



Senate

General Assembly

File No. 698

January Session, 2015

Substitute Senate Bill No. 813

Senate, April 16, 2015

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY
TRANSPARENCY.***

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

1 Section 1. Section 38a-1084 of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective October 1, 2015*):

3 The exchange shall:

4 (1) Administer the exchange for both qualified individuals and
5 qualified employers;

6 (2) Commission surveys of individuals, small employers and health
7 care providers on issues related to health care and health care
8 coverage;

9 (3) Implement procedures for the certification, recertification and
10 decertification, consistent with guidelines developed by the Secretary
11 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
12 of health benefit plans as qualified health plans;

13 (4) Provide for the operation of a toll-free telephone hotline to
14 respond to requests for assistance;

15 (5) Provide for enrollment periods, as provided under Section
16 1311(c)(6) of the Affordable Care Act;

17 (6) (A) Maintain an Internet web site through which enrollees and
18 prospective enrollees of qualified health plans may obtain
19 standardized comparative information on such plans including, but
20 not limited to, the enrollee satisfaction survey information under
21 Section 1311(c)(4) of the Affordable Care Act and any other
22 information or tools to assist enrollees and prospective enrollees
23 evaluate qualified health plans offered through the exchange, and (B)
24 establish and maintain a consumer health information Internet web
25 site, as described in section 2 of this act;

26 (7) Publish the average costs of licensing, regulatory fees and any
27 other payments required by the exchange and the administrative costs
28 of the exchange, including information on moneys lost to waste, fraud
29 and abuse, on an Internet web site to educate individuals on such
30 costs;

31 (8) On or before the open enrollment period for plan year 2017,
32 assign a rating to each qualified health plan offered through the
33 exchange in accordance with the criteria developed by the Secretary
34 under Section 1311(c)(3) of the Affordable Care Act, and determine
35 each qualified health plan's level of coverage in accordance with
36 regulations issued by the Secretary under Section 1302(d)(2)(A) of the
37 Affordable Care Act;

38 (9) Use a standardized format for presenting health benefit options
39 in the exchange, including the use of the uniform outline of coverage
40 established under Section 2715 of the Public Health Service Act, 42
41 USC 300gg-15, as amended from time to time;

42 (10) Inform individuals, in accordance with Section 1413 of the
43 Affordable Care Act, of eligibility requirements for the Medicaid

44 program under Title XIX of the Social Security Act, as amended from
45 time to time, the Children's Health Insurance Program (CHIP) under
46 Title XXI of the Social Security Act, as amended from time to time, or
47 any applicable state or local public program, and enroll an individual
48 in such program if the exchange determines, through screening of the
49 application by the exchange, that such individual is eligible for any
50 such program;

51 (11) Collaborate with the Department of Social Services, to the
52 extent possible, to allow an enrollee who loses premium tax credit
53 eligibility under Section 36B of the Internal Revenue Code and is
54 eligible for HUSKY Plan, Part A or any other state or local public
55 program, to remain enrolled in a qualified health plan;

56 (12) Establish and make available by electronic means a calculator to
57 determine the actual cost of coverage after application of any premium
58 tax credit under Section 36B of the Internal Revenue Code and any
59 cost-sharing reduction under Section 1402 of the Affordable Care Act;

60 (13) Establish a program for small employers through which
61 qualified employers may access coverage for their employees and that
62 shall enable any qualified employer to specify a level of coverage so
63 that any of its employees may enroll in any qualified health plan
64 offered through the exchange at the specified level of coverage;

65 (14) Offer enrollees and small employers the option of having the
66 exchange collect and administer premiums, including through
67 allocation of premiums among the various insurers and qualified
68 health plans chosen by individual employers;

69 (15) Grant a certification, subject to Section 1411 of the Affordable
70 Care Act, attesting that, for purposes of the individual responsibility
71 penalty under Section 5000A of the Internal Revenue Code, an
72 individual is exempt from the individual responsibility requirement or
73 from the penalty imposed by said Section 5000A because:

