



# Senate

General Assembly

**File No. 437**

*January Session, 2015*

Senate Bill No. 807

*Senate, April 2, 2015*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

***AN ACT CONCERNING FAIRNESS AND EFFICIENCY IN HEALTH INSURANCE CONTRACTING.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2015*) (a) Not later than January  
2 1, 2016, the Insurance Commissioner shall establish a pilot program  
3 that requires health insurance companies, health care centers and other  
4 entities that deliver, issue for delivery, renew, amend or continue an  
5 individual or group health insurance policy or health benefit plan  
6 providing coverage of the type specified in subdivisions (1), (2), (4),  
7 (11) and (12) of section 38a-469 of the general statutes in this state to  
8 offer at least one policy or plan with a tiered health care provider  
9 network that rewards insureds and enrollees for choosing low-cost,  
10 high-quality health care providers by offering lower copayments,  
11 deductibles or other out-of-pocket expenses, without limiting the total  
12 number of health care providers or restricting the choice of health care  
13 providers within the policy or plan. Such pilot program shall run for  
14 not less than three years.

15 (b) (1) The base premium for a tiered provider network policy or  
16 plan shall be at least ten per cent lower than the base premium of the  
17 health insurance company's, health care center's or other entity's  
18 nontiered policy or plan that is most actuarially similar.

19 (2) Each tiered provider network policy or plan shall only include  
20 variations on cost-sharing between health care provider tiers that are  
21 reasonable in relation to the premiums charged and shall provide  
22 adequate access to covered services at all tier levels including the  
23 lowest cost-sharing tier.

24 (c) The commissioner shall determine the network adequacy for a  
25 tiered provider network policy or plan based on the availability of  
26 sufficient health care providers in the overall tiered provider network  
27 policy or plan.

28 (d) (1) For the purposes of the pilot program, an insurance  
29 company, health care center or other entity may (A) reclassify a health  
30 care provider tier, or (B) determine health care provider participation  
31 in a tiered provider network policy or plan not more than once per  
32 calendar year, except such company, center or other entity may  
33 reclassify a health care provider from a higher cost tier to a lower cost  
34 tier or add new health care providers to its tiered provider network  
35 policy or plan at any time.

36 (2) If such company, center or other entity reclassifies a health care  
37 provider tier or a health care provider during a policy or plan year, it  
38 shall notify any insured or enrollee affected by such change at least  
39 thirty days before such change takes effect.

40 (e) The commissioner shall adopt regulations, in accordance with  
41 the provisions of chapter 54 of the general statutes, to implement the  
42 provisions of this section. Such regulations shall include, but not be  
43 limited to, objective quality and cost criteria that health insurance  
44 companies, health care centers or other entities subject to subsection (a)  
45 of this section shall use to classify a health care provider for tier  
46 placement in a tiered provider network policy or plan.

47 (f) Each health insurance company, health care center or other entity  
48 subject to subsection (a) of this section shall post on its Internet web  
49 site information about its tiered provider network policy or plan,  
50 including, but not limited to, a current list of health care providers  
51 participating in such policy or plan, the selection criteria for a health  
52 care provider to participate in such policy or plan and, if applicable,  
53 the tier under which each participating health care provider is  
54 classified.

55 (g) The commissioner, in consultation with the Healthcare Advocate  
56 and the chief executive officer of the Connecticut Health Insurance  
57 Exchange, shall annually review and report to the General Assembly  
58 on the implementation of the pilot program, including the number of  
59 insureds or enrollees for each tiered provider network policy or plan,  
60 aggregate demographic information of the insureds or enrollees that is  
61 not individually identifiable, geographic information of the insureds or  
62 enrollees, utilization trends, premium rates and other costs to insureds  
63 and enrollees, the average direct premium claims incurred for a tiered  
64 provider network policy or plan compared to nontiered policies or  
65 plans, quality of care and outcomes for and satisfaction of the insureds  
66 and enrollees. Such report shall include recommendations for any  
67 modifications to the program.

68 Sec. 2. (*Effective from passage*) Not later than January 1, 2016, the  
69 Insurance Commissioner and the Commissioner of Public Health shall  
70 jointly develop standard forms for uniform health care billing, health  
71 care benefit summaries, out-of-pocket expense explanations, prior  
72 authorization requests and any other industry forms for which said  
73 commissioners deem uniformity and standardization to be beneficial.  
74 Not later than February 1, 2016, said commissioners shall submit any  
75 proposed legislation they deem necessary to implement the use of such  
76 forms to the joint standing committees of the General Assembly having  
77 cognizance of matters relating to insurance and public health.

