ROBINSON & COLE LLP
Health Law Pulse

Cancer Clinical Trials: Final Connecticut Regulations Adopted

Connecticut is one of several states during the past few years to have enacted a law mandating insurance coverage for routine care associated with cancer clinical trials. Recently, the Connecticut Department of Insurance adopted final regulations requiring insurance coverage for "routine patient care costs" associated with cancer clinical trials as long as the clinical trial meets certain eligibility criteria required by Connecticut law. "Routine patient care costs" are defined as coverage for medically necessary health care services incurred as a result of the treatment being provided to the insured person for purposes of the cancer clinical trial that would otherwise be covered if such services were not rendered pursuant to a cancer clinical trial.

In addition to several requirements that must be met by insurers, the regulations also require all providers, hospitals and institutions seeking coverage for routine patient care costs of an insured person in a cancer clinical trial to submit a standardized Request for Authorization of Coverage form to insurers. Insurers must accept this form for requests for coverage of routine care associated with cancer clinical trials. The insurer may then approve or deny coverage for such services within five business days (or longer in some situations) of receiving such request. The insured, or the provider with the insured's written consent, may appeal any denial of coverage for medical necessity to an external, independent review agency.

The new regulations that set forth the required elements of the Request for Authorization of Coverage form can be found at http://www.ct.gov/cid/cwp/view.asp?a=126
http://www.ct.gov/cid/cwp/view.asp?a=1262&Q=254492&cidNav=|

Three Strikes and You're Out of Florida

Election Day in Florida resulted in more than 70 percent of Florida voters approving an amendment to the Florida Constitution that would require the revocation of a physician's license to practice medicine in Florida if the physician is "found to have committed" three or more incidents of medical malpractice. Likewise, physicians licensed in other states who have been "found to have committed" three or more incidents of medical malpractice will be prohibited from obtaining a license to practice medicine in Florida.

Under the amendment, the phrase "found to have committed" means that malpractice has been found in a final judgment of a court of law, a final administrative agency decision, or a decision of binding arbitration. Proponents of the amendment argue that it will protect patients from bad physicians by holding physicians more accountable. Opponents argue that the amendment will only foster more lawsuits and force settlements by physicians so they can avoid a strike at trial. Some fear that the amendment may prompt a shortage in high-risk specialties, such as obstetrics, neurosurgery and trauma care.

The amendment became law upon passage, but the Florida Hospital Association, a physician, and a number of hospital plaintiffs challenged the amendment in a lawsuit filed November 5, 2004. Among other things, the plaintiffs argued that the amendment was not "self-executing," but instead required legislative implementation. As a result, a temporary injunction was issued on November 15, 2004 blocking state officials from implementing the amendment until the end of the 2005 regular legislative session. This will give legislators time to determine the answer to several outstanding questions such as, what agency would have the authority to revoke physician licenses pursuant to the amendment and whether or not the law would be applied retroactively to past findings of malpractice.

Only time will tell if the amendment can withstand legal challenge or if physicians will close their practices in Florida rather than risk losing their licenses to practice medicine. Whatever the result, the amendment is likely to have an impact on whether such laws become a nationwide trend.

Jury Awards Physician $366 Million in Peer Review Case

In *Poliner v. Texas Health Systems*, N.D. Texas, No. 3:00CV1007-P (August 28, 2004), a Dallas, Texas jury managed to grab the attention of hospitals and medical staffs across the country by awarding a cardiologist $366 million in damages after a hospital suspended the cardiologist's privileges to perform heart catheterizations. The hospital argued that it based its decision to suspend the cardiologist's privileges on quality of care allegations raised by the hospital's peer review committee. The jury's decision was based, in part, on its finding that the peer review committee did not act with a reasonable belief that its action was warranted but instead acted out of malice.

The cardiologist claimed that his practice posed a competitive threat to other physicians on the hospital's medical staff. The cardiologist alleged that, though these other physicians developed a case to suspend the cardiologist's privileges based on claims that he did not meet the standard of care for providing catheterizations, their real motive was to stifle competition. In support of this allegation, the cardiologist offered at trial the testimony of three nationally recognized cardiologists who all agreed that there was no basis for the improper care claims. The obligation to pay the damages awarded to the cardiologist will

be divided among the hospital and each of the physicians that participated in bringing the false claims against the cardiologist.

As this case demonstrates, failure to take appropriate precautions to ensure independence and impartiality of peer review committees could have significant economic consequences for hospitals and physicians participating in the peer review process.

Questions
If you have any questions or need more information regarding the topics above, please contact any member of the Health Law Group at (860) 275-8200.