined by the [N]ational [C]ommittee for [Q]uality [A]ssurance." The demonstration is limited to Dayton and Lucas County, "...physicians who are board-certified in family medicine, general pediatrics, or internal medicine, as those designations are issued by a medical specialty board of the American medical association or American osteopathic association." The program includes practice supports such as training, technical assistance, and reimbursement for some of the cost of acquiring and learning to use appropriate medical home-related health information technology. The bill also includes a primary care practice scholarship, called Choose Ohio First scholarships, for medical students who commit to three years of primary care practice in Ohio, accept a to-be-determined percentage of Medicaid patients, and identify specific medical home training opportunities during medical training. The bill further allocates funds to the scholarship program and the medical home demonstration

program over SFY 2010 and 2011. The scholarship funds go to a family practice account and are noted to be used for the purposes of advancing the medical home.

Supporting Documents

- HB 198 Fiscal Note
- HB 198 House Analysis

STATUS: PENDING

Oregon SB 457

SB 457 requires specified healthcare workforce regulatory boards (Occupational Therapy Licensing Board, Medical Board, Board of Nursing, Board of Dentistry, Physical Therapist Licensing Board, State Board of Pharmacy, and Board of Examiners of Licensed Dietitians) to collect information from licensees and report information to the Office for Oregon Health Policy and Research for creation of a healthcare workforce database. Healthcare workforce regulatory boards are required to keep certain collected information confidential.

The Office for Oregon Health Policy and Research is tasked with creating and maintaining a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's healthcare workforce, including:

- (a) Demographics, including race and ethnicity;
- (b) Practice status;
- (c) Education and training background;
- (d) Population growth;
- (e) Economic indicators; and,
- (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to healthcare education.

The legislation passed after being folded into a larger health reform measure.

STATUS: ENACTED

Texas HB 1342

HB 1342 requires health plans to provide information to physicians at the point of care about what services are covered, the amount of the patient's co-pay and deductible and what the patient's out-of-pocket costs will be for services provided.

Supporting Documents

- HB 1342 Fiscal Note
- HB 1342 House Analysis
- HB 1342 Senate Analysis (Initial)
- HB 1342 Senate Analysis (Post-Amendment)

STATUS: ENACTED

Texas HB 2154

HB 2154 raised the smokeless tobacco excise tax to raise nearly \$102 million in new revenue. About \$22 million of that will go to fund the new primary care physician medical student loan repayment program, which will provide up to \$160,000 for primary care physicians who agree to practice for four years in health professional shortage areas. The TX AFP estimates that the bill should

bring as many as 225 physicians to health professional shortage areas each year. Administration of the new program will be the responsibility of the Texas Higher Education Coordinating Board.

Supporting Documents

- HB 2154 Fiscal Note
- HB 2154 House Analysis
- HB 2154 Senate Analysis (Initial)
- HB 2154 Senate Analysis (Post-Amendment)
- Two TX AFP Issue Briefs

STATUS: ENACTED

Utah HB 165

The legislation changes the way hospitals and health care providers send information and billing to patients and creates a health care delivery and payment pilot project. The measure also moves the state toward standardized swipe card technology for insurance cards that will allow patients and providers to access information about deductibles, copayments and insurance status.

Supporting Document

- HB 165 Fiscal Note

STATUS: ENACTED

Utah HB 188

The bill creates a new health plan, called NetCare, that insurers will be able to offer at one-half to one-third the cost of the average large-group health insurance premium. The plan will be exempted from certain state coverage mandates and will include wellness incentives, higher deductibles and caps on preventive care. The measure also allows small employers to give workers the choice of enrolling in an employer-sponsored health plan or using an employer contribution to purchase coverage on their own. Insurance companies would be required to cover workers regardless of pre-existing health conditions, and the Utah Health Re-Insurance Pool would provide assistance to insurers who experience a spike in costly claims. In addition, the legislation allows employers to offer NetCare rather than COBRA as an option for state residents transitioning from group coverage to individual health plans.

Supporting Document

- HB 188 Fiscal Note

STATUS: ENACTED

Utah SB 79

The bill increases the level of evidence plaintiffs must show for emergency department-related medical malpractice claims. In addition, the bill strengthens Utah's licensing laws to increase oversight of out-of-state medical expert witnesses.

Supporting Document

- SB 79 Fiscal Note

STATUS: ENACTED

Washington SB 5891

SB 5891 aims to allay some in the private insurance industry's concern over possible violations of antitrust law while taking part in multi-payor patient-

centered medical home demonstrations. The bill attempts to create a “safe harbor” for primary care providers to discuss payment methodologies with public and private payors. The legislation exempts participants from state antitrust law and invokes the state action doctrine to (hopefully) stave off federal antitrust action. The exemption contains a “good faith” caveat that, “[t]he legislature does not intend and does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services.”

STATUS: ENACTED

Wisconsin AB 75

AB 75, a state appropriations bill, contained a medical home pilot program provision. The Wisconsin AFP played a key role in recommending and developing the provision with the state legislature. The language directs the WI Department of Health and Family Services to develop a proposal to increase payment to providers in the medical assistance program (Medicaid) that are NCQA-certified patient-centered medical homes or that conform to standards developed by the Secretary of WI DHFS. The Secretary is directed in development of unique standards to consider aspects of care that follow closely the NCQA model. The Department is further directed to set payment levels at a level that, along with a to-be-determined monthly per-patient care coordination fee, will encourage providers to become a patient-centered medical home. A review of the program is ordered to begin at 39 months after the effective date of the statute.

STATUS: ENACTED

West Virginia SB 414

The legislation defines the medical home as, “...a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient centered medical home integrates patients as active participants in their own health and well being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include but is not limited to nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology.” The bill provides for the study of pilot programs to testing four different medical home models:

1. a chronic care model (focusing on smaller practices),
2. individual medical homes (focusing on larger practices),
3. community centered medical homes (focusing on linking primary care practices with community health teams), and,
4. medical homes for the uninsured (focusing on providing uninsured patients with primary and preventive care).

The bill also created the Governor's Office of Health Enhancement and Lifestyles Planning (GO-HELP) Advisory Council. Among the Advisory Council's tasks is advising GO-HELP on its overall health reform initiatives, particularly the medical

home pilot programs created in SB 414. By statute, a seat on the council is designated for a representative of the West Virginia Academy of Family Physicians.

STATUS: ENACTED

2009 Chapter Initiatives

North Carolina DNR and Medical Order for Scope of Treatment (MOST)

Submitted by the Georgia Academy of Family Physicians. The GA AFP is attempting to have similar legislation enacted in their state and uses the NC DNR/MOST statute as their model.

2001 North Carolina S 703

Established North Carolina's Do Not Resuscitate (DNR) statute.

2007 North Carolina H 634

Expanded DNR statute to include Medical Orders for Scope of Treatment (MOST), clarified the statute's relation to other statutes, and established the content and form of legal DNR/MOST documents.

Supporting Materials

- Background paper on medical orders for scope of treatment
- Current NC physician practice statute on DNR/MOST