78 Sec. 3. Section 19a-646 of the general statutes is repealed and the  
79 following is substituted in lieu thereof (*Effective October 1, 2015*):

80 (a) As used in this section:

81 (1) "Office" means the Office of Health Care Access division of the  
82 Department of Public Health;

83 (2) "Fiscal year" means the hospital fiscal year, as used for purposes  
84 of this chapter, consisting of a twelve-month period commencing on  
85 October first and ending the following September thirtieth;

86 (3) "Hospital" means any short-term acute care general or children's  
87 hospital licensed by the Department of Public Health, including the  
88 John Dempsey Hospital of The University of Connecticut Health  
89 Center;

90 (4) "Payer" means any person, legal entity, governmental body or  
91 eligible organization that meets the definition of an eligible  
92 organization under 42 USC Section 1395mm (b) of the Social Security  
93 Act, or any combination thereof, except for Medicare and Medicaid  
94 [which] that is or may become legally responsible, in whole or in part  
95 for the payment of services rendered to or on behalf of a patient by a  
96 hospital. Payer also includes any legal entity whose membership  
97 includes one or more payers and any third-party payer; and

98 (5) "Prompt payment" means payment made for services to a  
99 hospital by mail or other means on or before the tenth business day  
100 after receipt of the bill by the payer.

101 (b) No hospital shall bill under the hospital's tax identification  
102 number for services provided outside the hospital.

103 ~~[(b)]~~ (c) No hospital shall provide a discount or different rate or  
104 method of reimbursement from the filed rates or charges to any payer  
105 except as provided in this section.

106 ~~[(c)]~~ (d) (1) Any payer may directly negotiate with a hospital for a  
107 different rate or method of reimbursement, or both, provided the  
108 charges and payments for the payer are on file at the hospital business  
109 office in accordance with this subsection. No discount agreement or

110 agreement for a different rate or method of reimbursement, or both,  
111 shall be effective until a complete written agreement between the  
112 hospital and the payer is on file at the hospital. Each such agreement  
113 shall be available to the office for inspection or submission to the office  
114 upon request, for at least three years after the close of the applicable  
115 fiscal year.

116 (2) The charges and payments for each payer receiving a discount  
117 shall be accumulated by the hospital for each payer and reported as  
118 required by the office.

119 (3) A full written copy of each agreement executed pursuant to this  
120 subsection shall be on file in the hospital business office within twenty-  
121 four hours of execution.

122 ~~[(d)]~~ (e) A payer may negotiate with a hospital to obtain a discount  
123 on rates or charges for prompt payment.

124 ~~[(e)]~~ (f) A payer may also negotiate for and may receive a discount  
125 for the provision of the following administrative services: (1) A system  
126 ~~[which]~~ that permits the hospital to bill the payer through either a  
127 computer-processed or machine-readable or similar billing procedure;  
128 (2) a system ~~[which]~~ that enables the hospital to verify coverage of a  
129 patient by the payer at the time the service is provided; and (3) a  
130 guarantee of payment within the scope of the agreement between the  
131 patient and the third-party payer for service to the patient prior to the  
132 provision of that service.

133 ~~[(f)]~~ (g) No hospital may require a payer to negotiate for another  
134 element or any combination of the above elements of a discount, as  
135 established in subsections ~~[(d) and]~~ (e) and (f) of this section, in order  
136 to negotiate for or obtain a discount for any single element. No  
137 hospital may require a payer to negotiate a discount for all patients  
138 covered by such payer in order to negotiate a discount for any patient  
139 or group of patients covered by such payer.

140 ~~[(g)]~~ (h) Any hospital ~~[which]~~ that agrees to provide a discount to a

141 payer under subsection [(d) or] (e) or (f) of this section shall file a copy  
142 of the agreement in the hospital's business office and shall provide the  
143 same discount to any other payer [who] that agrees to make prompt  
144 payment or provide administrative services similar to that contained in  
145 the agreement. Each agreement filed shall specify on its face that it was  
146 executed and filed pursuant to this subsection.

147 [(h)] (i) (1) Nothing in this section shall be construed to require  
148 payment by any payer or purchaser, under any program or contract  
149 for payment or reimbursement of expenses for health care services, for:  
150 (A) Services not covered under such program or contract; or (B) that  
151 portion of any charge for services furnished by a hospital that exceeds  
152 the amount covered by such program or contract.

