

Legislative History for Connecticut Act

**PA 14-180**

HB5535

|               |   |     |
|---------------|---|-----|
| House         | 4691-4697, 4832-4943  | 119 |
| Senate        | 3461, 3475, 3480-3481   | 4   |
| Public Health | 1400-1412, 1413-1415,<br>1419-1423, 1426-1436,<br><u>1500-1501, 1894-1910</u> | 51  |

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GENERAL ASSEMBLY  
HOUSE**

**PROCEEDINGS  
2014**

**VOL.57  
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4451 – 4808**

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House Calendar 283 on page 9, favorable report of the joint Senate committee on Public Health. Substitute House Bill 5535, AN ACT CONCERNING NOTICE OF PATIENTS'

OBSERVATION STATUS AND NOTICE CONCERNING THE QUALIFICATIONS OF THOSE WHO PROVIDE HEALTH CARE AND CONSULTING SERVICES.

DEPUTY SPEAKER BERGER:

Representative Johnson, madam.

REP. JOHNSON (49th):

Good afternoon, Mr. Speaker. I move the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER BERGER:

Motion before the Chambers acceptance of the joint committee's favorable report and passage of the bill.

Please proceed, madam.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This bill has LCO Number 4636. I ask that this LCO Number be called and I be given leave of the Chambers to summarize.

DEPUTY SPEAKER BERGER:

Will the Clerk please call LCO Number 4636 which will be designated House Amendment Schedule "A."

THE CLERK:

House "A," LCO 4636 offered by Senator Johnson et al.

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-- Representative Johnson et al.

DEPUTY SPEAKER BERGER:

Representative seeks leave of the Chamber to summarize this amendment. Is there objection to summarization? Is there objection? Seeing none, please proceed with your summarization, madam.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This amendment strikes out Section Number 2 in its entirety. I move adoption.

DEPUTY SPEAKER BERGER:

Motion before the Chamber is adoption of House Amendment Schedule "A", LCO 4636

Will you remark further on House Amendment Schedule "A." Representative Srinivasan of the 31st, sir. You have been acknowledged, Representative. Do you wish to comment on House Amendment Schedule "A"?

REP. SRINIVASAN (31st):

Good afternoon, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Yes, sir, good afternoon.

REP. SRINIVASAN (31st):

I rise in strong support of this amendment. This amendment takes care of the most important part -- an important part when a patient is in an observation status

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in an emergency room and at that particular point what happens when they're discharged, you know, what happens to that is what we've been talking about.

But before that in the strike -- the strike amendment of Section "B," what we're trying to do is making sure that we -- yeah, the second Section 2 that we are trying to strike here, you know, wants to make sure that we are focusing on the critical part which is the observation status of the patient. Through you, Mr. Speaker, I rise in strong support of this amendment.

DEPUTY SPEAKER BERGER:

Thank you, sir

Will you comment further on House Amendment Schedule "A"? Will you comment further on House Amendment Schedule A? If not, I will try your minds. All those in favor of House Amendment Schedule "A" signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER BERGER:

Opposed? The ayes have it. The amendment passes

Will you comment further on the bill as amended?

Will you comment further on the bill as amended?

Representative Johnson.

REP. JOHNSON (49th):

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Thank you, Mr. Speaker. I also will be calling LCO  
Number 4926.

DEPUTY SPEAKER BERGER:

Will the Clerk please call LCO Number 4926? 4926,  
I'm sorry. House "B."

THE CLERK:

House "B," LCO -- you know what, excuse me, I don't  
have 4926, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Will the Chamber please stand at ease.

(Chamber at ease).

THE CLERK:

I have 5012.

REP. JOHNSON (49th):

Yes, sir, Mr. Speaker, I'm calling LCO Number 5012.

DEPUTY SPEAKER BERGER:

Will the Clerk please call LCO Number 5012, sir.  
Designated House Amendment Schedule "B."

THE CLERK:

House Amendment Schedule "B," LCO 5012 introduced by  
Representative Johnson, Representatives Srinivasan, and  
Senator Gerratana.

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DEPUTY SPEAKER BERGER:

Thank you. The House chair seeks leave of the Chamber to summarize the amendment.

REP. JOHNSON (49th):

Thank you so much, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Please summarize, madam.

REP. JOHNSON (49th):

Yes, so this bill is actually now a bill that just concerns, as the good ranking member said, the observation status of patient when they go into a hospital. What's been happening, Mr. Speaker, is that patients have been going into the hospital and they have not been admitted. They've been placed on the observation status.

And what happens when the patient goes into the hospital and is placed on observation status, and is not admitted to the hospital, a number of things with respect to their insurance coverage, for their medications, whether they're private insurance companies or whether they're Medicare Part D, they could be put in a situation where they would have to pay for their medications themselves.

Also, if they're on observation status, they could find -- and they're there for three days or more, and need

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to go to a skilled nursing facility, their Medicare coverage will be denied. So what happens is they lose their access to their health insurance coverage by being placed on observation status.

What this bill will do now is it will simply make sure that the hospital is in a situation where they will notify the patient that they're not going to be admitted, but they're going to be placed on observation status.

And the amendment clarifies the original language so that we will know that a notice will be given within the first 24 hours of the patient being placed on observation status.

And that circumstance, that is -- that is exactly what will happen. The notice will be there and we will -- we will have the patient get the notice, and I move adoption, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Will the Chamber please stand at ease.

(Chamber at ease).

DEPUTY SPEAKER BERGER:

Representative Aresimowicz.

REP. ARESIMOWICZ (30th):

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Yes, good afternoon Mr. Speaker. Mr. Speaker, I move  
we pass this bill temporarily.

DEPUTY SPEAKER BERGER:

Without objection, the bill is passed temporarily

Will the Clerk please call House Calendar Number 440.

THE CLERK:

On page 21, House Calendar 440, favorable report of  
the joint Senate committee on Judiciary, Substitute Senate  
Bill 209, AN ACT PROHIBITING UNSOLICITED COMMERCIAL TEXT  
MESSAGES AND INCREASING PENALTIES FOR VIOLATION OF THE DO  
NOT CALL REGISTRY.

DEPUTY SPEAKER BERGER:

Representative Baram.

REP. BARAM (15th):

Good afternoon, Mr. Speaker. I move for acceptance  
of the joint committee's favorable report and passage of  
the bill in concurrence with the Senate.

DEPUTY SPEAKER BERGER:

Motion before the Chamber is acceptance of the joint  
committee's favorable report, passage of the bill in  
concurrence with the Senate. Please proceed, sir.

REP. BARAM (15th):

Thank you, Mr. Speaker. This bill allows a consumer  
to place on the Do Not Call List for the State of

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THE CLERK:

S.B. 363 in concurrence with the Senate.

|                             |     |
|-----------------------------|-----|
| Total number voting         | 149 |
| Necessary for passage       | 75  |
| Those voting Yea            | 149 |
| Those voting Nay            | 0   |
| Those absent and not voting | 2   |

DEPUTY SPEAKER BERGER:

The bill is passed, in concurrence with the  
Senate.

Will the Clerk please call Calendar Number 283.

VOICES:

Calendar eight-what?

DEPUTY SPEAKER BERGER:

Two-eight-three.

THE CLERK:

House Calendar 283, on page 9, favorable report of the joint standing Committee on Public Health, Substitute House Bill 5535, AN ACT CONCERNING NOTICE OF PATIENT'S OBSERVATION STATUS AND NOTICE CONCERNING THE QUALIFICATIONS OF THOSE WHO PROVIDE HEALTH CARE AND COUNSELING SERVICES, previously passed.

DEPUTY SPEAKER BERGER:

Representative Johnson, you were recognized. We

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will both try this together, Representative.

REP. JOHNSON (49th):

Thank you so much, Mr. Speaker.

And I move the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER BERGER:

The question is acceptance of the joint committee's favorable report and passage of the bill.

Please proceed, ma'am.

REP. JOHNSON (49th):

Mr. Speaker, the Clerk is in possession of an amendment, LCO 5012, previously designated House "B." I would ask that the Clerk call the amendment.

DEPUTY SPEAKER BERGER:

Will the Clerk please call LCO Number 5012, previously designated House "B."

THE CLERK:

House "B," LCO 5012, as introduced by Representative Johnson, et al.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Mr. Speaker, I would ask that the amendment be withdrawn.

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DEPUTY SPEAKER BERGER:

Madam, the amendment is withdrawn.

REP. JOHNSON (49th):

Thank you --

DEPUTY SPEAKER BERGER:

Representative --

REP. JOHNSON (49th):

-- so much.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker, much appreciated.

The Clerk is in possession of an amendment, LCO 4926. Would the Clerk please call the amendment and then I be granted leave to summarize.

DEPUTY SPEAKER BERGER:

Will the Clerk please call LCO Number 4926, which will be designated House "C," sir.

THE CLERK:

House "C," LCO 4926, introduced by Representative Johnson, et al.

DEPUTY SPEAKER BERGER:

The Representative seeks leave of the Chamber to summarize the amendment. Is there objection to

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summarization?

Seeing none, please proceed with your  
summarization, ma'am.

REP. JOHNSON (49th):

Mr. Speaker, this amendment simply makes clear  
the time frame in which the hospital must present the  
notice, which is the subject of the -- and bill.

So I move adoption.

DEPUTY SPEAKER BERGER:

The motion before the Chamber is adoption of  
House "C."

Will you comment on House "C?"

Representative Srinivasan of the 31st, sir.

REP. SRINIVASAN (31st):

Good afternoon, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Good afternoon, sir.

REP. SRINIVASAN (31st):

Mr. Speaker, I just want to make sure because of  
what happened, just not too long ago, that we're all  
on the same page and we are now discussing LCO 5012.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Please proceed. We are on LCO 4926, sir.

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"B," LCO "B," 5012 has been withdrawn, sir.

REP. SRINIVASAN (31st):

Thank you.

DEPUTY SPEAKER BERGER:

Okay.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

I just wanted to be clear that 5012 was withdrawn, and hence we're talking on 4926.

DEPUTY SPEAKER BERGER:

That is correct, sir.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

Through you, Mr. Speaker, just a few questions to the proponent of the amendment.

DEPUTY SPEAKER BERGER:

Please proceed, sir.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, in line 5 we're now inserting unless such patient has been discharged or has left the hospital prior to the expiration of the 24-hour period.

Through you, Mr. Speaker, the discharge is from where, Mr. Speaker? Is it at the hospital or is it

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from the emergency room?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, there is no admission so there was no discharge.

What this bill does -- and I appreciate the good ranking member's question -- what this bill does is it provides notice to people who were put on something called "observation status." And they could actually be in anywhere in the hospital. They could be in the emergency room or they could be located in another part of the hospital.

The problem has been that people who are on observation status are in a situation where they don't know that they're in observation status. And so when they're in observation status and they don't know that, some things can happen that are adverse to their circumstances.

One thing that can happen is their insurance company may not pay for their medications, or if they're under Medicare Part D, the Medicare Part D Medication Program will not pay for their medications,

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or if they're under observation status for three days and they would have otherwise qualified for a nursing facility coverage under the Medicare program, they will be denied that coverage. So the reason for the notice is to make sure people understand that they're on observation status and they have not been admitted to the hospital.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, Representative.

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, so that I'm clear, are we talking about the amendment alone or are we also including the underlying bill?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson on LCO 4926.

REP. JOHNSON (49th):

An excellent question, thank you. I thank my ranking member. We are talking about the amendment which speaks specifically to receiving the notice within a 24-hour period.

Through you, Mr. Speaker.

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DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So, through you, Mr. Speaker, if some -- if a patient has been discharged from the hospital from the emergency room, has not been admitted, or if the person leaves the hospital prior to the expiration of the 24-hour period, in that situations, the person would not be needed to give this letter or be told that they are in observation status.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, that's an excellent observation. That's absolutely correct.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

And I want to thank the good chairwoman for the choice of word, because that's what you're talking about here, observation and observation status, so

that was a good choice of word, Madam Speaker --  
Chairwoman.

Mr. Speaker, sometimes I'm not sure if this amendment goes far enough, and I just wanted to clarify that. A person could be admitted in the hospital through the process, through due process. The admitting physician obviously feels that the patient needs admission, and then, admission happens. The patient is discharged after whatever it is, a week or two or whatever the time period in the hospital.

Years go by or months go by, and sometimes I've heard -- and I want to make sure we address -- that the RACs, that is the Recovery Audit Contractors, people who are contracted to come and look at the charts and just make sure that the admission was appropriate and claimed the money back from Medicare, by and large if the, if the admission in their opinion was inappropriate.

So would this apply if any way, what we're talking about in this amendment to people who are admitted in hospital and later on found that they should have not been admitted through the RAC program?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you for the question. This has absolutely nothing to do with the audit procedures or any of that thing. The whole purpose of this is to make sure people are aware of whether or not they've been admitted so that they'll be entitled to their benefits or if they're, if they haven't been admitted, then they won't be entitled to their benefits.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, when a person is in the hospital emergency room for less than 24 hours and has left the emergency room, discharged to go home, as I see the amendment, would they be given anything at the time of the discharge with regards to having been observed for a certain period of time?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the 24-hour period, the

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notice is given within the 24-hour period, so that would be only if they're in observation status. If they're not in observation status and they've been admitted, then they would be discharged as such.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, the good chairwoman talked about things that may not be covered, you know, when they are, quote, unquote, in this observation status, like their medications. And we heard, Mr. Chairman, in the public hearings that a simple tablet of aspirin could cost hundreds of dollars or at least into the thirties and 40 dollars for a tablet of aspirin in these situations in a hospital. So it is very important, very critical that our patients are aware, that will their medications be covered, medications not be covered, and all the other procedures that happen in the emergency room, are they covered or not covered.

Through you, Mr. Speaker, when the person is discharged within the 24 hour period, would they have to worry that they have been discharged within 24

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hours, that what treatment they received in the hospital prior to discharge -- they're not in observation status. They're not admitted -- but do they have to worry that some part of their bill, whether it be the medications, whether it be the procedures that were done, x-rays, block tests, whenever is done in an emergency room, that they may not be covered?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the idea that they would not be covered, they would really depend on some of the different types of coverage plans that -- that are made available to people.

But if we're talking about Medicare, then you'd have to have a determination as to whether or not the visit to the emergency room was appropriate. But none of the issues that come about from the problem with observation status would be a part of that analysis.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

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REP. SRINIVASAN (31st):

So through you, Mr. Speaker, in that case when the patient is discharged, if they have adequate coverage or the appropriate coverage through Medicare, that patient can go home, be relieved, and be comforted by the thought that a bill will not arrive in the mail sometime.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so if you're in a hospital and -- or at, rather -- if you've been, you went to the emergency room and you leave the emergency room after seeing someone there, that all depends on the level of care and what the determination is.

But that, the -- the point of this is when people are in a hospital for an extended period of time and have not been admitted and they think that they're an inpatient. So that's what this bill addresses. It addresses people who think they might be an inpatient but they never knew that they were not. And so that's what we're trying to get at here, not whether you're been in the emergency room and you might or might not

have been there appropriately.

What we're trying to address here is the fact that you're there in the hospital, for some reason, you think you've been admitted but the doctor has not admitted you. And we want to make sure that the person who's in that circumstance would be notified that they have not been admitted.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, and the last question on the amendment to the good chair, that if the person, the patient in the emergency room has been discharged and has been there within the 24-hour period, so it's not crossed that limit where they have to worry about observation status, nonobservation status, they're well under the 24-hour period. Let's say for discussion's sake, about 22 hours is where they are prior to discharge.

But through you, Mr. Speaker, as we all know, between the time that a discharge is actually written by the attending physician but the doctor there or who was taking care of the patient -- it could with a PA,

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it could be an APRN that is discharging the patient, whoever discharges the patient, but technically, mechanically the patient does not leave the emergency room for another couple of hours. You know, they -- they need a ride or they need certain things checked out, and the final physical leaving of the hospital, of the emergency room is beyond 24 hours. In that case, not that they were there for 24 hours -- medically they were only for 20 or 22, but physically they were there for a longer period of time -- would then they'd have to worry, quote, unquote, that they could be in observation status where some of these things that I'm sure we're going to talk about at length when we discuss the underlying bill, would they have to worry that they are in observation status?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, observation status really is -- is a problem when we need to have a determination as to whether or not somebody is admitted. So if there was no problem in terms of the, whether or not the person was admitted for qualifying

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for those types of services that might otherwise be covered in their insurance policy, then that would not be a problem.

However, if it would be a situation where they need to be admitted to qualify for their -- their insurance coverage, then that could be a problem. So we need to -- that's why we wrote the language more tightly and we had it, the notice provided within the 24-hour period. So -- so within 22 hours if they're still there, you know, at some point when you hit the 24-hour point, that notice should be in the hand of the person.

But, you know, in terms of when they finish care and when they don't finish care, I -- I don't have an answer for that.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Mr. Speaker, would it be fair to say to the good chairwoman that if the medical discharge from a medical point of view, not the mechanical point of view but the medical point of view, the discharge is within 24 hours, as I said earlier, 22, then they

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would qualify and not have to worry at all, quote,  
unquote, about their being in observation?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, as long as the note, as  
long as they're there, you know, within the 24-hour  
period and the notice is given within the 24-hour  
period, that's -- that's what we have to be focused  
on.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

And I want to thank the good chairwoman for "A,"  
the amendment, which it definitely makes the bill  
stronger, clarifies a lot of things in the bill, in  
the underlying bill, which we'll be talking about, and  
I want to thank you very much for your answers.

Thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, sir.

Representative -- Representative Betts of the 78th, sir. Do you wish to speak on the House "C," sir?

REP. BETTS (78th):

Yes, sir. Good afternoon, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Good afternoon, Representative.

REP. BETTS (78th):

A question through you to the proponent of the amendment?

DEPUTY SPEAKER BERGER:

Please proceed, sir.

REP. BETTS (78th):

Yes. I have a question dealing with people who are placed in the hospital and they are under observation. If the person is under observation, and let's say they're in there because they may be having a drinking problem, you know, maybe drying out or they may be having a psychological problem, where they need some psychiatric care and they are supposed to be given a notice, as I understand, to sign, to make sure they're aware of the fact it's under observation. What happens when they are shifted to another unit within the hospital but they are not discharged; in

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other words, they might have been transferred but they're still within the hospital. Is that considered to be a discharge, a transfer or what happens under that circumstance?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, that's a very excellent question. You know, this is the whole reason for the bill. The bill is going to make it clear exactly what the status of the patient is.

