StateSenateForwardsTortReformAmendment

Almost 15 years ago, the Arkansas General Assembly enacted – and then-Governor Mike Huckabee signed – The Civil Justice Reform Act of 2003, tort reform legislation supported widely by the business community, including healthcare organizations, which laid out several changes to the state’s civil justice system. Among its reforms, the law modified joint and several liability, limited the amount awarded for punitive damages, and revised rules regarding medical injury actions. Since that time, separate rulings by the Arkansas Supreme Court have chipped-away at provisions in the law, rendering it largely ineffective.

Those rulings are pointed to as a key reason why Arkansas’ climate for liability litigation has worsened over the years. In 2015, a survey released by the U.S. Chamber Institute for Legal Reform ranked the state’s climate for such litigation 41 out of 50 states. It reflected a drop of six places since the previous survey was conducted in 2012.

Last week, the State Senate went back to the drawing board in an effort to improve that climate, not by law but by placing a proposed constitutional amendment before Arkansas voters that would revamp how damages are awarded in lawsuits and give the legislature authority to set rules for all courts. SJR8, known as the tort reform constitutional amendment, passed the Senate State Agencies and Governmental Affairs Committee and the full Senate. It now goes to the House for action.

If put before voters in November 2018 and approved, the amendment will cap non-economic damages at $250,000; caps punitive damages at $250,000 or three times compensatory damages; limit contingency fees for attorneys to 33 1/3%; and allow the legislature to, by a 3/5 vote, amend court rules of pleadings, practice, and procedure. Governor Asa Hutchinson, who has voiced support for tort reform, said he has some concerns about the current draft and planned to meet with representatives from both sides while continuing to evaluate the proposed constitutional amendment.

AHAAnnualMeetingMay7-10,Washington,D.C.

The American Hospital Association’s (AHA) annual membership meeting is set for May 7-10 in Washington, D.C. This annual meeting provides an excellent forum for hospital execs and trustees to learn firsthand about AHA’s advocacy agenda and strategy for 2017. In addition, attendees have the opportunity to visit personally with the state’s senators and congressional health aides to deliver their messages on how federal legislative and regulatory issues are affecting their hospitals and communities.

As it has for the previous eight years, the Arkansas Hospital Association will reimburse each hospital CEO up to $1,000 for his/her registration fee and airline ticket. However, to receive the stipend, attendees must participate in the lunch held for the senators and congressional aides.

During the meeting, participants will have the opportunity to attain American College of Healthcare Executives Face-to-Face credit and attend executive briefings on topics such as achieving
meaningful regulatory relief, continuing the move to value in changing times, making healthcare more affordable, the future of healthcare coverage, ensuring access to essential healthcare services in vulnerable communities and healthcare politics.

Other educational opportunities will be available for hospital trustees covering issues such as effective governance in a time of challenge and change, leading and engaging boards in improving community health and creating a culture of innovation and safety.

Attendees also will hear presentations from political analyst Nicolle Wallace, New York Times best-selling author and former White House director of communications under President George W. Bush; Frank Sesno, former CNN Washington bureau chief; Bret Baier, Fox News Channel’s chief political anchor and host of the Special Report with Bret Baier; and former senators Trent Lott and Tom Daschle, coauthors of “Crisis Point: Why We Must – and How We Can – Overcome our Broken Politics in Washington and Across America.”

However, the most important event is the time set aside to meet with the state’s senators and key aides on health matters. Senator John Boozman and Senator Tom Cotton have been invited to attend and speak at the luncheon that will be held on Tuesday, May 9 from 11:00 a.m.-1:30 p.m. Because the House of Representatives is on recess the week of May 7, visits to the individual congressional offices will not be made; however, the congressional aides will be invited to attend the luncheon as well.

Meeting and registration information is available online at www.aha.org. Register by March 24, 2017 and save! Please fax a copy of your meeting registration form to Lyndsey Dumas at the Arkansas Hospital Association (501-224-0519) to receive special mailings detailing Arkansas events. You may also email attendance plans to ldumas@arkhospitals.org.

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AHA Recognized for Work on Early Elective Deliveries

During the February 2017 Arkansas Hospital Association (AHA) board meeting, Faith Sharp, Maternal & Child Health Director with the March of Dimes presented the organization’s first Community Partner Award to the AHA for its partnership and work with Arkansas hospitals in reducing early elective deliveries. The AHA partnered with the March of Dimes in the Banner Recognition program for hospitals which have achieved less than a 5% rate of early elective deliveries and implemented a “hard stop” policy to prevent early elective deliveries. To date 22 of the 39 birthing hospitals have applied for the award and received recognition.

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Proposal Aims at Improving Marketplace Participation

In a newly proposed rule, CMS is proposing changes in six specific areas related to Health Insurance Marketplaces (HIM). Aimed at enhancing a more robust participation by consumers to ensure a stable insurance risk pool and making it more inviting for insurers to participate in the HIMs so that consumers have at least one – but ideally multiple – coverage option available, the proposed changes affect the areas noted below:

- **SEP Pre-enrollment Verification**: CMS proposes to implement a pre-enrollment verification process for individuals seeking to enroll in coverage using a Special Enrollment Period (SEP). Specifically, the agency would require individuals to submit evidence of eligibility and be subject to approval prior to enrollment. Currently, CMS is scheduled to launch a pilot project to test such a process in June; however, if finalized, the
agency would eliminate the pilot and make the proposed process permanent for all SEP applicants at that time.