153 (2) Nothing in this section shall be construed to supersede or modify  
154 any provision of such program or contract that requires payment of a  
155 copayment, deductible or enrollment fee or that imposes any similar  
156 requirement.

157 [(i)] (j) A hospital [which] that has established a program approved  
158 by the office with one or more banks for the purpose of reducing the  
159 hospital's bad debt load, may reduce its published charges for that  
160 portion of a patient's bill for services [which] that a payer who is a  
161 private individual is or may become legally responsible for, after all  
162 other insurers or third-party payers have been assessed their full  
163 charges, provided (1) prior to the rendering of such services, the  
164 hospital and the individual payer or parent or guardian or custodian  
165 have agreed in writing that after receipt of any insurer or third-party  
166 payment paid in accordance with the full hospital charges, the  
167 remaining payment due from the private individual for such reduced  
168 charges shall be made in whole or in part from the balance on deposit  
169 in a bank account [which] that has been established by or on behalf of  
170 such individual patient, and (2) such payment is made from such  
171 account. Nothing in this section shall relieve a patient or legally liable  
172 person from being responsible for the full amount of any  
173 underpayment of the hospital's authorized charges excluding any

174 discount under this section, by a patient's insurer or any other third-  
175 party payer for that insurer's or third-party payer's portion of the bill.  
176 Any reduction in charges granted to an individual or parent or  
177 guardian or custodian under this subsection shall be reported to the  
178 office as a contractual allowance. For purposes of this section "private  
179 individual" [shall include] includes a patient's parent, legal guardian  
180 or legal custodian but [shall] does not include an insurer or third-party  
181 payer.

182 Sec. 4. (NEW) (*Effective October 1, 2015*) (a) As used in this section,  
183 "hospital" means a facility licensed as a hospital under chapter 368v of  
184 the general statutes, and "health system" has the same meaning as  
185 provided in section 19a-508c of the general statutes.

186 (b) Each hospital shall negotiate separately with a health insurance  
187 company, health care center or other entity that provides health care  
188 benefits to its insureds or enrollees and with health care providers,  
189 even if any hospitals are commonly owned.

190 (c) No hospital or health system shall include in any contract  
191 entered into, renewed or amended on or after October 1, 2015, with an  
192 insurer, health care center or other entity that provides health care  
193 benefits to its insureds or enrollees, any provision that (1) requires  
194 such insurer, center or other entity to (A) contract with all the health  
195 care provider locations or facilities within the system or for all services  
196 the hospital or health system offers, or (B) pay the hospital rate for  
197 covered services provided in outpatient facilities or health care  
198 providers' offices, or (2) prohibits or limits disclosure of price, cost or  
199 claims information.

200 Sec. 5. (NEW) (*Effective October 1, 2015*) (a) Each health insurer,  
201 health care center, hospital service corporation, medical service  
202 corporation, preferred provider network or other entity that contracts  
203 with health care providers to provide health care services to its  
204 insureds or enrollees, shall include in each such contract that is entered  
205 into, renewed or amended on or after October 1, 2015, site-neutral  
206 reimbursement policies as recommended by the Medicare Payment

207 Advisory Commission's June 2013, Report to the Congress: Medicare  
 208 and the Health Care Delivery System, as updated from time to time.  
 209 Such reimbursement policies shall, at a minimum, (1) require  
 210 reimbursement that is the same for all health care providers regardless  
 211 of where the services are performed for the following: (A) Evaluation  
 212 and management visits; (B) services classified by said commission as  
 213 Group 1 ambulatory payment classification in said report; and (C)  
 214 ambulatory surgical procedures and services identified by said  
 215 commission as appropriate for equal reimbursement, and (2) limit  
 216 reimbursement differentials to only the amount necessary for the  
 217 actual cost of packaging ancillary services for services classified by  
 218 said commission as Group 2 ambulatory payment classification in said  
 219 report.

220 (b) Each contract under subsection (a) of this section shall include a  
 221 conspicuous statement that the contract complies with site-neutral  
 222 reimbursement policies as required by law.