Right now, someone can go into a hospital facility and not know whether they're in observation status or whether they've been admitted. They can be moved from an emergency room to some other part of the facility and still be on observation status. So this notice will clarify that for the patient.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Betts.

REP. BETTS (78th):

Thank you. That's very helpful.

In this process, though, you're under

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observation. If I heard the good chairlady correctly, the -- the observation form does not have to be signed in the emergency room, it can take place at another unit within the hospital, that the criteria is the 24 hours as opposed to where you are when you first come into the hospital.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you so much.

That's correct. It really will be wherever you are within that 24-hour period, as long as the notice is provided to you. Wherever the hospital has decided to move you to, that would be where you would get your -- your notification.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Betts.

REP. BETTS (78th):

Thank you very much, and thank you for that answer.

Is the primary motivation for this legislation having to do to ensure that the patient has insurance

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coverage?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Yes. The primary motivation is to make sure that whenever there is a -- a situation where somebody might have a private insurance coverage policy or a Medicare-coverage situation, that they are aware, because there are certain standards for coverage.

So one of the simplest ones that you can think of is that there is a three-day hospital requirement, inpatient hospital requirement in the Medicare law, that if you're discharged from the hospital to the skilled nursing facility, that you would have that three-day, inpatient care.

And so what happens is if the person is in the hospital under observation status and they've never been admitted, then what will happen is they won't get the three-day hospital requirement met, and they won't be in a situation where they'll be able to get Medicare coverage for the skilled nursing facility days, which could be up to a hundred days, it could be several thousand dollars. So people are missing out

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on that opportunity.

Through you, Mr. Speaker

DEPUTY SPEAKER BERGER:

Representative Betts.

REP. BETTS (78th):

Thank you very much, Mr. Speaker.

And what happens in the bill -- I know that we're talking about the amendment but it also says in the bill -- that it says oral and written notification. What happens if they were just orally informed that they're under observation or let's just -- we'll say under that circumstance? Does that meet the criteria that's been outlined in this bill?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, I think that that would be really hard to prove down the road that you received the notice, if it was simply oral. But I think it's nice to be able to speak to somebody as they're giving them the notice in writing, so that they have something they could take with them.

Through you, Mr. Speaker.

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DEPUTY SPEAKER BERGER:

Representative Betts.

REP. BETTS (78th):

Okay. Thank you very much, for those answers. I appreciate it. And I thank you for your time and thank the good chairlady for her answers.

DEPUTY SPEAKER BERGER:

Thank -- thank you, sir.

Representative O'Neill, you wish to ask questions or speak on the amendment, sir?

REP. O'NEILL (69th):

Yes. Thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Please proceed, sir.

REP. O'NEILL (69th):

Just a couple of questions, I think.

In following the discussion and about this amendment, I mean the -- the key element here is -- or two key elements are that the patient has been discharged or has left the hospital prior to the 24-hour period. And in following the discussion about people being admitted or not admitted to the hospital, it seems like that's a critical element, that that's really what this, the underlying bill is about and

this is meant to modify that.

In the use of the word "discharge," does that have some sort of technical meaning in terms of hospital usages or is there a definition of what discharged means? Is admission to the hospital a precondition for discharge? Let me ask that.

Through you, Mr. President.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, well, it's -- the discharge is if you're admitted to the hospital, then, you can be discharged. If -- if, so if you're an inpatient, you can be discharged. So but you're not an inpatient, necessarily, when you're in an emergency room situation and you're discharged in those circumstances. So -- so it is a very excellent point the good representative raises, but I think that's pretty much why both -- both words are there.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

REP. O'NEILL (69th):

Okay. Well, I'd just like to -- to focus. If a

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patient is not admitted to the hospital, is it possible -- which is a precondition, I think, that's within in the bill, the underlying bill is that you're not admitted -- you're under this observation status? So can someone be not admitted to the hospital and then still be discharged?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the -- the fact is, is that if you're in an emergency room situation, you're discharged from the emergency room. When you're in it, when you're in a situation where you're not admitted to the hospital because you're, if you're in an emergency room situation, you're not admitted to the hospital, you're just in the emergency room.

So you would have, and as the language says, and as we -- so we have discharged or has left the hospital prior to the expiration of the 24-hour period -- so you can leave without being discharged. But you can also have a, some type of a situation where you're in an emergency room and you are, you are discharged with a plan of care to leave there but that you're not

an inpatient in the hospital.

I hope that makes it clear to the good representative.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

REP. O'NEILL (69th):

Not entirely. Maybe there's a distinction. Just let me start with this: Is it possible or when people go to the emergency room, are they admitted to the emergency room but not admitted to the hospital? Are those two, separate types of admissions?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

In terms of the way that many insurance policies are read, you have to be an inpatient in a hospital, which is a different, a different level of care, a different, a different way of looking at what the process is that the patient is going through when they go to the emergency room or they're in observation status or they're actually admitted.

The problem that we are trying to address, which has been a problem throughout the country in a number

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of, number of places, and to the extent that has been a problem in New York State, they passed similar legislation, is that people will go into the hospital and they think that they're an inpatient but they're not an inpatient. And so they think they've qualified for the coverage that they're supposed to have. And, in fact, unless they are determined to be an inpatient by the medical records and the treating doctor, then they are not considered to be an inpatient. So what this bill does is it tries to make sure that we're able to address the -- the inpatient situation.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

I -- I think I understand it. That's the -- the overall mission of the -- of the bill. But, you know, sort of focusing on the -- the amendment, which is basically carving out an exception to the new rule that the bill is to establish, which is that if you're, if you depart from the hospital in less than 24 hours or within the 24-hour period, then they never have to give you that notice that you were not an

inpatient person.

So I'm trying to figure out if, since the use of the word "discharged" seems to imply that you were admitted into the hospital, if you are, if you are admitted, does that make you an inpatient person, an inpatient patient?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you so much, Mr. Speaker, and thank you for the question.

So you have the word "discharged" and you also have "or has left the hospital," so that would cover both -- both types of analysis. So we wouldn't be concerned as much about whether or not this is applying to a situation with respect to admission, because obviously, as the good representative has pointed out, when you're admitted, then you're discharged.

But here we have different types of scenarios that are going on in the hospital. So you have the emergency room situation, where you're there for a short period of time and you are getting treatment.

Whether that's considered an admission, it's not an inpatient hospital admission; it's an emergency situation. That's different than if you're admitted to the doctor.

The doctor, you go into the emergency room and they say, oh, well. After some period of time they've evaluated you and they say, Oh, we're going to admit you to the hospital, or you could go in for surgery and at that point in time you would have a situation where the doctor would say, Oh, well, the surgery you have will require an inpatient admission.

So there are all different types of circumstances in which you might be, quote, unquote admitted. But we are here, in this situation, what happens is -- usually what happens is somebody goes into the emergency room and they aren't sure what to do. So they leave them in the emergency room or they move them to some other area of the hospital, and they don't admit them. They just have them there in the hospital, under observation status. And then they make a decision as to whether or not they leave the hospital or they, or they admit the person to the hospital. So that's pretty much how it goes, and that's -- that's why we have this notice.

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This has been an ongoing problem for many, many years, where hospitals have been doing this, and it's just gotten to the point now where the Centers for Medicare and Medicaid have, is issued a standard notice which has incorporated some of this for all hospitals throughout the country so that they will have this noticed, available, and can use it. So it's something that has -- has been a real problem for -- has been developing into a bigger problem in the last two years, but it has been an ongoing problem for several years.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

REP. O'NEILL (69th):

Okay. Thank you, Mr. Speaker.

See, but the -- I guess I'm looking at this from a standpoint of you're the patient and you've got this thing called a "discharge." And if you're trying to get coverage by your insurance company for the services that were rendered at the hospital, if -- if I had a discharge in my hand, I would think that in order to be discharged, I had to be admitted.

And if -- if admission is the criterion upon

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which coverage, medical insurance coverage is based, then even if there's no document that says I was admitted but I've got a discharge, I would at least argue that I must have been admitted, because how can they discharge me if they never admitted me. And so that's real the thrust of what I'm trying to get at here is to find out if there's something other than an admission that can lead to a discharge.

So I guess that's the question that I would put to the Chair of the Public Health Committee is: Are there any circumstances other than having been admitted to a hospital under which you would get a discharge?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

So I think that where we're running into some, maybe a look at this so we can -- and this is probably why we need the notice is because what's going on here is you have somebody who goes to the emergency room. And they're in there, and generally a person is in the emergency room, they take time to be seen. They, the doctor takes them in or whoever it is that's looking

at them, they take them in. And then, and then there's some notification after they're finished with whatever the evaluation is of the overall condition, and they are considered, quote, unquote, discharged. Right?

So then, you have the -- the situation that the good representative raises, where if somebody is admitted to the hospital and discharged. The reason we need this legislation is because we have a situation where people are going in to perhaps the emergency room -- and more often than not it's an emergency room situation -- and nobody is really admitting them. So there, maybe they're -- they're not admitted, has something called -- and maybe I'm making a mistake here in the way I'm explaining it -- but they're not admitted as an inpatient. They may be admitted as somebody on the emergency room, but they haven't been admitted as an inpatient.

So that is, that is, I think, the crux of your question. I apologize for taking such a long time to try and get to it, but I think that that's what you're trying to get at here. And so because of that, they can't be discharged as an inpatient, as a person who was an inpatient hospital person, they were only --

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they were not discharged as that type of a patient.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, madam.

Representative O'Neill.

REP. O'NEILL (69th):

Well, thank you, Mr. Speaker.

I -- I guess I was kind of hoping that by doing it this way, that if the hospital issued a discharge -- and I'm not sure exactly what that is. I guess it's a piece of paper that says something like, has the word "discharge" on it -- that that could be produced as evidence by the patient to justify having the health insurance company cover the costs of that visit. Even if they were discharged, they came in and spent 20 hours sitting on a gurney waiting for someone to take a look at them, and when someone finally did, they said, oh, you can leave, here's your discharge, but that -- that there's going to be a bill associated with that time that they spent at the hospital, and that perhaps even if they went there by ambulance.

Maybe an ambulance visit would be an issue, because that's a \$500 charge or more. And if you are admitted to the hospital, I guess -- I'm assuming --

that the ambulance is much more likely to get covered than if you're not admitted to the hospital, and so that the discharge, even if there's no formal admission, the fact that they kept you at the hospital long enough to end up issuing you a discharge would provide the basis upon which one could make a claim for coverage under a health insurance policy, rather than the patient being forced to absorb those costs out-of-pocket.

And the other thing I -- I guess, and moving away from the discharge is it has left the hospital prior to the expiration of the 24-hour period. Is -- that sort of implies the -- the patient just sort of gets up and leaves without the doctor or it's an APRN or somebody at the hospital saying you can leave now. You know, take some aspirin or here's a prescription or just get some rest and call us in 24 hours and see if the symptoms have disappeared or something like that, that the patient kind of sitting around, waiting for a few hours, not getting seen by anybody just gets up and leaves. I mean, I've seen that happen and certainly felt the urge to do that, myself, sometimes: And so that's what this one kind of implies, that it's sort of an unauthorized departure.

Is -- is that the intent of this, the second part here, or has left the hospital prior to the 24 hours, that the patient has just sort of gotten up and left without any kind of medical recommendation on that score?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

A keen observation by the good representative.

So the -- the purpose of this language is to really make sure that we limit the hospital's duty to the patient in a, for a 24-hour stay. The duty is to the patient to let them know that within that period of time, that notification, that they've made the decision there.

They're going to leave you there for observation status, and they want you to know that that's their decision so that you have now an opportunity to either say to the treating doctor, Doctor, I think that you should admit me, or Doctor, what are my alternatives, because I'm not going to be in a situation where I'm going to be able to afford the medications here or I'm not going to be in a situation where if I'm here for

three days and I'm going to need a skilled nursing facility level of care when I leave here, that I'm going to be able to afford to pay for that skilled nursing facility because I'm not going to be covered by my Medicare plan.

So the reason for that is we decided -- because the Hospital Association wanted to make sure that they limited their -- their, the requirement under this law to the 24-hour period -- that they wouldn't be, they wouldn't be required to somewhere down the line have to make sure that they had to give them notice some other time.

So the idea of the notice is to make sure that it's contemporaneous with a stay, that the patient is there in 24 hours, where the most good will be done for the patient having that knowledge. They'll be able to make a decision about whether or not they -- they want to stay there under observation status, despite the fact they might be held -- held liable for the medications that they take or would not, would not qualify for skilled nursing facility care.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

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REP. O'NEILL (69th):

Thank you, Mr. Speaker, and I thank the Chair of the Public Health Committee for her answers.

DEPUTY SPEAKER BERGER:

Thank you, sir.

Representative Ziobron of the 34th, ma'am --

REP. ZIOBRON (34th):

Thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

-- you have the floor.

REP. ZIOBRON (34th):

Thank you, sir.

I also have a couple of proponents (sic) for my friend, the Co-Chairwoman of the Public Health Committee, through you.

DEPUTY SPEAKER BERGER:

Please proceed, ma'am.

REP. ZIOBRON (34th):

Thank you.

And, you know, it was interesting when I was listening to the discussion about the observation status, because I had never heard the term "observation status" before you were actually checked into the hospital only after.

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In my experience with several family members, oftentimes once we got there, whether it was for a potential concussion or somebody didn't take all their diabetic medication or something along that lines, they kept them in the hospital for observation. But I wasn't aware that there was actually an observation period before you were actually brought into the hospital.

So my question, through you, Mr. Speaker, is that when does the actual clock start running on when you're actually, this begins? I know when, you know, I've gone with family members or my son, they'll put a bracelet or something on you and take that information. So when does that 24-hour period actually begin?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so when the person goes into the hospital, whether it's into the emergency room or I would presume that most of these things occur in the emergency room, so as soon as they get, move into the emergency room and are seen when they're

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in there, meeting with the medical professionals,  
that's when the -- the clock would start to kick --  
tick.

Through you, Mr. Speaker

DEPUTY SPEAKER BERGER:

Representative Ziobron.

REP. ZIOBRON (34th):

Thank you, Mr. Speaker.

So just to clarify for myself, so this is before  
they're technically admitted? So this is before that  
bracelet gets put on their wrist; is that correct?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, I'm not sure when the  
bracelet would be put on your wrist, but you go into  
the, well, you go into the emergency room and you have  
a couple of avenues of going in. Correct? So you go  
in either through an ambulance or you'd go in through  
-- through the door and wait to be seen. And so in  
either circumstance, if you would go in through an  
ambulance, I would presume you'd go right into a room  
where you'd be seen by a medical professional, or you

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would go in through the admitting procedure and then be seen by a medical professional.

At the point where you go through the process for the emergency room, that would be the time when the clock would start to tick.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Ziobron.

REP. ZIOBRON (34th):

Thank you, Mr. Speaker.

And the reason I ask that question is because, knock on wood, I haven't been in the back of an ambulance lately but, unfortunately, I have been, accompanying my son a couple times this year on trips to the emergency room, mainly, though, the 24-hour clinic nearby my community, so not the actual hospital but the 24-hour clinic. And the very first thing they do, the very first thing when you go in is they look your information up through their computer system and they print off a bracelet. And that bracelet is placed on -- on the patient's wrist, and that's why I was kind of wondering when that 24-hour-kind-of rule starts.

So if you're only in observation mode and you're

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not actually being admitted, then I'm trying to understand if you never actually go through that process and you're just there asking for information or advice on your condition. That's where -- where I'm a little confused.

Through you, Mr. Speaker, I hope the good chairwoman can clarify that for me.

DEPUTY SPEAKER BERGER:

Representative Johnson --

REP. JOHNSON (49th):

I --

DEPUTY SPEAKER BERGER:

-- for a --

REP. JOHNSON (49th):

I thank --

DEPUTY SPEAKER BERGER:

-- clarification.

REP. JOHNSON (49th):

-- the good representative for her question. And the -- so at the point in time where you are, you are, you give the information and they put you someplace in the, in a, in a room where you're waiting to see a medical professional, that would be where the, where this clock would start to begin to go. And some kind

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of notification would have to be given in 24 hours.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Ziobron.

REP. ZIOBRON (34th):

Thank you, Mr. Speaker.

Okay. So that -- that helps me. So what about in a case of, for instance, when the -- the patient is either under age, like in my -- my own case with my son, or you have a patient that may be suffering from dementia or some issue where they're not fully cognizant. How do you give them that notification when they are, you know, in that state where it might not be clearly understood to -- to them?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

A very excellent question. The bill -- but that's not in the amendment part, and I think we're still on the amendment, so that would -- but I'll -- let me -- be glad to answer that. It could be going --

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Only should --

REP. JOHNSON (49th):

-- through somebody.

DEPUTY SPEAKER BERGER:

We should focus on the amendment.

REP. JOHNSON (49th):

Okay. Thank you --

DEPUTY SPEAKER BERGER:

Any questions --

REP. JOHNSON (49th):

-- Mr. Speaker.

DEPUTY SPEAKER BERGER:

-- towards the bill and precede it, then will  
follow that.

REP. ZIOBRON (34th):

Great, I --

DEPUTY SPEAKER BERGER:

If you could, yeah.

REP. ZIOBRON (34th):

I'll be happy to, after we get through this, look  
at the underlying bill. I was just looking at this  
very first line as it regarded to the patient and a  
written notice, but if it's in the underlying bill,  
I'd be happy to look at it there as well.

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DEPUTY SPEAKER BERGER:

Thank you, madam.

REP. ZIOBRON (34th):

Thank you.

And also in this amendment it talks about hospital, and the preceding sentence was -- which is contained within the full sentence -- it says, a hospital as defined by Section 19a-490. And as I mentioned earlier, I was wondering about an emergency medical center or other places. So what exactly is contained in the definition of a hospital?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you for that question.

A hospital is, as it states, is defined there.

And, you know, this is an excellent point because we -- we really are having a lot of different types of facilities, as the good chair, as the good representative knows from being in the Public Health Committee. And but the, but this amendment really goes to the time frames, so that is out.

The -- the amendment, really, when you look at

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it, it's right in line 5. And so when you look at the amendment, it says in line 5, unless such patient has been discharged or has left the hospital prior to the expiration of the 24-hour period. So I suppose, I suppose the word "hospital" is in there.