74 (A) There is no affordable qualified health plan available through

75 the exchange, or the individual's employer, covering the individual; or

76 (B) The individual meets the requirements for any other such
77 exemption from the individual responsibility requirement or penalty;

78 (16) Provide to the Secretary of the Treasury of the United States the
79 following:

80 (A) A list of the individuals granted a certification under
81 subdivision (15) of this section, including the name and taxpayer
82 identification number of each individual;

83 (B) The name and taxpayer identification number of each individual
84 who was an employee of an employer but who was determined to be
85 eligible for the premium tax credit under Section 36B of the Internal
86 Revenue Code because:

87 (i) The employer did not provide minimum essential health benefits
88 coverage; or

89 (ii) The employer provided the minimum essential coverage but it
90 was determined under Section 36B(c)(2)(C) of the Internal Revenue
91 Code to be unaffordable to the employee or not provide the required
92 minimum actuarial value; and

93 (C) The name and taxpayer identification number of:

94 (i) Each individual who notifies the exchange under Section
95 1411(b)(4) of the Affordable Care Act that such individual has changed
96 employers; and

97 (ii) Each individual who ceases coverage under a qualified health
98 plan during a plan year and the effective date of that cessation;

99 (17) Provide to each employer the name of each employee, as
100 described in subparagraph (B) of subdivision (16) of this section, of the
101 employer who ceases coverage under a qualified health plan during a
102 plan year and the effective date of the cessation;

103 (18) Perform duties required of, or delegated to, the exchange by the
104 Secretary or the Secretary of the Treasury of the United States related
105 to determining eligibility for premium tax credits, reduced cost-
106 sharing or individual responsibility requirement exemptions;

107 (19) Select entities qualified to serve as Navigators in accordance
108 with Section 1311(i) of the Affordable Care Act and award grants to
109 enable Navigators to:

110 (A) Conduct public education activities to raise awareness of the
111 availability of qualified health plans;

112 (B) Distribute fair and impartial information concerning enrollment
113 in qualified health plans and the availability of premium tax credits
114 under Section 36B of the Internal Revenue Code and cost-sharing
115 reductions under Section 1402 of the Affordable Care Act;

116 (C) Facilitate enrollment in qualified health plans;

117 (D) Provide referrals to the Office of the Healthcare Advocate or
118 health insurance ombudsman established under Section 2793 of the
119 Public Health Service Act, 42 USC 300gg-93, as amended from time to
120 time, or any other appropriate state agency or agencies, for any
121 enrollee with a grievance, complaint or question regarding the
122 enrollee's health benefit plan, coverage or a determination under that
123 plan or coverage; and

124 (E) Provide information in a manner that is culturally and
125 linguistically appropriate to the needs of the population being served
126 by the exchange;

127 (20) Review the rate of premium growth within and outside the
128 exchange and consider such information in developing
129 recommendations on whether to continue limiting qualified employer
130 status to small employers;

131 (21) Credit the amount, in accordance with Section 10108 of the
132 Affordable Care Act, of any free choice voucher to the monthly

133 premium of the plan in which a qualified employee is enrolled and
134 collect the amount credited from the offering employer;

135 (22) Consult with stakeholders relevant to carrying out the activities
136 required under sections 38a-1080 to 38a-1090, inclusive, including, but
137 not limited to:

138 (A) Individuals who are knowledgeable about the health care
139 system, have background or experience in making informed decisions
140 regarding health, medical and scientific matters and are enrollees in
141 qualified health plans;

142 (B) Individuals and entities with experience in facilitating
143 enrollment in qualified health plans;

144 (C) Representatives of small employers and self-employed
145 individuals;

146 (D) The Department of Social Services; and

147 (E) Advocates for enrolling hard-to-reach populations;

148 (23) Meet the following financial integrity requirements:

149 (A) Keep an accurate accounting of all activities, receipts and
150 expenditures and annually submit to the Secretary, the Governor, the
151 Insurance Commissioner and the General Assembly a report
152 concerning such accountings;