223 Sec. 6. Section 38a-472i of the general statutes is repealed. (*Effective*  
 224 *October 1, 2015*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2015</i>	New section
Sec. 2	<i>from passage</i>	New section
Sec. 3	<i>October 1, 2015</i>	19a-646
Sec. 4	<i>October 1, 2015</i>	New section
Sec. 5	<i>October 1, 2015</i>	New section
Sec. 6	<i>October 1, 2015</i>	Repealer section

**INS**      *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

**OFA Fiscal Note**

**State Impact:**

<b>Agency Affected</b>	<b>Fund-Effect</b>	<b>FY 16 \$</b>	<b>FY 17 \$</b>
Insurance Department	IF - Cost	285,000	240,000
UConn Health Center	SF - Cost/Revenue Loss	See below	See below

Note: IF=Insurance Fund; SF=Special Fund (Non-appropriated)

**Municipal Impact:** None

**Explanation**

The bill is anticipated to result in a cost of \$285,000 to the Insurance Fund (IF) beginning in FY 16 for additional staff and resources at the Insurance Department. The bill requires the Department of Insurance to establish a tiered provider network pilot program. This cost consists of \$235,000 in salary and fringe benefits for two additional positions necessary to determine network adequacy under the pilot program. An additional one time cost of \$50,000 is required for necessary modeling software.

The bill will result in a revenue loss to the University of Connecticut Health Center (UCHC). The bill prohibits hospitals from billing for services provided “outside the hospital” and requires site neutral reimbursement. The bill does not define the parameters of “outside the hospital”. UCHC currently bills for numerous services that are provided outside of the John Dempsey Hospital building, either on the main UCHC Farmington campus, or at satellite facilities. Depending upon how stringently “outside the hospital” is interpreted, the bill would impact between \$9.2 million and \$31 million in annual UCHC billing. It is unclear whether UCHC would be able to otherwise recoup these billings, or that this would represent lost revenue.

Section 4 of the bill further requires hospitals and health systems to negotiate separately for each facility, and prohibits hospitals from requiring insurers to cover all services offered. This will result in an additional administrative cost to UCHC of approximately \$450,000 annually. This cost represents the salary and fringe benefit costs for three contracting staff to meet the need for additional separate contract negotiations. This section may further reduce revenue to UCHC if the health center's ability to negotiate rates and coverages is negatively impacted.

***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

**OLR Bill Analysis****SB 807*****AN ACT CONCERNING FAIRNESS AND EFFICIENCY IN HEALTH INSURANCE CONTRACTING.*****SUMMARY:**

This bill requires the insurance commissioner to establish a tiered provider network pilot program, which must run for at least three years, under which health insurers, HMOs, and similar entities encourage insureds and enrollees to use lower-cost, higher-quality health care providers. It establishes requirements for tiered networks and requires the commissioner to adopt implementing regulations and report annually to the legislature.

The bill also:

1. requires the insurance and public health commissioners to develop standard industry forms, including forms for health care billing and prior authorization requests;
2. prohibits hospitals from billing under their tax identification numbers for services provided outside of the hospital;
3. requires hospitals to negotiate separately with health insurers, HMOs, and health care providers, even if commonly owned;
4. requires health insurers' and HMOs' provider contracts to include site-neutral reimbursement policies; and
5. makes technical and conforming changes.

**EFFECTIVE DATE:** October 1, 2105, except for a provision requiring the insurance and public health commissioners to develop standard industry forms, which is effective upon passage.

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**§ 1 – TIERED PROVIDER NETWORKS PILOT*****Pilot Program***

The bill requires the insurance commissioner to establish a pilot program, which must run for at least three years, that requires health insurers, HMOs, and similar entities to offer at least one policy or plan with a tiered health care provider network. A tiered network policy or plan must reward insureds and enrollees for choosing low-cost, high-quality health care providers by offering lower copayments, deductibles, or other out-of-pocket expenses, without limiting the total number of providers or restricting a person's choice of providers.

The pilot program applies to health insurers, HMOs, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or benefit plans that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, and (4) hospital or medical services.

***Regulations***

The bill requires the commissioner to adopt regulations to implement the tiered network pilot program. The regulations must include objective quality and cost criteria for health insurers, HMOs, and similar entities to use when classifying a health care provider within a tiered network.

***Tiered Network Requirements***

Under the bill, the base premium for a policy or plan that offers a tiered network must be at least 10% lower than the base premium for a policy or plan that does not offer a tiered network but is otherwise most actuarially similar.

A policy or plan with a tiered network must (1) only include variations on cost sharing between tiers that are reasonable in relation to the premiums charged and (2) provide adequate access to covered services at all tier levels. The bill requires the commissioner to determine the network adequacy of a policy or plan with a tiered network based on the availability of health care providers in the

overall policy or plan.

Under the bill, an insurer, HMO, or other entity may, only once a year, (1) reclassify a health care provider's tier placement or (2) determine a health care provider's participation in a policy or plan that uses a tiered network. But, it may reclassify a provider from a higher cost tier to a lower cost tier or add new providers to its tiered network at any time.