So we could say that -- that the hospital is defined as -- as what you would know is a hospital. We also, as you know, have the urgent care centers. We have these other types of places that really create some question about whether or not a person is going to a hospital or not. So that's a very, very good question. But we're talking about a regular hospital that has an emergency room, and that's -- that's what this section refers to.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Ziobron.

REP. ZIOBRON (34th):

Thank you very much, Speaker.

And I really appreciate the answers to those questions. And once the amendment goes through, I'm -- I'm happy to go back to the underlying bill and see if I can further educate myself and then if I have further question look forward to the answers at that

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time.

Thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, madam.

Representative Carter of the 2nd, on Amendment  
"C."

REP. CARTER (2nd):

Thank you very much.

Good evening, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Good evening, sir.

REP. CARTER (2nd):

Looking at the amendment here, I was trying to understand a little bit more about the 24-hour period. The 24-hour period, as I understand it, is -- is something that was put in -- in statute, I guess, from the federal government. So I guess I'd ask a question, through you, to the good chair of the Public Health Committee.

DEPUTY SPEAKER BERGER:

Please proceed, sir.

REP. CARTER (2nd):

Thank you.

Through you, Mr. Speaker, the, what we're trying

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to amend, I see as -- as something that's done by the federal government, where they're establishing this 24-hour notice period or -- or I guess it's a billing period after, you know, somebody's placed in observation. Is that true?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

The -- the amendment speaks to the 24 hours, if that's what the good representative is referring to.

DEPUTY SPEAKER BERGER:

Representative Carter.

REP. CARTER (2nd):

Okay. So the, so the way I understand this, then, the goal of the amendment is to say if -- if during that, if somebody is placed in observation and then they have to be there for -- for 24 hours, and that's the billing period, this is saying that unless a patient has already left, then they don't have to be notified of the placement.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

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REP. JOHNSON (49th):

That's correct. We wanted to make sure that the hospital wasn't having to give out notices after the patients left, that they were there within the 24-hour period.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Carter.

REP. CARTER (2nd):

Through you, Mr. -- through you, Mr. Speaker, the -- the notification, itself, then, are we -- by, why by doing this in the amendment and saying that we don't have to give notification to the patient, are we interfering with the -- the federal law in any way?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

The -- the federal law is, there's a federal law that addresses waiver of liability, but that's outside the -- the scope of this law.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Carter.

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REP. CARTER (2nd):

Through you, Mr. Speaker, then -- then I -- I really want to make sure then I understand the intent of giving this notification in the first place. If we're, if we're going to re-amend it and say, well, if they already left the building, you don't have to give it. That makes sense. But wouldn't it make sense to say that they should have the notification before they leave the building?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, the notification is trying to address the fact that people have been put on observation status and they've been in the hospital for longer than a 24-hour period. So by getting that notice into the hands of the person if they're going to be there longer than 24 hours, but putting a limitation on when the hospital has to give the notice, seemed to be a good way to tighten the language and make sure that the hospital doesn't have to give the, give the notification somewhere down the road but only within that -- that window. And that

way the person is on the awares that they are in observation status.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Carter.

REP. CARTER (2nd):

Thank you, Mr. Speaker.

So in the amendment then, too, I was kind of curious about, it's about when the patient has been discharged or has left the hospital prior to expiration of 24 hours. What -- what does constitute left the hospital mean? I mean, if they're -- if they're, well, first off, if they're there and they're admitted, then that's the only way they could be discharged, I would, I would think. So if they're not admitted, they're not under observation.

Wouldn't that be true, through you, Mr. Speaker?

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, so there's a sequence of events, as was mentioned before by the other good representatives who asked this, and what we have is a number of things that occur when somebody goes to a

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hospital setting. They can be in a hospital setting for surgery, in which case there, where they may have a one-day surgery but they need to be admitted as an inpatient, or they could go in through the emergency room and then leave the hospital without having a discharge from the emergency room doctor, or they could go in and be into the emergency room, either by ambulance or walk-in, and they could be in a situation where they would have a -- a doctor see them. And then they would be left there, either in the emergency room or placed somewhere else in the hospital but not admitted by the doctor.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Carter.

REP. CARTER (2nd):

So -- so then, and so it's possible then through this process if somebody is there having surgery or doing something, that they're not actually admitted but they're still getting a discharge from a procedure?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

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REP. JOHNSON (49th):

I'm sorry. Could the good representative please repeat the question or rephrase it?

DEPUTY SPEAKER BERGER:

Please repeat or rephrase, sir.

REP. CARTER (2nd):

I -- I certainly will rephrase. You know, it will be my understanding that if I went to the hospital and they put me in observation, then that's not the same as being admitted. But I guess what this is saying is if I leave before that 24 hours, I'm technically being discharged, even though I was never really admitted because I was there for a surgery or a procedure and I was under observation?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson, would you --

REP. JOHNSON (49th):

Through you, Mr. Speaker, so you can have a number of ways of getting into the hospital but not be admitted.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Carter.

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REP. CARTER (2nd):

Thank you, Mr. Speaker.

I was just trying to understand. I -- I don't understand how somebody can be discharged from a hospital yet never have been admitted, so I was just curious about why discharge was included in the -- this, as far as the 24-hour period. Because I thought that the 24-hour period was somebody who came in, they were placed under observation, which is a kind of a separate billing class, and then when they leave observation, that there's no discharge because they were never admitted in the first place. That's just the way I understood it and I was just trying to understand that.

The other, the other part of this that I'm curious about is when a patient leaves. I know it's going to sound funny, but what constitutes leaving? Like if somebody leaves for a little bit and then shows back up, does that start the 24-hour clock all over again?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

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Through you, Mr. Speaker, the -- we're just looking at 24 hours and a patient going into the hospital and having -- having a need to know their status, you know, if they're within the 24-hour period.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Carter.

REP. CARTER (2nd):

Thank you, Mr. Speaker.

And I thank the good chairwoman for her questions -- or answers, rather.

I guess in looking at this, I would be thinking that if -- if I were, if I were brought to the hospital and something were happening and I weren't feeling well but I wasn't sick enough to be admitted, then that -- that is going to kind of start my -- my 24-hour clock, we'll say, and that if I'm put in that, in that situation, they're going to have to notify me.

But this is saying if for whatever reason I leave during that period, I'm just wondering then does that start it all over again for me? Because I could see plenty of, you know, reasons to me, and one is might want to sneak out of there for a while and then end up

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back in the hospital, still not feeling well. Because that's what happens, a lot of people, you know, who might be returns or let's say frequent fliers to the emergency room, this could be a, could be something that's questionable.

So I'll continue to listen to the debate and look forward to commenting on the bill.

Thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, sir.

Representative Molgano of the 144th, sir, on House "C."

REP. MOLGANO (144th):

Thank you, Mr. Speaker. Good evening.

DEPUTY SPEAKER BERGER:

Good evening, sir.

REP. MOLGANO (144th):

Maybe I'll be able to get an answer for you, because I might be suffering from insomnia in a couple days, so I'll let you know.

DEPUTY SPEAKER BERGER:

Yes, sir.

REP. MOLGANO (144th):

One quick question to the proponent of the

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amendment, sir.

DEPUTY SPEAKER BERGER:

Please proceed, sir.

REP. MOLGANO (144th):

From my experiences in an emergency room -- I was, I want to build on Representative Ziobron's questions on when the clock begins to tick -- when I've gone into the emergency room, taking myself there, not going by ambulance, when I go in, you go through the registration's desk and as Representative Ziobron said, you get your bracelet. Most of the time when I received a bracelet, I had to remain in the waiting room for quite a bit of time before I was seen by someone.

Then they call you to come into a room where they start checking you out and seeing how your, what your problem is and what your illness may be. So my question is: When that bracelet was put on you, is that exactly the moment that the clock begins to tick or was it, is it when they take you into the room for the doctor to look at you and -- and see what the issues are?

Through you, Mr. Speaker.

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Representative Johnson.

REP. JOHNSON (49th):

So the notice really is supposed to address the situation where somebody would be in there more than the 24-hour period, but in order to cut short the -- the obligation of the hospital, we have put the onus on the hospital to just -- just within the 24-hour period let the patient know that they would be on observation status and not admitted.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Molgano.

REP. MOLGANO (144th):

So if I understand that correctly, Mr. Speaker, they just let me know that as soon as I come into the emergency room?

Through you.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, could the good representative please rephrase?

DEPUTY SPEAKER BERGER:

If you could, Representative Molgano, if you

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could please just restate your question, please.

REP. MOLGANO (144th):

No problem, Mr. Speaker.

All I was asking is: Does that mean that the emergency room will let me know about this observation period as soon as I enter the emergency room from outside the building?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, they -- what's -- what's been happening is sometimes someone will go into the emergency room and then for whatever reason, the hospital makes a decision about moving the person from one place, and maybe even outside of the emergency room but still within the area of the hospital where somebody might be comfortable, and -- and have some of their needs addressed.

So that's what happens here and so they're in a situation where, you know, they -- they are unaware that they haven't been admitted. They don't know that this is something that has been occurring. And they think, well, I'm here. I'm -- I'm no longer in the

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emergency room, but I'm here in this other part of the hospital, so I must be admitted. And so what this notice will do is it will clarify the fact that that's -- that's what's going on, and they'll have knowledge that they'll be able to make a decision about their health care in conjunction with their provider that, you know, either they're going to continue to stay in observation status and/or they're going to be in a situation where they're going to make a decision maybe to move some, to some other type of a health care setting.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you, Representative.

Representative Molgano.

REP. MOLGANO (144th):

Thank you, Mr. Speaker.

So the way I understand it, therefore, is like when you're in the emergency room, you're already been in and checked and they found something wrong. The doctor makes a decision whether they're going to admit you or send you home with some kind of a procedure to follow. So I would think that that's the time, if I understand this correctly, is when you would be told

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that this 24-hour period has been met or not.

Can I -- is that a pretty good statement, through you, Mr. Speaker?

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, I think that that's a very excellent analysis.

DEPUTY SPEAKER BERGER:

Thank you, Representative.

Representative Molgano.

REP. MOLGANO (144th):

I thank the good chairlady and I thank you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

The question before the Chamber is adoption of House Amendment Schedule "C."

Will you remark further on House "C?" Will you remark further on House "C?"

If not, I will try your minds. All those in favor of House "C," signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER BERGER:

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Oppose? Ayes have it; the amendment is adopted.

Will you comment further on the bill as amended?

Will you comment further on the bill as amended?

Representative O'Neill of the 69th, sir.

REP. O'NEILL (69th):

Thank you, Mr. Speaker, and now on the bill.

We've debated this bill now, I think over the course of a couple of different days and at some length. In looking at the underlying bill, it says the hospital will give this notice to the patient. And I'm again -- now that we've got the amendment -- they have to sit there for at least 24 hours.

And so let's say 36 hours or 48 hours into a stay at the hospital, the -- the patient is, has having received the notice that they were there for observation purposes. The hospital fulfilled its duty and the patient is basically on notice that they may not qualify for insurance coverage. And that's apparently not going to be arguable, because the hospital is clearly saying you were never admitted to the hospital as a patient, as an inpatient, and therefore if that means no coverage, then -- then you're basically not going to be able to argue coverage.

What happens to the hospital if the patient never receives the notice that we are requiring in this statute?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, there is no penalty in this legislation.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And then what happens to the patient if they don't receive the notice from the hospital? Now that we've required the hospital to provide the notice, will the patient be able to argue not having received the notice that I was there for observation, will the patient be in a position to at least more persuasively argue to have a basis for saying I should get insurance coverage for this time that I spent at the hospital because the law requires they notify me if I'm not there for, as an admitted patient, if I'm only there for observation. They didn't give me the

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notice, therefore I wasn't there just for observation, insurance coverage should apply. Is -- is that a possibility that the patient can now argue more effectively for coverage?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, absolutely. I think that that's a definite possibility. I think at that point in time they say, well, that you have, we have this legislation. We're supposed to be told that we haven't been admitted, so now we haven't been told we were admitted either, but you're -- the good representative is absolutely right.

In fact, a number of times in the, in the history of this difficulty that has been going on for years and years, it is possible to go back and look at the medical record and take a look at the type of care the person received under observation status or so-called observation status and see that, compare it, perhaps, with a similar situation with somebody who had been admitted and see that there's really not much difference in terms of what has happened with the

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observation status and what has happened with somebody who has actually been admitted and have, at that point in time, demonstrate those types of things to the, to the insurance company, to the Medicare program that, in fact, this is something that, you know, there is no actual standard in terms of coverage for hospital care. There's no written standard, that the -- the standard really is based on what the treating doctor says. And this problem is -- is arisen, as the good representative, ranking member has mentioned, these issues have come up through the audit process three years later, which has nothing to do with this bill.

This bill is to just protect the patient. It's just to protect them to make sure that they know the situation that they're in, so that they will be able to effectively make a decision with their health care provider to see that they're placed in a place that either, where they'll might be liability to pay for their -- their care while they're in observation status or make a decision to go someplace else.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you.

Representative O'Neill.

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REP. O'NEILL (69th):

Thank you, Mr. Speaker, and I thank the lady for the -- the answer.

So if you receive this notice from the hospital 36 hours into your stay at the hospital that you're really not, you're not being admitted and you want to be admitted, then your -- your recourse, it sounds like (1) go someplace else, try to find another facility, hospital, or is there, is there an opportunity with this document in-hand to basically argue for admission at this point? Is -- is that part of what the patient is going to have as an option?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Mr. Speaker, yes. The good representative has made an excellent point, again, and this is something that the patient and the -- or the patient's family would be able to say to the doctor. Well, you know, isn't it possible that this -- this is a situation where this, our relative or I should be admitted to the hospital? And, you know, and -- and work with the doctor to do a better analysis about the

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overall condition, maybe some difficulty with how the record is documented so that more information about the overall condition can be put in there, can be put in the record, and that way coverage would be unquestionable.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Thank you.

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And -- and in looking at the -- the -- and now we're at this stage where the patient has this document that clearly indicates what their status is and they're in a position to argue for it. Is -- is there, is there any motivation that hospitals have not to admit patients? I mean, are they penalized by insurance companies? Do they get classified in some sort of negative way? Does Medicare, you know, subject them to a more intensive auditing, or is there any reason why hospitals would be inclined to not admit patients that perhaps medically it would be indicated but there's some administrative or financial justification for the hospital -- and not

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justification, but -- but reason why the hospital might try to avoid admitting patients?

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative Johnson.

REP. JOHNSON (49th):

Yes. This is the exact analysis that is going on right now. The hospital has realized over time that primarily the Medicare program has been looking at the admissions of people to the hospital as inpatient, and they've been critical of the hospital admissions. And so three years down the road, when they do random audits, they hold the hospital liable. So this has been a -- a bad problem for the hospital, but really, we're -- it's -- it's something that has to be addressed on the federal level with respect to the audits, because that's a real Medicare/hospital issue.

So what has happened because of that, because of the numerous times the hospitals have been held liable, they've decided not to admit anybody and put them on an observation status. And then what happens? Well, then they don't get, they don't have a problem with the audit but what happens is -- is the poor patient is left there with the, with holding the --

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the liability, so to speak, when they counted on the coverage through their Medicare program or through their private insurance company.

Through you, Mr. Speaker.

DEPUTY SPEAKER BERGER:

Representative O'Neill.

REP. O'NEILL (69th):

Well, thank you, Mr. Speaker.

And -- and I -- I apologize to the Chair of the Public Health Committee, if -- if she's given this explanation in answer to other questions from other members. I have been listening and trying to follow along. Sometimes it's not that easy, depending on how the question was framed. But I -- I really appreciate it and I -- I hope that the other members of the Chamber, as well as anyone who's witnessing this, watching it on television, understands that there are things going on in the whole field of medicine where the driving factor may not be good medical care but financial considerations or even administrative classifications driven by governmental agencies -- in this case, the -- the Medicare institution that make people make decisions that may not be in the best interest to the patient, both medically and then later

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on financially and that that's what this piece of legislation, which seems fairly innocuous -- give the patient a piece of paper saying you're not being admitted to the hospital. You're only in this observation status -- but it really, I think, it's we're pulling on a thread here and it's unraveling an entire fabric of problems with our existing medical system.

And I suspect that as we roll out the health care program from Washington, the Affordable Care Act, that there's going to be more and more pressure on hospitals or all institutions to try to curb costs. And what we don't want to see happen is that those cost curbs are at the expense of the patient's health, certainly, and nor do we want to see patients being unpleasantly surprised that they go to the hospital, a couple years later they go again and find that exactly the same treatment that they received for the almost exactly the same condition is going to lead to a completely different result in terms of being admitted and in terms of who's going to pay for the treatment that they receive.

(Deputy Speaker Miller in the Chair.)

REP. O'NEILL (69th):

So I want to thank you, Madam Speaker -- a change in the -- the guard at the, at the dais -- for the question or the answers to my questions from the Lady Chair of the Public Health Committee.

Thank you.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Will you remark further on the bill as amended?

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

Madam Speaker, through you, a few questions to the good chairwoman.

DEPUTY SPEAKER MILLER:

Representative Johnson, will you respond? Frame your question, madam.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

I know when we discussed this bill in committee, there were some questions about where this originated, and I apologize if you've been asked this question before, but what was the issue that kind of got this,

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got this bill going?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, I appreciate the good representative's question. The issue has been an ongoing issue for a very long time, where hospitals have, over the years, put more and more patients in observation status because apparently their audits have been, more and more often they've been determined by the auditors that they should not have admitted patients.

And so as a consequence of those determinations over time, the hospitals have decided to put people in observation status. And that, in and of itself, is -- is a difficult situation because the impact on the patient is that they will find themselves in a situation where they will be held liable for some of their prescription medications or if they're there for more than three days, they would have ordinarily been eligible for a skilled nursing facility coverage perhaps, and under the Medicare program, and now they're going to be disqualified for that. So it

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would put the burden financially on a patient who would be otherwise insured.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

And just for my own clarification, the difference between observation status and being admitted. So if I, if I'm not feeling well and I go to the emergency room or my local hospital and I'm -- I go in there and they, you know, do all the things that they do and they -- they put me in a sort of room, would I be able to figure out on my own if I had observation status or I was actually admitted?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, that's a very excellent question, and that has been part of the problem. There is not -- sometimes people will go, say, into the emergency room and maybe for whatever reason the hospital decides to move them into another

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room in another part of the hospital. And so the person wouldn't know that they hadn't been admitted under those circumstances. So that is the reason that we created this legislation, to make sure that the people know what their status is and what the outcome will be when they have their claims submitted to the insurance companies.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

And through you, are there any -- how shall I put it -- are there any commonalities that would lead you to believe that you were admitted? I mean, I know, you know, we've all been to the emergency room. We've been in hospitals, and there's, you know, depending on the hospital, some emergency room areas look room-like.