- **Guaranteed Issue**: Insurers would be permitted to require consumers to repay any past premium debt before they can be re-enrolled in coverage for the subsequent year. This only would apply when a consumer with unpaid premiums from the prior year attempted to enroll in any plan offered by the same insurer.

- **Actuarial Value**: The “de minimus” range used for determining the level of coverage offered by an issuer would be increased. In other words, a plan that qualifies as a QHP at a particular metal level could vary farther from the set actuarial value (AV) while retaining its metal level designation, thereby providing lower cost (but also less coverage) options to consumers. These changes would apply to bronze (60% AV), silver (70% AV), gold (80% AV) and platinum (90% AV), but not to silver plan variations (73%, 87% and 94% AV). The new de minimus range beginning in the 2018 benefit year would be -4%/+5% for certain bronze plans and -4%+/+2% for silver, gold and platinum plans.

- **Network Adequacy**: The rule would make several changes to the network adequacy requirements and oversight process. First, states with sufficient minimum access standards and review processes would assume responsibility over insurer compliance with network adequacy requirements. Also, the rule would change the network adequacy requirements related to essential community providers (ECPs), which are providers who serve predominately low-income, medically underserved individuals. Specifically, the agency would allow insurers to indicate in writing the ECPs that are in their networks, as opposed to using the list established by CMS as a result of provider application. The agency also would reduce the percentage of ECPs that plans would be required to contract with from 30% to 20%.

- **QHP Certification Calendar**: CMS proposes to revise the certification timeline for submission and approval to give insurers additional time to finalize their coverage options for 2018. The agency intends to release additional guidance with an updated certification timeline.

- **Open Enrollment Period**: CMS proposes to shorten the annual open enrollment period for 2018 to be November 1, 2017 to December 15, 2017 rather than until January 31, 2018. This change would accelerate by one year the agency’s plans to align the annual open enrollment period for the Marketplaces with other coverage programs, including employer-sponsored coverage and the Medicare program.

The American Hospital Association (AHA) expressed its appreciation that the Trump administration has signaled a commitment to improve the Health Insurance Marketplaces, which continue to face challenges related to plan pricing and participation, putting consumer access to coverage at risk. However, AHA will be reviewing the proposals in more detail to ensure that they both improve consumer access to coverage and maintain important consumer protections including maintaining access to essential community providers. Comments on the proposed changes are due March 7. If you have questions please contact Molly Smith, AHA senior associate director for policy, at mollysmith@aha.org.

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**Rule on Home Health CoP Effective July 13, for Now**

The Centers for Medicare & Medicaid Services published a January 13 final rule to substantially update the conditions of participation that home health agencies (HHA) must meet to participate in Medicare and Medicaid. Among other changes, the rule expands the standards for patient rights,
patient assessments, clinical records, care coordination, personnel, and HHA organization and administration of services. It also requires HHAs to have quality assessment and performance improvement programs and enhanced infection prevention and control practices.

The final rule states that its effective date is July 13. However, this timing may be delayed. Recent memorandums issued by the White House and the Office of Management and Budget direct agencies to review regulations that have been published in the Federal Register but have not yet taken effect. Effective dates for these regulations, subject to certain exceptions, could be postponed to complete this review. We expect more information about how these directives affect the HHA rule will be provided once the new Department of Health and Human Services leadership is in place. Until then, the effective date remains July 13.


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**Health Insurers’ Antitrust Exemption Gets Hearing**

A subcommittee of the House Judiciary Committee held a hearing last week on legislation to repeal the antitrust exemption available to health insurers for anticompetitive conduct, including price fixing, bid rigging and market allocation. *The Competitive Health Insurance Reform Act* (H.R. 372), introduced last month by Rep. Paul Gosar (R-AZ) with 19 co-sponsors, would apply to health insurance issuers the same federal antitrust laws and policies that apply in other sectors to protect competition and consumers and has surfaced at a time when Republicans are deciding on the best way to repeal and replace the Affordable Care Act (ACA).

Insurers are among a few business groups, including Major League Baseball, which have a special exemption from federal antitrust laws. Their particular exemption comes from the *McCarran-Ferguson Act*, passed in 1945, that gives states the power to regulate the “business of insurance,” granting insurers a limited exemption from federal antitrust scrutiny. Insurers, for example, under the federal antitrust exemption may be able to meet, share information and agree on pricing for premiums, but most states prohibit that practice under their own rules.

The last time that the matter of repealing the antitrust exemption for health insurers gained attention was in 2010, during the debates over legislation that would become the ACA. Then, it was House Democrats who were sponsoring a bill meant to spur competition among insurers and bring down costs for consumers.

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**The AHA Calendar**

February 2017

- **21** CAH CoP 2017 – Ensuring Compliance: A 3-Part Series – Part 3 (Webinar T4009)
- **23** 2017 Medical Staff Leadership Series – A 4-Part Series – Part 4
- **23** HFMA Revenue Cycle Seminar, AHA Classroom, Little Rock
- **23** Risks and Rewards of e-Communications and Social Media in Health Care Part 2: Focus on Social Media Use in Health Care – Webinar T4011
- **24** Arkansas Hospital Engineers Scholarship Trust Trap Shooting Tournament, The Arkansas Game and Fish Foundation Shooting Sports Complex, Jacksonville

*Information on all AHA educational programs and activities is available at [http://www.arkhospitals.org/events](http://www.arkhospitals.org/events).*