An insurer, HMO, or entity that reclassifies a provider's tier placement during a policy or plan year must give notice to affected insureds and enrollees at least 30 days before the change takes effect.

### ***Public Notice***

The bill requires each insurer, HMO, or other entity that participates in the pilot program to post on its website information about its tiered network policy or plan. The post must include a current list of participating providers, how the providers were selected, and each participating provider's tier placement.

### ***Annual Report to the Legislature***

The bill requires the commissioner, in consultation with the Healthcare Advocate and Access Health CT's chief executive officer, to annually review and report to the legislature on the pilot program. The bill does not specify a due date for the report.

The report must include:

1. the number of insureds or enrollees covered under a tiered network policy or plan;
2. aggregate demographic information for the insureds and enrollees;
3. geographic information for the insureds and enrollees;
4. utilization trends;

5. premium rates and other costs to insureds and enrollees;
6. the average direct premium claims incurred for a tiered network policy or plan compared to those of non-tiered network policies and plans;
7. quality or care and outcomes for, and satisfaction of, the insureds and enrollees; and
8. recommendations for any changes to the program.

## **§ 2 – STANDARD INDUSTRY FORMS**

The bill requires the insurance and public health commissioners to jointly develop standard forms for health care billing, health care benefit summaries, out-of-pocket explanations, and prior authorization requests and any other industry forms they determine would benefit from uniformity.

The commissioners, by February 1, 2016, must submit to the Insurance and Real Estate and Public Health committees any proposed legislation necessary to implement the use of the standard forms.

## **§ 3 – HOSPITAL BILLING**

The bill prohibits a hospital from billing under its tax identification number for services provided outside of the hospital. It does not specify if it means a federal or state tax identification number. Also, it is unclear who the hospital is billing. Presumably the hospital is billing payers, which includes those legally responsible for the payment of services rendered to a patient (e.g., insurers and HMOs). It is also unclear to what “outside the hospital” refers. Presumably it means services provided at a different location than the hospital’s main facility or campus.

## **§ 4 – HOSPITAL CONTRACTS**

The bill requires each licensed hospital to negotiate contracts separately with (1) health insurers, HMOs, and other entities that provide health care benefits and (2) health care providers. Thus, even if

hospitals are commonly owned, each must negotiate separately.

Under the bill, hospitals and health systems may not include in any contract entered into, renewed, or amended on or after October 1, 2015 with a health insurer, HMO, or similar entity, any provision that:

1. requires the insurer, HMO, or entity to contract with all the health care provider locations or facilities within the health system or for all services the hospital or health system offers;
2. requires the insurer, HMO, or entity to pay the hospital rate for covered services provided at outpatient facilities or provider offices; or
3. prohibits or limits the disclosure of price, cost, or claims information.

By law, a “health system” is (1) a parent corporation of one or more hospitals and any entity affiliated through ownership, governance, membership, or other means or (2) any entity affiliated with a hospital through ownership, governance, membership, or other means.

#### **§ 5 – PROVIDER CONTRACTS TO INCLUDE SITE-NEUTRAL REIMBURSEMENT POLICIES**

The bill requires each health insurer, HMO, hospital service corporation, medical service corporation, preferred provider network, or other entity that contracts with health care providers to include in each contract entered into, renewed, or amended on or after October 1, 2015, (1) site-neutral reimbursement policies and (2) a conspicuous statement that the contract complies with the law’s site-neutral reimbursement policies requirement.

Under the bill, the site-neutral reimbursement policies must be as recommended by the Medicare Payment Advisory Commission’s (MedPAC) June 2013 report to Congress, *Medicare and the Health Care Delivery System*. They must also:

1. require reimbursement that is the same for all health care

providers regardless of where the services are performed for (a) evaluation and management visits, (b) services MedPAC classifies as "group 1 ambulatory," and (c) ambulatory surgical procedures and services MedPAC identifies as appropriate for equal reimbursement and

2. limit reimbursement differentials to only the amount necessary for the actual cost of packaging ancillary services MedPAC classifies as "group 2 ambulatory."

### **§ 6 – REPEALER**

The bill repeals a statute that requires insurers, HMOs, hospital service corporations, medical service corporations, and fraternal benefit societies that contract with a physician or a physician's group to provide services under a group or individual health insurance policy, to establish a payment amount for the physician's services component of covered colonoscopy or endoscopic services that is the same regardless of where the services are performed.

### **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 18    Nay 1    (03/19/2015)