So what is the actual definition of being admitted versus being under observation? Because I think the Chairwoman said in -- in the committee meeting that there are some people that are under observation, per se, for a week or two. I think there

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was -- it was either testimony or somebody said that.  
So would there be any commonalities, one could say,  
okay, this person is -- is admitted versus this person  
is under observation?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, there is no way for  
the patient to really understand whether they are in  
observation status or if they have been admitted. So  
that's why we decided to do this. This is a  
legislation that has also been recently passed in New  
York, just so that their patients are going to know  
what their status is, so they'll be able to talk to  
their doctor or make a decision to maybe go someplace  
else. So that's -- that's the purpose of this,  
because there's no way for them to really understand  
what the situation is, a very excellent question. I  
appreciate it, very much.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

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Through, Madam Chair, what is the difference, though, technically? Like why would somebody, why would a doctor choose to admit somebody versus keeping them in for observation?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

So the doctor would be in a situation where they would maybe decide that the person could be under observation status, and with a little bit of prodding from the family or from the person might be able to make a -- a record, based on how the doctor writes the record, that is more complete about the overall condition. So there may be a problem in terms of how the claim is submitted by the, by the doctor or by the provider that requires more analysis in terms of the overall condition. Some of these audit issues probably have something to do with the condition of the medical record, not really the condition of the patient.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

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REP. KLARIDES (114th):

Thank you, Madam Speaker.

But is there a medical explanation as to why someone should be moved? I understand the Chairwoman just gave some examples, but if -- I mean, she's not a medical doctor nor am I, so we wouldn't know that -- but through maybe some of her conversations in the public hearing or is speaking to -- to medical doctors, would there be -- is there a technical, medical reason somebody should be shifted from observation to being admitted?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, this really gets into the issue in terms of how you defined what inpatient hospital care is. And it would be really hard to create a definition of inpatient hospital care overall.

So when you have an inpatient hospital situation, there, under the Medicare law, it's just requiring some medical necessity. It's also in the state statutes that we have medical necessity. So it, the

treating doctor, the providers make the determination about medical necessity, but the standard is determined by the treater and there's no -- no written-out standard for care.

Like there might be, say, for example, skilled nursing facility care, which has a whole list of different types of things that people would have to do in order to receive coverage under the Medicare law, for example, or home care, you know, requiring a -- a certain type of nursing or physical therapy services with a certain, a time frame.

So in the hospital care, hospitals provide a huge range of services, so to try and define whether or not somebody is in a situation where they would be hospital-admitted, that would have to be done by the treating physician. And there, that's a judgment call. And I think that probably there's not -- and, in fact, there -- there haven't been in the, in the experience that I've -- I've seen in terms of the cases or the discussions with doctors -- there isn't really any difference between the people who are in observation status, by and large, or the people who are actually admitted as needing to be a hospital inpatient.

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Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Chair -- Madam Speaker, excuse me.

If the chairwoman could take a look at line 42, subsection (c), I just have a question about this. This section says what this, what this bill will not apply to. And it says "This section shall not apply to hospitals, inpatient health care facilities, home health care providers, federally qualified health care centers or entities offering religious services. That's just a little confusing to me. Does that mean that all of those, are all of those religious entities or is just the last section? It just, it's just confusing to me. If the, if the Chairwoman could -- could explain it, I would appreciate it. Thank you.

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Thank you so much.

And through you, Madam Speaker, so as -- as you

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know, back when we first brought the bill out, we had House Amendment "A," 4636, which struck that section in its entirety.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker. I -- I think I missed that part but thank you.

I know some of my colleagues have asked about the oral-and-written requirement. Has the Chairwoman answered the -- the question of how the oral part will be confirmed, but would there have -- would the patient have to sign something saying, yes, I've been told and understand?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, it's just that ordinarily one of the reasons we put oral and written, obviously if it's just oral, then it's hard to prove that you got oral notice. But if you have circumstances where we have seen a noticed situation,

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where there is no comment when somebody is handed the notice, they may not read it. I mean, so I've, I had circumstances where people received a notice that was placed in the night stand drawer and they weren't notified that they had the notice in there, yet the notice was handed to -- in the, in the room with them. So in this circumstance, that is why it says "oral and written."

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

I -- I understand that part of it, I think, but how do we -- what's our proof, I guess, that the patient has gotten oral and/or the written notice?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, the -- the proof is -- is that the written notice is described in the -- shall be signed and dated by the patient receiving the notice that's -- or the patient's legal guardian or

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somebody there that -- that they have, a guardian, conservator or authorized representative. So that's, that is how they would know that the person had received it.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Klarides.

REP. KLARIDES (114th):

Thank you, Madam Speaker.

I thank the lady for her answers.

DEPUTY SPEAKER MILLER:

Will you remark further on the bill as amended?

Will you remark further?

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Madam Speaker. Good evening to you.

DEPUTY SPEAKER MILLER:

Good evening to you, sir.

REP. NOUJAIM (74th):

Madam Speaker, I'm standing in here, listening to what Representative Klarides and -- and the Chairwoman, and I was, like, tempted to pull my cord and just go talk to her about the questions that I have to ask. But I do have, through you, Madam

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Speaker, just two questions about this piece of legislation, if I may, to Representative Johnson.

It seems to me through the legislation that there are two hospitals that are going to be required to add more to additional notification, and the two -- let me rephrase this -- additional notification requirements will be made on two hospitals according to this legislation. Is there is reason for this issue, Madam Speaker?

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, so the notification is required by the hospital to the patient within a 24-hour period.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Noujaim.

REP. NOUJAIM (74th):

I understand that, ma'am, and I appreciate that, Madam Speaker.

But through you, I am reading in here, it says although the two hospitals, one with them and the

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second one, will have additional notification requirements due to the bill. What is the reason for two hospitals to have additional notifications' method upon them?

Through you, Madam Speaker, and I'm reading this in the OFA analysis, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

I thank the good gentleman for that clarification in terms of where the question is coming from. So -- so I'm looking at the OFA analysis and I'm wondering if -- if the good representative wouldn't mind just telling me a little bit more about where he is looking at the, where he's getting the question from.

REP. NOUJAIM (74th):

Sure. Thank you, Madam Speaker.

REP. JOHNSON (49th):

Sure. Thank you.

REP. NOUJAIM (74th):

I am reading. It says, explanation, the bill requires hospital to provide additional notice to patients in certain situations -- I understand that -- and it says although the John Dempsey Hospital and the

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University of Connecticut Health Center will have  
additional notification requirements due to this bill.

And that's where I'm reading.

Now you know it --

REP. JOHNSON (49th):

Thank you.

REP. NOUJAIM (74th):

-- Madam Speaker, thank you.

Through you.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

I appreciate the good gentleman's help with this,  
and I'm saying that this -- this OLR report was  
written before we struck Section 2 from this, so we  
are now just referring to someone who is in a hospital  
situation and -- and that's -- that's really all the,  
all this applies to, so those -- that -- through you,  
Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Madam Speaker.

Therefore if I am to conclude that this item is

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no longer in existent (sic) and is not included in  
this bill, am I correct?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, that -- that is  
correct.

The -- there should be a notice whenever anybody  
is in the actual hospital as to whether or not they  
are an inpatient or not or they're under observation  
status, rather. So -- so we're making sure that  
people who are in observation status when they go into  
a hospital setting, that they would be notified.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Madam Speaker. I truly appreciate the  
explanation.

And I have one further question, a very simple  
question is a definition of observation status. And  
if -- if Representative Johnson has already said it  
before -- I truly apologize. It's been a long

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conversation, back and forth. So I would like to ask for a definition of observation status as it is meant in this bill.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, so observation status is something that is referred to in the -- that we have been looking at, because we had to name it something. And it means that the person did not or was not admitted by the treating doctor to the hospital. So they were never really admitted, so that's how the observation status has been. It's kind of a -- a term that has been developed over the years.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative --

REP. NOUJAIM (74th):

Thank you.

DEPUTY SPEAKER MILLER:

-- Noujaim.

REP. NOUJAIM (74th):

Thank you, Madam Speaker. I truly appreciate the

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answers.

You know, it's funny. I have here, myself, so many notes to ask, but as other representatives were asking the questions, I was simply crossing them out. So I ended up with only a couple, simple -- simple questions to be explained. So I truly, truly appreciate that, and I appreciate Representative Johnson's consideration.

Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Representative Case of the 63rd.

REP. CASE (63rd):

Good evening, Madam Speaker.

DEPUTY SPEAKER MILLER:

Good evening, Representative.

REP. CASE (63rd):

How you are today?

DEPUTY SPEAKER MILLER:

I'm well, thank you.

REP. CASE (63rd):

Good. A few questions through you to the proponent of the bill, please?

DEPUTY SPEAKER MILLER:

Representative Johnson, will you prepare yourself to answer, ma'am?

Representative Case, please frame your questions.

REP. CASE (63rd):

Thank you, Madam Speaker.

A quick question for you, on lines 2 through 5 of the bill, where it says, shall provide oral or written notice to each patient that the hospital places them under observation.

The question for you: If the patient is under the influence of medication and they don't have a conservator with them or somebody who can sign off, when does that form get filled out and signed off on to say that they're just under observation?

Through you, Madam Chair --

DEPUTY SPEAKER MILLER:

Representative --

REP. CASE (63rd):

-- Speaker.

DEPUTY SPEAKER MILLER:

-- Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, that is an issue that will, you know, it's a, it's one of the problems you

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run into when you're in a hospital setting and maybe you're not in a, in a -- maybe you've been hurt, but in all, in all hope that there would be some family member or patient's legal guardian or conservator or somebody who would be able to come to be with the person who is injured at that point in time and be able to accept the notice. That's why it's written so broadly so that we'd be able to get that notice delivered within that 24-hour period.

And hopefully by the time some -- the, you know, the 24-hour period is expiring, that they have been able to locate the family member or somebody who can help someone who might be not -- not conscious or incoherent.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Case.

REP. CASE (63rd):

Thank you.

And through you, Madam Speaker, so if a patient is requested by the doctor to go to the ER, they sit in the ER for approximately 12 hours, they get put into a room, are they covered under insurance up until that period?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, well, it would depend on their circumstances. Certainly we can't make a decision about whether or not someone would be covered unless they were really in the situation that -- that their policy provided coverage for. So this really speaks to a situation not so much that's contemporaneous with a few, first few hours of being in an emergency room but rather it speaks to a situation that addresses someone who is perhaps going to be there longer than the 24-hour period.

The reason we put 24 hours in there was to make sure that a hospital didn't have an obligation before or after a 24-hour period. We had to make an end to when the hospital makes a notice available to the patient.

So we did this as a, on the recommendation of the Hospital Association, and that way the person will know where they stand when they're there. They'll know whether or not they're in a situation where they're either an observation person or they're

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actually an inpatient person.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Case.

REP. CASE (63rd):

Thank you, Madam Chair, for your -- your answers to the question.

Ironically enough, I ran into this on Monday where a family member went to a hospital. The doctor called and said, 'Send him to the ER. Twelve hours later, he was put into a room.

An hour after that, the social worker came in and said you need to sign this form to say that you're just under observation. And I think it was not until two o'clock the next day, he had emergency surgery.

But they made him sign it when he was under the influence of morphine and a bunch of other pain meds. And I was just curious -- because I'm kind of scared now, if I'm going to get a large bill because that might not be covered -- if that's the case. Because they did have him sign a piece of paper that says he's just under observation.

Through you, Madam Chair.

REP. JOHNSON (49th):

I, first of all, through you, Madam Speaker,  
first --

REP. CASE (63rd):

Madam Speaker.

REP. JOHNSON (49th):

-- I'm sorry to hear about your family member  
being admitted to the hospital, emergency situation.

The good representative raises an excellent  
question. This is something that hospitals do try to  
do. They try to make sure that -- that the family,  
someone is able to be there when someone is not  
coherent, so as long as some family member is there to  
be able to understand that the observation status is  
there.

Now you have that opportunity to, once the notice  
is received, had the opportunity to go to the doctor  
and say, Hey, my family member was first of all you  
thought observation status but then later on had  
surgery. So, you know, go back to the doctor, I would  
recommend, and say to the doctor, I think that that  
determination was wrong and/or you can do it while  
you're right there at the hospital, especially once  
you hear that the family member is going in for  
emergency surgery.

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Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Case.

REP. CASE (63rd):

Thank you, Madam Speaker.

And I thank the -- the good chair for her answers. And, like I said, I'm just concerned for all of us, and I think the hospitals are trying to cover themselves; the insurance companies are trying to cover them. Given what happened on Monday, myself, unfortunately -- fortunately my wife was there -- I was stuck here, with my second family, which was okay.

And I would like to, you know, make sure that we're doing the right thing for the people in the state of Connecticut in if somebody goes into the ER and they're just in observation, that they're not going to get socked with a bill because the insurance companies aren't going to cover it. That's my main concern.

And I thank the good chair for her questions. Hopefully we can vet this out and make a good bill.

Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Will you remark further on the bill as amended?

Representative Srinivasan of the 31st.

REP. SRINIVASAN (31st):

Thank you, Madam Chair, good to see you there.

DEPUTY SPEAKER MILLER:

Good seeing you, sir.

REP. SRINIVASAN (31st):

Thank you, Madam Chair.

Through you, Madam Chair, for clarification purposes, to our good chairwoman of the Public Health Committee on the bill as amended.

Through you, Madam Chair.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. SRINIVASAN (31st):

Through you, Madam Chair --

DEPUTY SPEAKER MILLER:

Please prepare yourself to respond. Please --

REP. SRINIVASAN (31st):

Thank you.

DEPUTY SPEAKER MILLER:

-- frame your questions, sir.

REP. SRINIVASAN (31st):

Through you, Madam Speaker -- I apologize for

saying "chair" in the past -- I apologize for that -- through -- through you, Madam Speaker, just a few questions.

Line 2 talks about provide oral and written notice. Does it specify in what language or languages? Obviously knowing the population of that particular hospital, does it have to be in more than one language?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, this bill focuses on just the fact that it's a written notice, but as the good ranking member is aware, we had some excellent legislation just recently that discussed the fact that we must make sure that people understand the communication between themselves and the provider.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Madam Speaker, I'm very glad that the good chairwoman brought about a very good bill

that we just passed earlier in session.

So as I understand it, Madam Speaker, when information is given orally or written to the patients, we will automatically be following what you've already passed before, if it meets that particular threshold of five percent of the population.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

That's correct, Madam Speaker, through you.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, if this information of the observation status is given orally only and not by, along with the oral in a written form as well, would there be any consequences to the hospital for that?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

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Through you, Madam Speaker, there's no -- no indication of consequences in this bill.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, as we all know, medical decisions cannot be made by the clock. You know, you may not, the doctor or the poor doctor who was providing services may not be able to decide within a 24-hour period that -- that the person has to be admitted or go into observation status.

So what happens, through you, Madam Speaker, if a decision by the physician is not made whether the person is admitted or in observation status for the right reasons, because he or she is still observing the patient past the 24 hours?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, the only requirement is that the notice be given that the patient is on observation status within the 24-hour period.

Through you.

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DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Madam Speaker, as I understand it, the doctor is not able to make the decision into the 36-hour period whether to admit or to keep in observation, so automatically the patient is in observation status at that particular point and the necessary paperwork will have to be given to the patient.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, so you really need to have the notice within the 24-hour period, and if the doctor decides something different later on then and admits the patient, then that would be another type of circumstance. But the -- the biggest problem that the patient is faced with is when they have no idea that they're on observation status.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

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REP. SRINIVASAN (31st):

So through you, Madam Speaker, so that I'm clear, if a patient is in an emergency room or in an adjacent room for a 36-hour period while the physician is deciding to admit or to be in observation status, the appropriate personnel will go out to the patient or the family or whoever is representing the patient and make sure that they're informed that they have not yet been admitted, 26 -- 24 hours are over and that they need to sign the form that they are in observation status.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, so the requirement would be that the person would be in a situation where they would receive that notification within the 24-hour period.

And the treating doctor, of course, would be able to continue to make determinations with the observation status, but also this would give the patient an opportunity to speak with the doctor and negotiate, perhaps, or maybe have the doctor take a

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look at making medical records that have more -- more information in it so that a determination would be maybe where they would decide to admit the patient, so it really asks for -- this will create more communication with the, with the treating doctor and the patient and the family. And I think that that's something that will really go a long way to good patient care.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, I want to thank the good chair for that answer. I appreciate that. You definitely clarified one of my concerns.

Through you, Madam Speaker, is there any time limit in this bill as to how long somebody can be in observation status?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, the determination is made between the -- there's nothing in the bill that

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puts a limitation on observation status. The only purpose of the bill is to make sure that the patient gets the notice within a 24-hour period.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, in lines 7, 8, and 9, we talk about the observation status impacting Medicare, Medicaid or private insurance. I can understand that private insurance is so wide that one may not know what the coverage for observation status is. But Medicaid and Medicare should be pretty straightforward whether they cover observation, how much of observation they cover or not.

Is that true, Madam Speaker, that the coverage for Medicaid and Medicare is straightforward as far as observation status is concerned?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, the -- the situation with Medicare and Medicaid is that there is really

actually no written rule about what the hospital inpatient care looks like or what observation status looks like or what any of those standards. The doctor makes the determination about where the patient should be. If the doctor feels the patient is in danger but doesn't want to admit, then the doctor will put them in observation status.

The standards for coverage fall, in certain circumstances, with respect to observation status when it comes to accessing ancillary services. So when you have ancillary services, for example, the medications or when you have skilled nursing facility care, those are the types of services that are contingent upon inpatient admissions. So this is why it's important for patients to be able to understand what their status is in the hospital.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, is it possible that in Room A you have a patient on Medicare on observation status and -- and, Madam Speaker, Room B has another patient on Medicare also, same standard

Medicare that Patient A has. And it is possible, through you, Madam Speaker, that in this observation status Patient A could be covered and Patient B may not be?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, I think that that's a very interesting question. It's hard to be able to answer that really with any type of certainty.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, the good chair is so right because sometimes you do not know. You assume that you're covered and then you have this, find out this unpleasantly -- obviously very unpleasantly -- that the coverage does not exist. And so informing patients, even though they are on Medicare -- that they're on Medicaid, where the observation status more than likely is covered -- you want to make sure that they are aware that there is a possibility. There is

a possibility that it may not be covered, and so please make sure we contact the appropriate authorities, the appropriate insurances and get that information.

Through you, Madam Speaker, would the same scenario of Patient A and Patient B be applicable if somebody is on Medicaid?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

Through you, Madam Speaker, if somebody is on Medicaid, then pretty much it's a different type of circumstance. So with Medicaid, eligibility is determined by financial need, so there's medically -- it's a -- so you have a different type of thing. You've HUSKY A, B, and C, a D, and they have all, they -- you get the coverage based on your financial circumstance. So whatever the treating doctor orders and however those things occur, that's -- that's pretty much how Medicaid works.

So that would be, end up being if a, if a Medicaid, if a Medicaid decided, through the State of Connecticut, that somebody was not eligible for the

stay, that would become a -- a situation where it would between -- be between the hospital and the State and the patient, and unless the patient had a situation where they're moving in between being able to be eligible for Medicaid and then maybe being a situation where they would perhaps be more -- more qualified under, you know, some type of an insurance policy through the Affordable Care Act. Then in those circumstances, there might be waiving between in, you know, each program.

But under the Medicare program, that, there is no, there is no standard for coverage but -- but the patient does have eligibility. The standards are a little bit different. So you get a Medicare by -- by virtue of the fact you qualify because you're 65 years or older or you've been deemed disabled by Social Security for two years or more. So those are the qualifications. And then there are standards for coverage all the way through.

So when you have those standards for coverage under the Medicare program, the Medicare Part D, which is the pharmaceutical program, or under Medicare Part A, which is a skilled nursing facility coverage, there are certain standards of care that you have to meet in

-- in terms of qualifying for being eligible. So there's standards you have to meet for treatment.

The same is true for certain types of health insurance plans. They might have a coverage provided contingent upon, you know, some type of hospital care or a stay in a hospital. So what this notification does is it creates a circumstance that will allow people to know whether or not their policy, whether their plan is going to be providing coverage.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

I do appreciate that answer, and you're just highlighting all our concerns here in the Chamber that insurances and medicine is so complex and complicated that there is no one straight answer for anybody and everybody. And so they do have to check with their own insurance carrier, whether it be Medicaid, Medicare or a private insurance as to what the coverage will be during an observation status or in any other situation.

Just a few more questions, Madam Speaker, and

then I'll wrap up. The -- I'm very concerned and appalled, actually, at lines 9, where hospital services, medications, and pharmaceutical supplies may not be covered when you are in observation status. We heard that in the public hearings and I almost couldn't believe my ears when I hear -- heard what people had to say.

And my concern -- I'm not sure if this is addressed in the bill -- but for discussion and for debate, through you, Madam Speaker, in the case as our good representative Jay Case just pointed out, if somebody in coming into the hospital is now being treated with morphine because of -- of the pain that they're in or other medications, how would they be able to find out whether these medications that they need in the hospital are covered or not covered? And then what happens if the medicines are not covered and they're stuck with this huge bill?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. JOHNSON (49th):

So they would be informed and hopefully a family member would be there so that they would be able to

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receive the notice if the person is -- is incoherent.  
And so that would be a circumstance that we would, you  
know, hope that would be resolved and that there would  
be a way to address that.

But, again, I think that probably what's happened  
over the years is that there -- there's some language  
in the federal law under the audit program for the  
Medicare program and perhaps in other types of  
insurance policies that are audited that -- that are  
attacking this area, because there's no real  
definition of what it means to be an inpatient written  
in law for purposes of coverage.

And so they look at that, and if the record isn't  
complete and it isn't thoroughly documenting the  
overall condition of the patient, then maybe that  
gives the auditor a little leeway. So maybe what will  
happen over time is the doctor would, at the request  
of the patient, the family working together, may be  
able to get the doctor to -- to write more  
comprehensive information in the medical record.

Through you, Madam Chair -- Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, I definitely hope so, that a more comprehensive history and details are given, as much as possible, so that the person who is in this very compromised position in a hospital, in an acute setting, whether it be pain or some other clinical manifestation, does not have to worry that over and above the medical condition, they now have a financial situation that they need to be worried about also.

Through you, Madam Speaker, my final question is: through you, Madam Speaker, can a person who is in observation status, let's say for two days or three days, at that point in time can (a) the person be discharged from the hospital or do they have to be admitted prior to being discharged?

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Johnson.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, so it all goes to the question as to whether or not where we're admitting and discharging from, because there are different certifications throughout the hospital. And as you look at the different certifications, you have the

inpatient hospital care. Then you've got the emergency room certification for care. There are different areas that a person might be in, so it would just depend on, well, what the situation was.

Now, certainly there would be no prohibition in this law that would stop the doctor from admitting the patient after -- after a day or two. They could certainly do that admission, that would be no limitation there.

Through you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, I want to thank the good chair for her answers, both on the amendment, as well on the bill as amended.

And I hope that my colleagues on both sides of the aisle will join the good chairwoman and me in supporting this very important piece of legislation.

Thank you, Madam Speaker.

DEPUTY SPEAKER MILLER:

Thank you, sir.

Will you remark further on the bill as amended?

Will you remark further on the bill as amended?

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If not, will staff and guests please come to the well of the House. Will the members please take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by roll.

Members to the Chamber please. The House of Representatives is voting by roll. Members to the Chamber please.

(Deputy Speaker Orange in the Chair.)

DEPUTY SPEAKER ORANGE:

Have all members voted? Have all members voted?

Please check the board to determine if your vote has been properly cast -- did I vote?

If so, the machine will be locked, and the Clerk will take a tally, please.

And will the Clerk please announce the tally.

THE CLERK:

Madam Speaker, House Bill 5535 as amended by House "A" and House "C."

|                       |     |
|-----------------------|-----|
| Total number voting   | 143 |
| Necessary for passage | 72  |
| Those voting Yea      | 143 |

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Those voting Nay 0

Those absent and not voting 8

DEPUTY SPEAKER ORANGE:

The bill as amended passes.

Are there any announcements or introductions?

Are there any announcements or introductions?

Representative McGee.

REP. MCGEE (5th):

Thank you, Madam Speaker. Good evening.

DEPUTY SPEAKER ORANGE:

Good evening, sir.

REP. MCGEE (5th):

I stand for the purposes of an introduction.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. MCGEE (5th):

Yes, in the gallery, above there, we have Troop 149, from Windsor, Connecticut. On behalf of Representatives Baram, Sayers, and myself, we'd like to welcome you to the House of Representatives.

So I'd ask that all of the House members stand and give them a hardy welcome.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

**S - 679  
CONNECTICUT  
GENERAL ASSEMBLY  
SENATE**

**PROCEEDINGS  
2014**

**VETO  
SESSION**

**VOL. 57  
PART 11  
3246 – 3508**

pat/gbr  
SENATE

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THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

The second item, Madam President, Calendar 569, House Bill 5040, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Third item, Calendar 566, House Bill 5535, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving now to Calendar Page 27, Calendar 574, House Bill 5564, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And also, Calendar Page 27, Calendar 578, House Bill 5220, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving to Calendar Page 28, where there are four items. The first, Calendar

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003475

Calendar 500, House Bill 5547.

On Page 18, Calendar 507, House Bill 5530.

On Page 19, Calendar 512, House Bill 5386.

Calendar 514, House Bill 5521.

Calendar 516, House Bill 5500.

Calendar 517, House Bill 5305.

On Page 20, Calendar 527, House Bill 5592.

Calendar 528, House Bill 5453.

On Page 21, Calendar 531, House Bill 5299.

Calendar 533, House Bill 5290.

On Page 22, Calendar 541, House Bill 5456.

Calendar 539, House Bill 5294.

On Page 24, Calendar 551, House Bill 5588.

Calendar 552, House Bill 5269.

On Page 25, Calendar 564, House Bill 5489.

Calendar 562, House Bill 5446.

(HB5466)

On Page 26 --

THE CHAIR:

Hold on. Okay. Sorry. Please proceed.

THE CLERK:

On Page 26, Calendar 568, House Bill 5434.

Calendar 569, House Bill 5040.

Calendar 566, House Bill 5535.

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SENATE

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SENATOR LOONEY:

If we might pause for just a moment to verify a couple of additional items.

Madam President, to verify an additional item, I believe it was placed on the Consent Calendar and Calendar Page 30, on Calendar Page 30, Calendar 592, Substitute for House Bill 5476.

THE CHAIR:

It is, sir.

SENATOR LOONEY:

It is on? Okay. Thank you. Thank you, Madam President. If the Clerk would now, finally, Agenda Number 4, Madam President, Agenda Number 4 one additional item ask for suspension to place up on Agenda Number 4 and that is, ask for suspension to place on the Consent Calendar an item from Agenda Number 4.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Madam President, and that item is Substitute House Bill Number 5566 from Senate Agenda Number 4.

Thank you, Madam President. If the Clerk would now, if we might call for a vote on the Consent Calendar.

THE CHAIR:

Mr. Clerk. Will you please call for a Roll Call Vote on the Consent Calendar. The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate.

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An immediate Roll Call on Consent Calendar Number 2 has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk will you please call the tally.

THE CLERK:

Consent Calendar Number 2.

|                             |    |
|-----------------------------|----|
| Total number voting         | 36 |
| Necessary for adoption      | 19 |
| Those voting Yea            | 36 |
| Those voting Nay            | 0  |
| Those absent and not voting | 0  |

THE CHAIR:

The Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Two additional items to take up before the, our final vote on the implementer. If we might stand for just, for just a moment.

The first item to mark Go is, Calendar, to remove from the Consent Calendar, Calendar Page 22, Calendar 536, House Bill 5546. If that item might be marked Go.

And one additional item, Madam President, and that was from Calendar, or rather from Agenda Number 4, ask for suspension to take it up for purposes of marking it Go, that is House Bill, Substitute for House Bill 5417. Thank you, Madam President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

**JOINT  
STANDING  
COMMITTEE  
HEARINGS**

**PUBLIC  
HEALTH  
PART 4  
1268 – 1862**

**2014**

DEB MIGNEAULT: Yes. Senator Gerratana -- I'm sorry, she's not here. Representative Johnson, my name is Deb Migneault. I am the Senior Legislative Analyst for the Connecticut's Legislative Commission on Aging and I'm here to provide comment on House Bill 5535.

As you know, the Connecticut's Legislative Commission on Aging is a nonpartisan public policy office of the General Assembly devoted to preparing Connecticut for a significantly changed demographic and enhancing the lives of present and future generations of older adults.

We are here today to provide our support for H.B. 5535, An Act Concerning Notice of Patients Observation Status and Notice Concerning the Qualifications of Those Who Provide Healthcare and Counseling Services. We are very much grateful for this Committee to raise this bill and try to address a growing problem for Connecticut's older adults specific to observation status, and we are here to support it, as I said.

We've been following this issue very closely with our partners and friends, national experts, the Center for Medicare Advocacy. They've been doing a lot of work on the national level with the observation status and, in fact, filed the class-action lawsuit to challenge this illegal practice. I believe you will be hearing from the Center for Medicare Advocacy in a little while, and that's wonderful because they really truly are experts. And if you have any questions, they can answer anything and everything Medicare related.

As you are aware, increasingly hospital patients are finding they have been in the

hospital under observation status, and what that means is they are in a hospital bed receiving care from hospital physicians and nurses, eating hospital food. People are coming to visit them in a hospital room, and yet they come to find out that they're actually not admitted. They might have been there for two days, three days, five days, even as much as 14 days, and for billing purposes they have not been admitted.

They are considered observation status. And what that ends up meaning is that some of their benefits under Medicare don't come into play for coverage of -- coverage in the hospital, things like prescription drugs that they might be taken -- taking for chronic illnesses like hypertension or diabetes. They will be responsible for paying. Medicare won't pay for those in the hospital. They also might be paying -- have to pay for physician visits or testing that's being done in the hospital but is not covered under Medicare because they're not considered inpatient.

Also has an effect if they're released to a skilled nursing facility for rehabilitation. Coverage of a skilled nursing facility under Medicare does not come -- does not begin until they have a three-day hospital stay, inpatient hospital stay. And, so, they could have been in the nursing -- in a hospital for three days, but then are released to a skilled nursing facility and, in fact, they were never actually admitted to the hospital. So, they're, they're -- they are not covered for skilled nursing facility coverage which, as you know, is extremely expensive.

Medicare does not require hospitals to notify patients of their status. Many times, patients believe they are inpatients because they're in

a hospital bed in a hospital and they don't realize the potential effects that it has on their Medicare benefit. So, again, we are here to support this bill. Providing this information to patients while they're in the hospital is really important for them to understand how their status affects their coverage and their benefits.

We do have some -- a little bit of suggestions just to strengthen the bill. The intent is great and we just have few little, small suggestions to strengthen it. We would suggest that the notice to patients includes information about what it means to be considered observation status, particularly that patients may be responsible for cost of medications and skilled nursing facility coverage, if needed. And we would also suggest the notice include that questions regarding their status in addition to their health insurer and the Office of Healthcare Advocate be directed to the admitting or primary physician.

So, it's just a couple of suggestions just really to strengthen it. But, again, we're very supportive of Section 1 of this bill and are very grateful that you are trying to address a very, very challenging problem here in Connecticut, but across the country nationally.

REP. JOHNSON: Thank you so much for your testimony. Have you run into any, any people personally through your organization, in your work who have had this situation happen to them?

DEB MIGNEAULT: Certainly. We have received phone calls into our office about this, and we always direct to the Center for Medicare Advocacy because they are a wonderful resource and will

advocate on behalf of that patient to try to, to manage the, the situation. So, what we do is refer to experts, which is the Center for Medicare Advocacy. We're very lucky to have them in our state. They're national experts, but they are located here.

But, yes, it's certainly something that we've heard of, and we also know of really horror stories nationally about bills that come in after they've been in the skilled nursing facility for a couple weeks, and then all of a sudden they are left responsible with thousands of dollars of medical bills because Medicare, in fact, is not paying -- will not pay.

REP. JOHNSON: Great, thank you so much for your testimony.

Any questions? Yes, Representative Klarides.

REP. KLARIDES: Thank you so much for coming in today. I'm not as -- that familiar with, with how this works, but how does -- how is it decided if somebody should only be there for observation or be called, you know, under observation?

DEB MIGNEAULT: Yeah, there are, there are -- well, basically it's when somebody comes into the hospital and they're, they're assessed. Usually they come in through the Emergency Room. They're really too sick to return home, and then they're admitted into the hospital. They sign all the paperwork, but they are not actually admitted and that -- that is because they -- the hospital feels they're too sick to return home but they need -- so, they need to observe them and perhaps do further testing or things like that. And, so, it's, it's really a billing procedure that happens with the hospital.

It's Medicare rules that determine that and there is legislation in Congress that's trying to kind of correct some of these challenges with Medicare. Obviously, it's a Federal issue. So, it's not so much that the hospitals are doing anything that they shouldn't be doing. They're using -- it's Medicare rules. It's just that these Medicare rules are making it quite cumbersome and difficult for inpatient medical stays. And, so, this is a trend that is becoming increasingly -- happening more and more here in Connecticut and nationally.

REP. KLARIDES: Well, I mean, that makes sense to me, I guess, if it were a day or two. But, I mean, you used an example of a couple of weeks.

DEB MIGNEAULT: Yes, uh-huh.

REP. KLARIDES: And, so, I guess that's what the concern is, I would assume.

DEB MIGNEAULT: Yes, and that is when -- especially concerning a skilled nursing facility, when somebody is released to skilled nursing facility. If somebody has been in a hospital for three days inpatient then they are covered under Medicare for skilled nursing facility rehabilitation for a certain length of time. However, what's happening is somebody may actually be in the hospital for three or more days but under observation status, and then they are released to a skilled nursing facility. But because they have been under observation status and not inpatient, Medicare does not pay for the rehabilitation in nursing facility.

So, it's a billing practice. There are certain guidelines through Medicare that distinguishes whether somebody is inpatient or observation

status and that -- those problems with those billing coding and rules are causing these lengthy stays, that aren't actually -- they're not inpatient and they really don't look anything different than, than -- you would go visit somebody, you would not be able to tell. A person in the hospital bed would not know ; unless they specifically asked. In fact, I have had the experience several times over the last year or so with family members and me advising, "Make sure you find out. Please ask are you observation status because unless you know, you could be stuck with some really significant bills." And that's the time that you potentially could advocate for a change in status if that's possible.

REP. KLARIDES: Thank you.

DEB MIGNEAULT: Uh-huh.

REP. JOHNSON: Very good. Are there any additional questions?

Thank you so much for being here, for your testimony. It's very much appreciated.

DEB MIGNEAULT: Thank you.

REP. JOHNSON: Next on our list is Jim Iacobellis.

JIM IACOBELLIS: Good afternoon. My name is Jim Iacobellis. I'm the Senior Vice President of Government and Regulatory Affairs for Connecticut Hospital Association. It's a pleasure to be able to testify here this afternoon on House Bill 5535 and three other bills and I'm going to try to do that in three minutes.

With respect to H.B. 5535, it's broken down into two sections and I'll take the first

SB257

SB413

HB5537

section first. It has to do with observation stays, and we applaud and thank the Committee for trying to figure out a way in which we can clarify what is going on. But to pick up where the last testimony left off, we have patients, doctors and hospitals caught between this complicated Medicare regulatory scheme. The Medicare Recovery Audit Contractors and the False Claims Act, these are all intersecting here at the same time. Medicare rules define when you can be an inpatient and when you can't be an inpatient.

So, a physician has to certify that you are an -- that you are an inpatient. And as the last woman just, I think eloquently spoke about, there are situations when you're in the hospital and you think you're admitted, but under the billing status you are in observation. That does impact your paying what is covered under Medicare. It impacts if you need -- if you need further care. We have concerns over this bill and I've had conversations about it and we're going to try to look at where some other states have gone to make sure that we don't complicate this any more.

I think as we've heard, there are bills in Congress that are trying to straighten out what is observation status. There's conversations about trying to deal with ways in which we deal with short stays with what we're talking about. There are lawsuits and there are actions by Recovery Audit Contractors and they all intersect.

So, I want to say that we are interested in working with this Committee to make sure that what we do doesn't complicate an already complicated problem, but it is one that we know we have to address because patients are caught

in between, doctors are caught in between, and hospitals are caught in between. And one of the most, I think, troubling aspects is three years after somebody leaves the hospital, a Medicare Recovery Audit Contractor can change their status.

Quickly, Section 2 is a bill that is -- is a section that's directed I think at those types of outpatient settings which are not regulated currently by the Department of Public Status -- Public Health as drafted. It includes emergency departments. I don't think it means to include emergency departments or other hospital clinics which are regulated by the Department of Public Health. We've added some language in our testimony I think to straighten that out.

SB257

The second bill, An Act Concerning Hepatitis C Testing, we support. We've added some technical clarifications. One, the bill refers to a nurse practitioner. I think the bill needs to refer to an APRN. That's the licensure status. Two, in lines 17 and 18 it requires the physicians to provide a hepatitis C test. In most cases the physician is not going to provide it. He is going to give them documentation in order to go get a blood test. So, I think it's technical, but highly important.

And lines 28 to 33 statutorily mandates the conversation or the next steps between the physician and the patient, and we feel pretty strongly, to the best that we can, we should not put in statute what a physician has to do when he receives a test result, what that conversation should be like. So, consider looking at that section and either modifying it or deleting it.

We support the Senate Bill 413, the MOFLT bill. We are part of that working group and we look forward to working with the Department and implementing that.

And with respect to 5537, the DPH revision bill -- and I bring this up, we have written testimony on it because I want to talk about it publicly. We've asked for a section to be added. We have a section in Connecticut statutes which governs access to laboratory records. We are always waiting for the Federal government to come in and do their Federal regs on clinical laboratories and HIPAA. They have now done so. It is a way in which I think goes exactly where we want to go as a state, giving patients access to their lab results. Our language hopefully just conforms those two so we're on the same page so there's no confusion, but the result is exactly where we wanted to go for a number of years and the Federal government has just caught up with us.

Took longer than three minutes.

REP. JOHNSON: But you covered so much ground. Very nice.

So, yes, I think the Committee is definitely willing to work with you on, on the language issues that you raise, and the fact that -- you mention in your testimony regarding House Bill 5535 Section 1, the fact that other states have passed legislation that are similar to what we're proposing here. And, so, I think the state of New York has certainly done that and I, I respectfully ask you to take a look and make sure that, you know, we're not doing anything that will complicate the issue, but just make sure that the patient and the family of the patient understands the circumstances that they're in and the change, although

there's no regulatory change, no statutory change in how Medicare is supposed to operate with respect to the provision of healthcare services and the payment. There is administrative changes that have occurred that will have an impact.

And there are so many times when people say, "I've heard Medicare was changed," but, you know, really quite, quite truly it's not the law itself that changes but the way it's being administered. And I think that this has been going on not just for the last ten years, but it's been a way for perhaps some bureaucrats who are administering the program, who are doing the audits, a way for them to figure out a way to save money on the Federal level. But what does it do here in the state? It creates a situation where people will have to have -- either pay from their own pocket or go onto the Medicaid program, which -- that was not the vision of the, of the folks when they, when they crafted the Medicare program back in 1965.

JIM IACOBELLIS: I couldn't agree with you more. I think we have -- we had the Centers for Medicaid and Medicare Services come out (inaudible) with the regulation. They immediately delayed it for six months and they immediately delayed it again. It's known as the Two Midnight Rule. And how can we clarify when and when you're not in observation status?

Congressman Courtney has a piece of legislation which we support and have been working with him on which would deal with a small part of this as it relates to observation days, and then care in long-term nursing homes, to count those as, as the three days.

Part of what -- and we will check with our colleagues in these states where something like

this has been implemented to make sure we don't do anything that makes this more complicated for the patient. We may have to deal with some part of it whether this notice's intent deals with the fact that maybe a year or two later an auditor may go and change a status, and whether that notice provision would require the hospital to go back and try to track someone down a number of years later to do that. But that, I think, is part of the conversation when we see how it's working in New York, but I welcome that conversation because this is an area that's critically important to patients, doctors and hospitals.

REP. JOHNSON: It seems like it's just mushrooming because of the administrative difficulties and, so, the hospitals have tried to implement policies that are really inconsistent with the intent of the Medicare law. So, thank you so much for being here and working with us on the legislation.

JIM IACOBELLIS: Thank you.

REP. JOHNSON: Any questions? Yes, Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you very much for being here this afternoon for your, for your testimony. Two questions, one on 5535, the observation status. Am I to understand that you feel that with whatever is going to happen hopefully soon at the type of level that your involvement with Congressman Courtney, that to wait to see what happens before we institute this in our state, is that how I am reading you?

JIM IACOBELLIS: I don't think Congressman Courtney's specific bill addresses the notice

provisions of this bill in the state of Connecticut. His bill specifically addresses what is -- a problem is if you're in observation status then you go to long-term care, those days don't count, so you, the patient, have different financial responsibilities. His bill treats the observation days as something that will count towards the three days to go in there. So, his bill won't do that.

My concern is, is the new regulation coming down from CMS and how they define what is observation and what isn't observation may put different parameters around this notice requirement. So, I just want to make sure that we are coordinating everything and we don't do anything that complicates it. My conversation with Representative Johnson is that this was modeled after New York, and we're going to make sure that we have conversations with them and this Committee to make sure that what we do doesn't complicate an already complicated area because we don't mean to do that because it is important for the patients to know, first of all -- and this is a billing issue -- what their financial responsibilities are. It's very important.

REP. SRINIVASAN: Thank you very much for sharing that. And I definitely agree, the last thing we need to do is complicate it and make it even more difficult to comprehend by everyone. But I also feel that patients in the Emergency Room, by and large, to whom this applies, you know, should be aware as to whether they are in observation or not because obviously it's going to impact them, not only in their long-term care which is a different issue altogether in the number of days counting, but in the hospital itself that -- you know, because a lot of people don't know what's happening. I mean,

you know, the doctor, the nurse comes in to check them every so often and they, they assume that (inaudible) there that they are going to be automatically admitted only to find out, "No, you've been in observation status this entire period and now you're ready to go home" or whatever medical decision is made.

So, that information -- you're right, we've got to do it correctly. Look at New York and see how -- so that we learn from them. But informing the patient, informing the patient's relatives, the appropriate relatives that the person here is not being admitted but under -- is under observation status, would be very useful information as far as the patients are concerned. But you've got to do it right.

JIM IACOBELLIS: You know, I think -- I think you're absolutely right, because the patient has -- has the right to know what and how this -- how this status is going to impact them. And I think we need to do everything that we can do to make sure we do that. But, again, the thing that -- and we may have to deal with this bill, how do we deal with the fact that maybe six months, a year, three years later an Audit Contractor will come in and change someone's status, which doesn't impact anything to do with their care, but how does this notice requirement -- and I think we can figure out a way in which, in which to deal with that.

It is appropriate for the people and the patients while they're in the facilities to know what they are and this notice appears to be focused in that direction as opposed to some retrospective type of issue, but I look forward to working with the Committee to actually straighten that out.

REP. SRINIVASAN: And a second question is on, on

SB257

your Bill 257 which (inaudible) the hepatitis C screening. And what I kind of gleaned from you was that the testing obviously is being -- is being offered at the M.D.'s office, but the test would be done at the laboratory. And when the results come in, that was the part that I missed or couldn't comprehend. When the results come in, you're saying not to put in the statute that this conversation has to happen between the physician and the patient and just leave it like any other thing where obviously when the results come in, whether it be a CAT scan or blood test or whatever it is, and we are not mandating that or requiring that a CAT scan result has to be discussed or a bone density is to be discussed.

So, this would be no different is what I'm understanding from what you're saying. The tests are in, the results are in, and obviously it is the responsibility of the physician to discuss those results, A, and to discuss option B, and then leave it to the patient to decide what they want to do.

JIM IACOBELLIS: Exactly.

REP. SRINIVASAN: Thank you. Thank you.

Thank you, Madam Chair.

REP. JOHNSON: Thank you so much.

HB5535

And just, just as a -- one of the things I heard you say was that you have to figure out a way to deal with something that occurs between the hospital and the Medicare agency and the auditors. That's a separate issue from what occurs between the hospital and the patient. Those are two separate things. They shouldn't be confused or connected in any way. The -- under the Medicare certification requirements,

whether it's through the hospital -- between the hospital and the patient, between the, between the patient and the skilled nursing facility or patient home care provider, the patient and the treating doctor, they all have a duty to tell the patient whether or not at the time of the visit there is coverage. And if there is not coverage then the patient has that responsibility of payment.

So, this isn't something that, that was ever intended that down the road, if the hospital has made an error in the determination of whether coverage exists or not, that the patient should somehow be responsible.

JIM IACOBELLIS: No, I didn't -- and I think a lot of times when we talk about the hospital or the physician making an error, part of the whole problem is, is the disagreement over whether or not the -- an auditor is coming in, deciding whether somebody was inpatient -- should be an inpatient or an outpatient. We have these judgments and it is I think you rightly putting -- that's a debate going on between the, the hospital and the physician and the Recovery Audit Contractors. It shouldn't impact the patient.

I just want to make sure that the notice actually reflects that and it is different from that.

REP. JOHNSON: So do I. We're in agreement.

JIM IACOBELLIS: We are.

REP. JOHNSON: Thank you. Thank you so much. I really appreciate it. I just want to make sure everybody understands that we're not trying to meld the two and I want to be very, very clear about that.

JIM IACOBELLIS: And my concern is to make sure that the notice doesn't do exactly what we are agreeing.

REP. JOHNSON: That's right.

JIM IACOBELLIS: Thank you.

REP. JOHNSON: We don't have any desire to do that.

Thank you so much.

Representative Wood. Welcome, yeah.

REP. WOOD: Or happy Friday or --

REP. JOHNSON: Well, we'll see how, how long it lasts.

REP. WOOD: Yeah.

Good afternoon, Senator Gerratana, Representative Johnson, Senator Welch and Representative Srinivasan. I'm Terrie Wood, State Representative for the 141st District, which is Darien and Norwalk. I'm here to testify in opposition to Senate Bill 416, An Act Concerning the Department of Public Health Recommendations Regarding A-Level EMTs in Connecticut.

I represent a district that relies heavily on the skills and training of the A-advance level emergency medical technician. Our EMS service is staffed and run by Darien High School students. The students participate over four years and many continue on to be graduate reserves. As sophomores, the students take the State certified EMT course and the requisite State exams when they turn 16. After two more years of service and experience, many of the

son who is and two kids who are full EMTs, so, three all together. So, I do have a lot of perspective on this. And I will ask the group of adults and see the graduate reserves -- how they would like to see this managed because it does save -- ultimately, it does save money and it saves lives. So, it's a win/win. So, thank you. I will take you up on that.

REP. JOHNSON: Great, thank you. Look forward to it. Thanks so much.

REP. WOOD: Thank you again.

REP. JOHNSON: Any other questions?

Okay, thanks so much.

REP. WOOD: All right.

REP. JOHNSON: Next person I have on the list is Jean Rexford..

JEAN REXFORD: (Inaudible) need to -- sorry. The need on this to --

REP. JOHNSON: I'm doing it. Just for the record, so that -- when you don't have the microphone on, we don't get the recording. So, if you could just, just recap briefly your name and we'll start all over again.

JEAN REXFORD: Thank you so much.

HB5535  
Jean Rexford, Executive Director of the Connecticut Center for Patient Safety, in strong support of allowing patients to know if they are on observation status, but it is the beginning of the need for patients to know cost.

There is nothing that I get more questions

about right now than the problems of affiliation charges when someone has a colonoscopy. I just walked out into the, into the atrium and someone said, "Oh, my God, I was just charged \$500 for two Advil." As we are expanding healthcare, patients are putting much more skin in this game. And to be informed patients means we will make decisions on cost.

I have done it. The dentist says, "You need to have a full set of X-rays." I say, "No, I don't," because I know what that cost is. And I believe that it will be a more responsible, a more accountable system when we provide transparency of costs of all procedures so that patients can and will make decisions based on those.

So, thank you for your time. Thank you for your work. I haven't been testifying before Public Health in a few years and I realize -- you know, I love all the issues and you do such important work. But as we make radical changes to our delivery system, if we remember the patient needs to come first, I think that some of those decisions will be easier to make.

Thank you..

REP. JOHNSON: Thank you so much. And, also, as we make changes in the delivery systems but also has -- science makes changes and the different types of medical techniques and -- we also probably need to look at the laws that were put into place more than almost 50 years ago now and take a look at that and bring things up to date because the one thing that hasn't changed is the cost of medical care has continued to increase. So, we need to make sure people are covered as they -- as we move into these new areas.

JEAN REXFORD: I had this -- the paradigm thought the other day that 20 percent of -- almost 20 percent of our economy is healthcare costs and yet most of us are really, really healthy people. So, what does that mean on, on how we are spending money? It is probably not all patient centric money. It is -- these are industries that manage to churn and we're paying them. So, thank you.

REP. JOHNSON: Thank you so much.

Any questions? Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you for being here this afternoon and for your testimony. So that I'm clear, I know you are supporting House Bill 5535 because that -- is it the observation status that you were referring to?

JEAN REXFORD: Yes.

REP. SRINIVASAN: Or for the Section 2 where it talks about in the private offices?

JEAN REXFORD: It's the observation status. It is such a huge expense, particularly for people who are on limited income that -- there's a fairness issue on observation status, but I think I heard you particularly say with critical.

REP. SRINIVASAN: So, the transparency inasmuch as informing the patient and the family that this person is on an observation status at this point in time.

JEAN REXFORD: Yes.

REP. SRINIVASAN: And eventually either a decision

to go home or to be admitted will be made. So, that is what you want to make sure happens.

JEAN REXFORD: Absolutely. Thank you.

REP. SRINIVASAN: Yes. And the other comment was, I'm not sure where they'd fit it in where you talked about the dentist and, you know, his saying that you need X, Y and Z; and then you feel -- obviously you have the background, you have the knowledge, you're able to do that and say, "I really don't need a full set."

JEAN REXFORD: Right.

REP. SRINIVASAN: "And a partial is good enough." But once again, going back to the average Joe, you know, who goes for the dental workup or any other workup, like the colonoscopy you were just mentioning as you were in the corridor, and they have to go with whatever the physician or the provider tells them because obviously they feel that is in their best interest.

JEAN REXFORD: Absolutely. And, so, I think what you said is just critically important. So, what if the patient is getting a colonoscopy could say, "What is the total cost of this procedure?" and that could be provided, that patient will make those decisions. There is a fecal test that England uses that is probably 100th of the cost of the test that we use in this country. So, that whole movement that we're seeing towards informed decision making, shared decision making I think will help expose the cost of care.

REP. SRINIVASAN: You are absolutely right. And I definitely concur on that because patients then -- patients and families in limited budgets or limited health access that they have can then decide, you know, what is appropriate

for them and what they do not need at that point in time.

JEAN REXFORD: Yes. Thank you.

REP. SRINIVASAN: Thank you very much for your testimony. I appreciate that.

Thank you, Madam Chair.

REP. JOHNSON: Thank you so much. Thank you so much.

The next person -- any additional questions?  
No?

Next person is Representative Berger. Welcome.

REP. BERGER: Welcome.

REP. JOHNSON: Thank you.

REP. BERGER: Good afternoon, Madam Chair and Committee members. Thank you for having this hearing on a Friday afternoon at 1 o'clock. Hopefully your day will be short.

For the purposes of the record, my name is Representative Jeffrey Berger representing the 73rd Assembly District in Waterbury. As a way of an observation, Madam Chair, before I get into my testimony, I, I have not appeared before the Public Health Committee very often. But having a doctor on Public Health is very, very comparable to having an economist on Finance Committee, so.

I am here in support of House Bill 5537, An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes. I have submitted before you a -- additional change in Section

REP. JOHNSON: -- and taking the time. Really appreciate it.

REP. BERGER: Thank you, Madam Chair, and thank you, Committee members.

REP. JOHNSON: Okay. The next person I have on the list is Terry Berthelot. Welcome, and please state your name for the record. And I might not have pronounced it just right. I'm sorry.

TERRY BERTHELOT: Thank you.

My name is Terry Berthelot. I'm a Senior Attorney with the Center for Medicare Advocacy. The Center is a national not-for-profit law firm. Our mission is to ensure that the elderly and people with disabilities have access to Medicare coverage and to ensure access to quality healthcare.

I'm here today to express our strong support for Raised Bill Number 5535 spoken about earlier. It is the bill that would require that hospitals give notice when patients are put on observation status. At the Center, we know firsthand how terrible being put on observation status is for a patient. There are very, very serious financial and health consequences. Financial consequences, the biggest is that when a person is on Medicare and she's put on observation status, she will not have the required three inpatient days as an inpatient for her subsequent care at a skilled nursing facility.

At the Center, I personally represented someone who was put on observation status for 12 days. After 12 days of being in a hospital bed, anybody will need the kind of care that one can only get in a skilled nursing facility. The cost of care in a skilled nursing facility in

Connecticut can be as much as \$15,000 a month. So, to be put on observation status because of a crazy billing rule can have dire financial effects but also health consequences, because most people don't have \$15,000 lying around. Many people are forced to go home and not get the necessary care. Those folks, sadly, will often fail and end up back in the hospital in much more serious medical condition.

Getting this notice will not solve all the problems, but it will go a very long way for helping people and families to advocate for themselves. I speak nationally on this issue and locally and was recently at a community center where a woman spoke up and said they formed a committee. Their rule was friends don't let friends end up on observation status.

Reality is if you have knowledge, you can advocate for yourself. You can ask the treating physician, the admitting physician what your status is and why you're on that status. You can get your community physician involved to advocate for you because, in reality, medically there's no such thing as observation status. It's a myth. It's a billing issue and it's an issue that is extremely complicated and being made often -- the decision to put a person on observation status by the Utilization Review Committee, often overruling the initial admitting physician.

I've seen in discharge summaries where, where treating physicians are writing over and over again, "This person should have been admitted." So, we have financial and we have medical concerns when people are put on observation status. So, it will be a great service to the people of Connecticut if they could get notice from the hospital when they're on observation

status.

The other issue is when you're on observation status, your medications will not be paid for by your Part D Plan. This can be very, very expensive because folks are forced to pay whatever it is the hospitals charges for these medications. So, an Advil can truly be very, very expensive. Most people do have chronic conditions, things like high blood pressure or diabetes. They need these medications while they're in the hospital.

The other issue is that folks will be responsible for their Part B cost sharing. That's the 20 percent that Medicare beneficiaries usually pay when they see a physician. The other issue is that many folks don't have Medicare Part B. So, these folks, when they are hospitalized, will have literally no insurance and have to pay the entire hospital bill out of pocket.

We do have a few suggestions we'd like to make to make the bill stronger. We would like to see language added encouraging patients to talk to their treating physician and possibly their community physician about their status. Because this is a medical decision, these are the folks who are best able to possibly change the person to an inpatient.

The other thing that would be a great help would be if hospitals were required to allow folks to bring in their medications from home and that the notice would tell folks that they could do this. We see some hospitals in Connecticut already doing this. This could save Medicare beneficiaries especially quite a bit of money.

The other thing that could be improved is the

notice. The language of the notice could be a bit stronger. It should -- often when folks are admitted to the hospital they are overwhelmed. They are frequently confused because of medications or possibly even a head trauma. It's very important that the notice be given to a capable recipient and, further, that the notice be given in a language that the person can understand or with the presence of a translator.

And additionally, being somebody who needs reading glasses, to make sure that if the person can't read it herself -- lots of times when folks go in an ambulance, they don't remember their glasses -- if somebody reads the notice to her.

The last thing that we would add is, though I think most hospitals will comply with this willingly, as we heard earlier, there seems that there needs to be some sort of, um, sanction if hospitals don't comply. Whether financial sanction or other, that certainly seems to be something that could make this strong -- a stronger bill going forward.

Thank you.

REP. JOHNSON: Thank you so much for those recommendations and taking the time to be with us today. Just -- you said that you had a number of cases that you have been dealing with. Go a little bit through the procedure in terms of how the case comes to you, the appeals process, and what the patient might have to do in order to get skilled nursing facility coverage or Part D Medicare Prescription Drug Coverage if one of these is -- if, in fact, they are just observation status and then transferred from the hospital to the skilled nursing facility.

TERRY BERTHELOT: Often folks call us after the fact generally because they're not getting notice. So, just yesterday one of my colleagues took a phone call where her father had been in the skilled nursing facility for two weeks and the skilled nursing facility and the family had just been given notice that he had never been admitted to the hospital.

Fighting these cases is -- after the fact is enormously challenging, largely because even though there may be a right to appeal on one level, there is no process for appeal.

The other issue is that because of the administrative process for Medicare appeals right now is extremely backlogged, our cases are taking about two years at best to get a decision from an administrative law judge. And because these are so complicated, not all of the cases make it all that way.

Regarding the prescription drug medications, again, there is a right to have them billed to a Part D Plan, but there is no official process. And I've not seen somebody successfully do that yet. The hospital is -- will be out of network. So, even if the Part D Plan agrees to pay for the medications, the person will pay at a higher rate than she would have had she been -- had she brought in her medications from home.

REP. JOHNSON: So, when you look at the scheme that you have and the regulations for Medicare, they have something called the Waiver of Liability. So, if the hospital or the skilled nursing facility, some provider does not provide notice then the patient doesn't have to pay. How does that work when someone goes into a skilled nursing facility and they've had an observation

status situation?

TERRY BERTHELOT: That's an excellent question. The Waiver of Liability provision only applies when the question is whether or not the care is custodial or skilled. It doesn't apply when it's a technical denial, and lack of a three-day inpatient stay is a technical denial. So, that particular provision that would hold the skilled nursing facility rather than the family or the patient financially responsible does not apply.

REP. JOHNSON: Very good. So, so, for sometime the patient could be on observation status, go to a skilled nursing facility, and be continuously on the unawares of, of the financial burden they've been incurring?

TERRY BERTHELOT: Exactly.

REP. JOHNSON: And thousands of dollars later, and if they have any resources like a home or any of those things, then at that point in time the, the -- those assets are in jeopardy.

TERRY BERTHELOT: Indeed. I fielded one phone call from a woman who was on Medicare because of disability who paid with a credit card to get into the nursing home and quickly was looking at 21 percent interest. People are, are making enormous sacrifices in order to get the care they need including, sadly, putting their, their homes and all of their assess -- assets in jeopardy.

REP. JOHNSON: So, by your comments, you have a two-prong situation here. Perhaps they have to absolutely be in the skilled nursing facility after having been in the hospital with an observation status for three days or more. And in that circumstance they have to find a way to

pay, but they won't necessarily know that they'll -- that they'll have to find a way to pay.

In terms of -- are you familiar at all with the Medicaid process?

TERRY BERTHELOT: Um, not an expert, but somewhat familiar.

REP. JOHNSON: So, in, in a circumstance where the lady had used her credit card, if she was medically needy under the Medicaid law, she might have used that if she had had proper assistance through the nursing facility.

TERRY BERTHELOT: It is possible, and it's a good thing that we have such a strong Medicaid program here in Connecticut. But one of the consequences of observation status is the shifting of liability from the Federal government to the State government for care that should be being paid for by Medicare.

REP. JOHNSON: And then the other circumstance might be where if there was a chance someone had the observation status might know of, of a way to provide around-the-clock care at home instead of the skilled nursing facility, that might be another avenue if they had a family member or something that would be able to save the cost to --

TERRY BERTHELOT: That is true -- that is true. Some of us are lucky enough to come from families that do have enough people who are -- who don't have to work and are able to be with us around the clock, but unfortunately that's not everybody.

REP. JOHNSON: Very good.

Do you have any questions? Yes, Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you very much for your testimony. You gave us a lot of insight. And even though I am in the medical world, I mean, there are a lot of things about this that I was not aware of and appreciate -- the entire Committee appreciates that very much.

You know, when a patient goes on observation status, to the best of your knowledge, is there a limit in number of days that the person, he or she could be? I thought there was, and you said -- you gave an example of somebody being on observation for 12 days and not being admitted, and that is astounding. And I wasn't sure if there was any rules on that -- on that aspect.

TERRY BERTHELOT: Observation status is only addressed and defined in policy by the Centers for Medicare and Medicaid Services, and there it's suggested that it shouldn't be more than 24 to 48 hours. But in reality, folks are frequently on observation status for many, many days.

REP. SRINIVASAN: Thank you. And that's what I thought all along that you would -- you know, because the condition of the patient is stable, unstable, stable, unstable. Still you want to keep them under observation, but typically would -- I would guess by 48 hours you will know what to do, that they would admit them or send them home. Thank you for that clarification, but that's what I thought all along and I was absolutely shocked when you said this person was on observation for 12 days and obviously didn't know about that fact of it

at all.

I want to thank you for all your recommendations. They are very, very practical and, and I'm glad some of the hospitals are already complying. And, obviously, we need to make sure that getting the medications from home, which will save these people a ton of money, and obviously they don't have it. Nobody does, and definite this group does not have the extra money when the medicines are already paid for as an outpatient.

And my last question is I'm trying to figure out what would be the rationale if a physician says in his notes over and over again that this patient's status as such is labile and, you know, should be admitted in the hospital, and then the hospital does not do that. Utilization or whatever it is, does not admit the patient and continues to keep them in an observation status?

The only occasion or the only scenario that comes to my mind is, you know, in Medicare if you get readmitted within a certain period of time, I mean, the hospital obviously has, has a penalty to pay. It's done. There's, you know, red flags go up, and so on and so forth. So, other than that, what would be the motivation or the reason? I'm hoping not financial, but what would be the reason that the hospital, in spite of the physician's recommendation to admit, continues to keep the patient in observation status?

TERRY BERTHELOT: You asked a question that I'm frequently asked, and lots of folks assume that the hospitals must be making a lot of money on observation status and that's why they're doing this, but that's not true at all. They're losing money when they put people on

observation status.

The reason they're putting people on observation status was alluded to earlier. The Recovery Audit Contractors, often known as the RAC, I think of them as the Spanish Inquisition. They're literally bounty hunters who are using criteria that are far more limited regarding what should be covered by Medicare than what the actual law is and they're doing this retroactively. And if you are overturned -- if you're a hospital system and you're overturned too frequently, you will be investigated for fraud and you'll definitely end up on the front page of the local paper, and no hospital wants to be there.

So, I'm afraid they're, they're -- they're feeling forced into this even against their own physician's wishes. And doctors are told -- if you're a nerd like me and you look at -- you Google things and you find PowerPoints that are being taught in hospitals, you'll see that doctors are being told -- promised that regardless of what status their patient is on, the patient will get the same kind of care, and not to worry about it. But what, what the doctors don't know often is the later ramifications.

REP. SRINIVASAN: Thank you very much for all those clarifications. We appreciate that.

Thank you, Madam Chair.

REP. JOHNSON: Thank you, Representative.

Any additional questions?

Thank you so much. We want to work with you on some of your recommendations and really appreciate having this conversation. So, thanks so much

for being here today.

TERRY BERTHELOT: Thank you very much for the opportunity.

REP. JOHNSON: Okay. The next person on our list testifying for House Bill 5330 is Jerry Silbert, followed by Tara Cook-Littman.

JERRY SILBERT: Thank you very much.

REP. JOHNSON: Welcome. Thank you, and please state your name for the record.

JERRY SILBERT: My name is Dr. Jerry Silbert. I'm a physician, I'm trained in pathology, and I'm testifying for Bill 5330, and I want to thank the Committee for raising this bill. And I -- it would be the right thing if you're voting for this bill as well because you may never know the children you are helping. But rest assured, you'll be saving lives and you'll (inaudible) saving suffering to the Connecticut's children.

I think the evidence is clear. There is independent science in peer-reviewed journals talking about the health effects of pesticides on children. Neurological effects, brain tumors, lymphoma, leukemia, birth defects, asthma, behavioral disorders -- all of this can be related to wide a variety of different pesticides, many of which are lawn pesticides.

In term of -- you'll be hearing testimony here that, that grounds keepers need to use these pesticides in order to maintain fields. You'll be hearing testimony that these fields deteriorate and are a danger to children because of compaction, because of clumps of crag grass and they're going to trip. But I would say this, I've had personal experience

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March 14, 2014  
9:00 A.M.

DR. HELEN NEWTON: Thank you so much.

SENATOR GERRATANA: I don't know if anyone has any questions. I guess not. Thank you for coming and testifying.

DR. HELEN NEWTON: Thank you again.

SENATOR GERRATANA: Okay, we're going back to House Bill 5529, and next is Matt Katz, Connecticut State Medical Society. And to follow Matt is Vic Vaughan.

MATTHEW KATZ: Senator Gerratana, Representative Johnson, and members of the Public Health Committee, my name is Matthew Katz. I'm the EVP CEO of the Connecticut State Medical Society, and I'm here today representing not only the State Medical Society, but the Connecticut Chapter of the American College of Physicians, and a number of other medical specialty societies actively practicing in the state of Connecticut.

HB 5535

We appreciate the intent of House Bill 5529; however, we have concerns associated with the removal of language that presently we believe functions effectively when it comes to peer review and peer review of literature. Though we recognize the interest and intent of including mental health and related issues into the bill which we think would be helpful, the concern is eliminating anything that has been effective would be problematic, we believe, for physicians and patients.

So we again recognize the -- the intent and appreciate the Committee's efforts, but are concerned about elimination of language tied to peer reviewed literature that could have an unintended consequence for those patients that need medically-necessary care that physicians

determine is in their best interest based upon the peer-reviewed literature that they review.

Finally, I do remiss not to mention Bill 5535. Real quickly, Section 2 we think has significant concerns for us because it provides an undue burden on physician offices having at each visit to provide information to patients about who provided care and what care was provided which could differ on every patient encounter. So we ask the Committee to look at that-section again, and thank you very much. And I'll take any questions.

SENATOR GERRATANA: May I -- I know Representative Johnson has questions and I apologize. Were you only testifying on 5529? Did you just include -- ?

MATTHEW KATZ: I -- I -- we did not submit 5535, but I just wanted to raise it to the Committee's attention that Section 2 of that bill has some, I think, language -- we have some language concerns with because it may be overly broad to cause a patient to receive information at every visit, at every encounter that may be different for each patient.

SENATOR GERRATANA: Oh, I see. Okay. Thank you very much.

MATTHEW KATZ: You're welcome.

SENATOR GERRATANA: Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair, and thank you for providing testimony today. And so I appreciate your remarks with respect to evidence-based, peer-reviewed materials, but I'm not sure that's the exact language in the medical necessity statute. I'm not sure it says peer-reviewed, evidence -- it's just

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Testimony on HB 5535: AAC Notice of a Patient's Observation Status and Notice Concerning the Qualifications of Those Who Provide Health Care and Counseling Services

Public Health Committee  
March 14, 2014

Submitted By: Stephen A. Karp, MSW

The National Association of Social Workers, CT chapter supports Section 2 of HB 5535. It is important that consumers be fully informed as to the qualifications, including license and certification, of the mental health practitioner providing counseling services to them.

In Connecticut the provision of mental health services is not strongly regulated. There are the six professions that are licensed or certified by DPH: Social Work, Psychiatry, Psychology, Marital and Family Therapy, Professional Counselors and Alcohol & Drug Counselors. Individuals being treated by a practitioner of one of these licensed or certified professions can be assured the practitioner has a license or certification and that the consumer may file a complaint with DPH if they believe practice standards were not maintained in the treatment.

There are individuals however who offer counseling services without a state license or certification, thus the consumer cannot seek redress through DPH and the consumer may not be receiving proper treatment as the provider may not have a qualified certification or degree. The reason for this is that "Psychotherapist" is not a protected title in Connecticut. Anyone can hold themselves out as a psychotherapist as long as they do not claim to be a licensed practitioner when they are not. Consumers can wrongfully assume that they are seeing a master or doctoral trained mental health provider whose degree is actually in a mental health field. HB 5535 addresses this issue by making sure that the consumer is informed as to the professional's qualifications, license and certifications or lack thereof.

HB 5535 also makes sure that the consumer is aware of the qualifications of the staff that will be involved in counseling them. This is an important point as a consumer may go to a licensed provider's practice but be treated by an employee of the licensed practitioner that may not be as qualified. Again, consumers need to be fully informed of such matters.

We urge the Public Health Committee to pass this consumer friendly provision that will assure consumers are fully informed as to the qualifications, level of training, and expertise that their mental health provider has attained.



Connecticut's Legislative Commission on Aging  
*A nonpartisan research and public policy office of the Connecticut General Assembly*

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Testimony of

**Deb Migneault**

Senior Policy Analyst

Connecticut's Legislative Commission on Aging

**Public Health Committee**

March 14, 2014

Senator Gerratana, Representative Johnson and esteemed members of the Public Health Committee, my name is Deb Migneault and I am the Senior Policy Analyst for Connecticut's Legislative Commission on Aging. I thank you for this opportunity to comment today on HB 5535.

As you know, Connecticut's Legislative Commission on Aging is the non-partisan, public policy office of the General Assembly devoted to preparing Connecticut for a significantly changed demographic and enhancing the lives of the present and future generations of older adults. For over twenty years, the Legislative Commission on Aging has served as an effective leader in statewide efforts to promote choice, independence, empowerment and dignity for Connecticut's older adults and persons with disabilities.

**HB 5535: An Act Concerning Notice of Patient's Observation Status and Notice Concerning the Qualifications of Those Who Provide Health Care and Counseling Services**

**~ CT's Legislative Commission on Aging Supports**

We are very grateful to this committee for working to address a growing problem for people utilizing Medicare, Medicaid or private insurance coverage. CT's Legislative Commission on Aging supports this bill that helps people understand their hospital status, their benefits and their rights. We have been following this issue closely through the work of our partners and national experts on this issue, The Center for Medicare Advocacy, who has filed a class-action lawsuit to challenge this illegal practice.

As you are aware, increasingly hospital patients are finding they have been in the hospital under "Observation Status" even though they have been cared for in a hospital for many days. These patients have been treated in a regular hospital room,

have been cared for by hospital doctors and nurses, just as you would expect of a stay in a hospital. However, they have not been officially "admitted". There are cases when an individual has been in hospital for as long as 14 days and yet was never officially admitted.

For people on Medicare the implications seem especially jarring. According to Medicare benefit rules, these patients on observation status are considered "outpatient" and will not have access to the same Medicare benefits as someone who is considered "inpatient".

The patient on Medicare in observation status will have to pay co-pays for doctor visits and testing and also have to pay for routine drugs they may take for chronic conditions (like high blood pressure and diabetes). Additionally, if the patient is discharged to a skilled nursing facility (SNF) for rehabilitation, the care they receive in the SNF will NOT be covered because they have not met the 3-day inpatient hospital stay requirement. The patient is then responsible for the cost of SNF care.

Medicare does NOT require hospitals to notify patients about their status. Many times, patients believe they are inpatient and do not realize the potential effects to the Medicare benefits. Further concerning is that this practice - of Medicare beneficiaries entering the hospitals as observation patients - is on the rise, according to Kaiser Health News. The number increased by 69% in five years, to 1.6 million people nationally in 2011.

HB 5535 requires hospitals to give written and oral notice of their observation status. CT's Legislative Commission on Aging fully supports providing this information to patients and most importantly helping the patient to understand how this status affects their coverage and benefits.

To strengthen the intent of the bill and help inform and protect patients, we would suggest that the notice to patients includes information about what it means to be considered "observation status", particularly that patients may be responsible for the cost of medications and the skilled nursing facility coverage (if relevant). We would also suggest that the notice include that questions regarding their status in addition to their health insurer and Office of Health Care Advocate, be directed to the admitting and/or primary physician.

*Thank you for this opportunity to comment. As always, please contact us with any questions. It's our pleasure and privilege to serve as an objective, nonpartisan resource to you.*

Center for Medicare Advocacy, Inc

www.medicareadvocacy.org

**Testimony Regarding An Act Concerning Notice of a Patient's Observation Status  
Raised Bill No. 5535**

March 14, 2014

I am a senior attorney with the Center for Medicare Advocacy. The Center is a private, non-profit organization headquartered in Mansfield, Connecticut and Washington, DC with offices throughout the country. At the Center we know firsthand the medical and financial ramifications of observation status and very much appreciate your attention to the problem. We strongly support the proposed bill and would like to make a few suggestions to make it stronger.

The Center provides education and legal assistance to advance fair access to Medicare and quality healthcare. We represent older and disabled people throughout Connecticut, respond to approximately 6,500 calls and emails annually, host two websites, and lead the National Medicare Advocates Alliance. The Center also provides written and electronic newsletters, myriad seminars, expert support for Connecticut's CHOICES program, and a vast array of other services on behalf of Medicare beneficiaries throughout Connecticut and the United States.

**OBSERVATION STATUS IS A SERIOUS PROBLEM FOR MEDICARE BENEFICIARIES**

In 2012, 1.5 million Medicare beneficiaries were admitted to the hospital on observation status rather than as inpatients. This usually means the beneficiary went to the emergency room, was assessed by the emergency room physician as too sick to return home, was admitted to the hospital, signed all the admission paperwork, donned a hospital gown and spent one, two, three, five, or even twelve nights or more in a hospital bed receiving the full array of hospital services including specialized tests and access to specialists. Unfortunately, when Medicare

beneficiaries must stay in a hospital bed for several days, they very often suffer from a condition known as "Post-Hospital Syndrome." This condition was described by Dr. Harlan M. Krumholtz in the New England Journal of Medicine:

During hospitalization, patients are commonly deprived of sleep, experience disruption of normal circadian rhythm, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that can alter cognition and physical function, and become deconditioned by bed rest or inactivity. [N Engl J Med 2013; 368:100-102 January 10, 2013 DOI: 10.1056/NEJMp1212324]

This means that following the hospitalization, patients admitted as either inpatients or on observation status for several days, regardless of diagnosis, need the kind of intensive rehabilitation generally delivered in a skilled nursing facility (nursing home). However, traditional Medicare will only pay for skilled nursing facility care if the beneficiary was admitted to a hospital as an inpatient for three consecutive nights. When a beneficiary is admitted to the hospital on observation status, she is admitted as an *outpatient* rather than an inpatient. Consequently, Medicare will not pay for her very necessary rehabilitation at the skilled nursing facility. In Connecticut, care at a skilled nursing facility can cost as much as \$15,000 per month. Many people do not have the money to pay for the necessary care. Additionally, beneficiaries put on observation status may be billed for the cost of medications they received while hospitalized and for the Part B cost sharing for all procedures received while on observation status. Moreover, Medicare Part B is an optional benefit. When Medicare beneficiaries without Part B are put on observation status, it is as if they have no insurance, they become financially responsible for all the care rendered while they were hospitalized.

**A NOTICE REQUIREMENT WILL HELP CONNECTICUT RESIDENTS PLACED ON OBSERVATION STATUS**

There is no federal rule requiring hospitals to notify Medicare beneficiaries that they have been admitted on observation status rather than admitted as inpatients. This means that many Connecticut residents do not find out that they were not admitted to the hospital until the time of their discharge or even after they have been admitted to a skilled nursing facility. The proposed

bill will mean that Medicare beneficiaries in Connecticut will be told within 24 hours after placement on observation status that they are on observation status and that placement on observation status may affect the cost of their medications and the availability of Medicare coverage for post-hospital skilled nursing facility care. However, the bill could be stronger

To begin with, Medicare beneficiaries with traditional Medicare are affected by observation status very predictably. Thus the proposed notice in the bill should clearly say that if a Medicare beneficiary with traditional Medicare is put on observation status rather than admitted, the costs of her medications while hospitalized and, if needed, her post-hospital skilled nursing facility care will not be paid for by Medicare. This stronger language is necessary to alert patients that there are very real financial and healthcare access problems caused by observation status.

As written, the notice described in the bill will encourage the patient put on observation status to contact her health insurance provider or the Office of the Healthcare Advocate. Additionally, the proposed notice in the bill should encourage patients put on observation status to speak to the admitting physician about why they have been put on observation status rather than admitted. Moreover, the proposed notice should encourage patients to contact their community physicians about their hospital status. This is because placement on observation status has both financial and medical consequences.

One of the many costs associated with placement on observation status rather than inpatient status while hospitalized is the out-of-pocket cost for medications. The proposed bill would be improved if it required hospitals to allow those put on observation status to bring in medications from home and to take those medications while hospitalized. To this end, the proposed notice described in the bill should notify those put on observation status that they have a right to bring in their medications from home and that if they do, they will avoid the costs associated with receiving them from the hospital.

As was stated above, receiving a notice from the hospital that one has been put on observation status will be very helpful. As written, the bill requires that the proposed notice "be signed and dated by the patient receiving the notice or such patient's legal guardian, conservator or other authorized representative." Given that many patients enter the hospital with an altered mental status due to their illness, or without their reading glasses, this language would be better if it read "be signed and dated by a mentally competent patient who is able to read and comprehend the information described in the notice or such patient's legal guardian..." Moreover, since many of Connecticut's residents do not read English, the bill would be better if it required that the notice be rendered in the patient's language or rendered with the assistance of a translator.

Finally, the bill would be improved if it included a financial sanction for hospital non-compliance.

#### CONCLUSION

The Center for Medicare Advocacy supports Raised Bill No. 5535 requiring hospitals to give notice when patients are put on observation status with the following recommendations:

1. Add clear language to the notice regarding consequences of observation status for patients with traditional Medicare.
2. Add language to the notice directing patients on observation status to speak to their admitting physicians and community physicians about their designation on observation status and its potential medical consequences post-hospitalization.
3. Require hospitals to allow patients on observation status to bring in and take medications from home to avoid significant financial burden of paying for medications administered by the hospital
4. Add language to the proposed notice regarding patient's right to bring in and take medications from home.

5. Add language to the proposed notice ensuring that it will be given to beneficiaries able to comprehend its contents and in a language they can understand.

Thank you for the opportunity to testify regarding this important matter.

Respectfully submitted,

Mary T. Berthelot, MSW, JD  
Senior Attorney



**TESTIMONY OF  
JAMES IACOBELLIS  
SENIOR VICE PRESIDENT, GOVERNMENT AND REGULATORY AFFAIRS  
CONNECTICUT HOSPITAL ASSOCIATION  
BEFORE THE  
PUBLIC HEALTH COMMITTEE  
Friday, March 14, 2014**

**HB 5535, An Act Concerning Notice Of A Patient's Observation Status And Notice  
Concerning The Qualifications Of Those Who Provide Health Care  
And Counseling Services**

My name is James Iacobellis. I am Senior Vice President, Government and Regulatory Affairs at the Connecticut Hospital Association (CHA). I am testifying today concerning **HB 5535, An Act Concerning Notice Of A Patient's Observation Status And Notice Concerning The Qualifications Of Those Who Provide Health Care And Counseling Services**. CHA opposes the bill as written.

Before outlining our concerns, it's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, equitable, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done. Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

HB 5535 attempts to address two different issues, both of which can affect a patient's experience when seeking healthcare. CHA appreciates that the bill's purpose is to make a patient's healthcare experience easier and more transparent, but CHA opposes the bill as written because it will not accomplish these goals, and it will unnecessarily burden hospitals.

Section 1 of the bill is directed to "observation level" status at a hospital and would require a hospital to provide "oral and written notice to each patient that the hospital places in observation status" no later than 24-hours "after such placement."

Observation status is a type of billing and coding category for a patient that has presented to the hospital; the patient may not be medically safe to send home, but he or she does not meet the technical billing guidelines and insurance reimbursement requirements that qualify for an inpatient stay. Hospitals have no control over these billing criteria, which are the product of often complicated federal HHS and CMS billing rules, as well as private insurance rules.

Please know that hospitals are incredibly frustrated by the confusion, hardship, and negative effects that these billing and insurance rules cause for patients.

Hospitals are actively seeking clarification and changes from the federal government to respond to the harsh results that the observation status rules and inpatient criteria limitations have caused. Currently, this topic is being fiercely debated on a national level. A final rule was published by CMS in fall 2013 purportedly to clarify the application of observation level and inpatient criteria for Medicare billing. These efforts were almost universally criticized by hospitals and patient advocates alike as unhelpful to patients and confusing for providers, leading to a series of attempts at the federal level to amend the rules to be more workable. After a series of initial delays and failed efforts at clarifying language, CMS has now delayed the bulk of the new rule until September 2014.

We are hopeful that Congress will intercede and fix this issue in a way that supports patients and reimburses hospitals appropriately. We do not believe that taking action at a state level at this time will assist patients in a meaningful way, and we ask that you not take this action while the federal questions are being sorted out. We note that, with respect to Medicare beneficiaries, we believe that this bill oversteps the role of CMS in determining what notices are required for Medicare beneficiaries.

HB 5535 is also unworkable. Due to the vagaries of billing rules, hospitals will not always contemporaneously know whether a patient is on observation status or if a patient's next setting of care will be covered by insurance. Additionally, notifying patients who have already left the hospital will be unachievable in many cases. To comply with the bill, hospitals will likely be forced to give every patient a notice that he or she might be on observation status - which will only lead to greater confusion and potentially cause some patients to leave the hospital against medical advice or to forego necessary medical procedures.

Section 2 of the bill seeks to require all outpatient providers to list the "qualifications" of persons providing services, as well as a description of the services provided. The bill as drafted appears to require a hospital to list the credentials of every service provider for all outpatient services – a list that would be hundreds and sometimes thousands of providers long. This is both unworkable for providers and unhelpful to patients.

The bill's exemption for "inpatient health care facilities" is not sufficient to cover hospital settings because it does not exempt a wide variety of services, including but not limited to the emergency department, clinics, same-day surgery, and diagnostic and testing services.

We ask that all hospital-related services be exempt from the requirements of Section 2 of the bill.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.



## Real Possibilities

Testimony of AARP CT

H.B. # 5535: AN ACT CONCERNING NOTICE OF A PATIENT'S OBSERVATION STATUS AND NOTICE CONCERNING THE QUALIFICATIONS OF THOSE WHO PROVIDE HEALTH CARE AND COUNSELING SERVICES

March 14, 2014

Dear Members of the Public Health Committee,

Thank you for the opportunity to comment on H.B. 5535, Section 1, regarding notice for a patient's hospital observation status. AARP is a nonpartisan social mission organization with an age 50+ membership of nearly 37 million nationwide, and over 602,000 here in Connecticut. AARP believes that one's possibilities should never be limited by their age and that, in fact, age and experience can expand your possibilities, whether they be personal or professional. AARP is a network of people, tools and information and an ally on issues that affect the lives of our members and the age 50+ population in general.

Today, AARP offers our support of the proposed notification requirement outlined in Section 1 of H.B. 5535. The focus of Section 1 is very simple: hospitals should notify patients when they are in observation status and classified as outpatients, and help them to understand the impact that outpatient status may have on the patient's coverage and costs.

Recently, the Medicare Payment Advisory Commission and the Centers for Medicare & Medicaid Services have noted that frequency and duration of observation stays has been increasing. Patients in observation status are classified as hospital outpatients, not inpatients. In many hospitals, actual medical services provided in the inpatient and observation settings are virtually identical, so it's not always clear to patients how they have been classified. Patients are called outpatients despite the fact that they may stay for many days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food just as if they would if they were inpatients.

Unfortunately, the financial impact for Medicare beneficiaries who spend time under observation can be burdensome, and this bill makes sure that patients are made aware of this. Due to the loophole in Medicare law relating to payment for hospital outpatient services, Medicare beneficiaries under observation may be responsible for out-of-pocket costs that substantially exceed the 20 percent coinsurance imposed for other Medicare Part B services. In addition, since Part B does not cover the cost of self-administered drugs provided in the outpatient setting, these beneficiaries are typically responsible for the full hospital charges for these drugs. These out-of-pocket costs can quickly add up, especially for beneficiaries on fixed incomes.

In addition, time spent under observation does not count toward the three-day prior inpatient stay required for Medicare coverage of skilled-nursing facility services, so some beneficiaries who need this post-acute care may fail to qualify for coverage, even though they have spent more than three days in the hospital under observation. Hospital stays classified as observation, no matter how long and no matter the type or number of services provided, are considered outpatient. These hospital stays do not currently qualify patients for Medicare-covered care in a skilled-nursing facility.

Because of the serious potential impact on a patient's out-of-pocket costs, outpatient status should be communicated to the patient while they are in the hospital, rather than coming as a surprise later. This will help reduce beneficiary confusion about what services and costs will be covered by Medicare.

There are bi-partisan efforts currently underway at the federal level led by Connecticut's Second District Congressman, Rep. Joe Courtney, to deem a Medicare beneficiary receiving outpatient observation services as an inpatient during this time period. AARP has endorsed that legislation—Improving Access to Medicare Coverage Act—but, in the meantime, Section 1 of H.B. 5535 may provide some benefit to consumers in understanding their cost sharing obligations and potentially provide the tools to take action and have their status resolved. Under this approach, the notification and referral to the Health Care Advocate may help consumers understand their cost sharing obligations. However, it is crucial that the patient is well enough, when notification is received, to understand the information provided so that they (or a family caregiver) can advocate for a change in status while they are still in the hospital.

AARP recommends the following changes to strengthen H.B. 5535, Section 1:

1. Require that the standard elements of the notice be set forth in regulation through a collaborative stakeholder process. This would provide an opportunity for additional stakeholder consideration and input resulting in a more effective and useful notice;
2. Include a sunset provision should Congress fix Medicare policies regarding outpatient status (e.g. with passage of the Improving Access to Medicare Coverage Act). For example, Connecticut could include text from a similar notification proposal in Pennsylvania:

"...(a) Notice.--If the Federal Government amends 42 CFR 409.30(a)(1) (relating to basic requirements) to eliminate or modify the Medicare three-day qualifying hospital stay requirement in a manner that makes the notification required under section [#] unnecessary, the [Commissioner of Public Health] shall submit notice of the amendment for publication in the [Connecticut Law Journal].

(b) Time.--This act shall expire upon publication of the notice under subsection (a)."; and

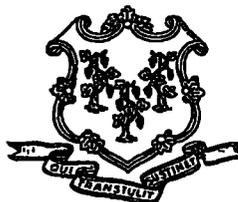
3. Ensure that the staff giving notice is properly trained to answer questions and that such information about the impact on Medicare beneficiaries is up-to-date and accurate.

In conclusion, AARP Connecticut supports the objectives of H.B. 5535, Section 1. We will continue to work with you to make additional improvements on the bill and will make ourselves available to you for any additional questions or support on this matter.

If you have any questions please contact, Claudio Gualtieri, AARP Associate State Director of Advocacy at (860)-548-3185 or [cgualtieri@aarp.org](mailto:cgualtieri@aarp.org).

**SENATOR MARTIN M. LOONEY**  
**MAJORITY LEADER**

Eleventh District  
*New Haven, Hamden & North Haven*



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March 14, 2014

Good afternoon Senator Gerratana, Representative Johnson and Members of the Public Health Committee. I would like to offer my support for H.B. 5535 An Act Concerning Notice Of A Patient's Observation Status And Notice Concerning The Qualifications Of Those Who Provide Health Care And Counseling Services. This bill would require hospitals to provide patients with notice of placement in observation status and require providers of health care and counseling services to provide notice of their qualifications and a description of the services provided. Patients left on observation status can find themselves in disadvantageous situations with insurers that have different (often less generous) coverage for in-patient vs out-patient procedures. The issue of observation status can be especially difficult for Medicare patients as some patients who require nursing home care and have spent time in the hospital on observation status have had nursing home transfers rejected by Medicare because they have not fulfilled the required pre-nursing home hospital stay. Notice of being on observation status would be quite helpful to these patients. Thank you for hearing this important legislation.

TO: MEMBERS OF THE PUBLIC HEALTH COMMITTEE

FROM: JEAN REXFORD, EXECUTIVE DIRECTOR  
CONNECTICUT CENTER FOR PATIENT SAFETY

DATE: MARCH 14, 2014

**PLEASE SUPPORT HOUSE BILL 5535 – AAC NOTICE OF A PATIENT'S OBSERVATION STATUS AND NOTICE CONCERNING THE QUALIFICATIONS OF THOSE WHO PROVIDE HEALTH CARE AND COUNSELING SERVICES**

Friends:

Good morning, I am Jean Rexford, Executive Director of the CT Center for Patient Safety. I am here today in support of HB 5535 but it is only a first step in providing much needed price transparency for all residents of our state.

Residents make decisions all the time based on cost. We know what a vet charges, a dentist, and we have care options based on those costs. Yet most of the time we have no idea of the cost of procedures and medications that have been ordered until we get the bill and for many people that cost is unaffordable and it is too late.

I had hoped for passage of a bill this year that, like Maine's bill last year, would require doctors to provide cost transparency on regularly-performed procedures that he/she performed. This is only fair to the patient who suddenly may be looking at added-on costs by the anesthesiologist and or an affiliation fee because the physician practice is now tied to a hospital system.

We are seeing rapid change in care delivery. Patients' needs must be the driver of care – not the needs of our convoluted and often inefficient system.

I have the privilege of being appointed to national groups that are grappling with reform. Just last week I was a guest of the Gordon and Betty Moore Foundation, convening on the meaning of patient engagement – cost transparency is a fundamental driver in changing systems.

FairHealth in New York, [www.fairhealthconsumer.org](http://www.fairhealthconsumer.org) is a fine example of patient access to costs of care by procedure and facility.

I realize that this would be an added initial burden on the practitioner's practice. We keep saying we want shared decision-making, engaged patients, increased patient participation in their care, - fundamental to that is knowledge and cost, as well as quality, is critical

Section 1 of House Bill 5355 requires hospitals to provide oral and written notice to a hospital patient that the patient is under "observation status" -- and has not been "admitted." This is extremely important information for patients -- because their status could ultimately affect the patients' insurance coverage, Medicaid/Medicare coverage, other hospital services and/or future homecare or nursing home services.

On November 11, 2013, a *Hartford Courant* Editorial stated: "Meanwhile, Connecticut's General Assembly should require hospitals to tell patients and families within 24 hours of admission what their status is and explain the potential financial differences."

It is great that the Public Health Committee is taking action to help hospital patients obtain crucial information regarding their status and treatment.

THANK YOU VERY MUCH FOR YOUR SUPPORT OF HOUSE BILL 5355.

Jean Rexford  
Executive Director