153 (B) Fully cooperate with any investigation conducted by the
154 Secretary pursuant to the Secretary's authority under the Affordable
155 Care Act and allow the Secretary, in coordination with the Inspector
156 General of the United States Department of Health and Human
157 Services, to:

158 (i) Investigate the affairs of the exchange;

159 (ii) Examine the properties and records of the exchange; and

160 (iii) Require periodic reports in relation to the activities undertaken
161 by the exchange; and

162 (C) Not use any funds in carrying out its activities under sections
163 38a-1080 to 38a-1089, inclusive, and section 38a-1091 that are intended
164 for the administrative and operational expenses of the exchange, for
165 staff retreats, promotional giveaways, excessive executive
166 compensation or promotion of federal or state legislative and
167 regulatory modifications;

168 (24) Seek to include the most comprehensive health benefit plans
169 that offer high quality benefits at the most affordable price in the
170 exchange;

171 (25) Report at least annually to the General Assembly on the effect
172 of adverse selection on the operations of the exchange and make
173 legislative recommendations, if necessary, to reduce the negative
174 impact from any such adverse selection on the sustainability of the
175 exchange, including recommendations to ensure that regulation of
176 insurers and health benefit plans are similar for qualified health plans
177 offered through the exchange and health benefit plans offered outside
178 the exchange. The exchange shall evaluate whether adverse selection is
179 occurring with respect to health benefit plans that are grandfathered
180 under the Affordable Care Act, self-insured plans, plans sold through
181 the exchange and plans sold outside the exchange; and

182 (26) Seek funding for and oversee the planning, implementation and
183 development of policies and procedures for the administration of the
184 all-payer claims database program established under section 38a-1091.

185 Sec. 2. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
186 section:

187 (1) "Allowed amount" means the maximum reimbursement dollar
188 amount that an insured's health insurance policy allows for a specific
189 procedure or service;

190 (2) "Episode of care" means all health care services related to the

191 treatment of a condition and, for acute conditions, includes health care
192 services and treatment provided from the onset of the condition to its
193 resolution and, for chronic conditions, includes health care services
194 and treatment provided over a given period of time.

195 (3) "Exchange" means the Connecticut Health Insurance Exchange
196 established pursuant to section 38a-1081 of the general statutes;

197 (4) "Health care provider" means any individual, corporation,
198 facility or institution licensed by this state to provide health care
199 services;

200 (5) "Health carrier" means any insurer, health care center, hospital
201 service corporation, medical service corporation or other entity
202 delivering, issuing for delivery, renewing, amending or continuing any
203 individual or group health insurance policy in this state providing
204 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
205 of section 38a-469 of the general statutes;

206 (6) "Hospital" has the same meaning as provided in section 19a-490
207 of the general statutes;

208 (7) "Out-of-pocket cost" means costs that are not reimbursed by a
209 health insurance policy and includes deductibles, coinsurance and
210 copayments for covered services and other costs to the consumer
211 associated with a procedure or service;

212 (8) "Outpatient surgical facility" has the same meaning as provided
213 in section 19a-493b of the general statutes; and

214 (9) "Public or private third party" means the state, the federal
215 government, employers, a health carrier, third-party administrator or
216 managed care organization.

217 (b) (1) The exchange shall establish a consumer health information
218 Internet web site to assist consumers in making informed decisions
219 concerning their health care and informed choices among health care
220 providers. Such Internet web site shall: (A) Contain information

221 comparing the quality, price and cost of health care services, including,
222 to the extent practicable (i) comparative price and cost information for
223 the most common referrals or prescribed services categorized by payer
224 and listed by facility, health care provider and provider organization,
225 (ii) comparative quality information by facility, health care provider,
226 provider organization or any other provider grouping for each service
227 or category of services for which comparative price and cost
228 information is provided, (iii) data concerning health care-associated
229 infections and serious reportable events, (iv) definitions of common
230 health insurance and medical terms, as determined by the Insurance
231 Commissioner pursuant to section 6 of this act, so consumers may
232 compare health coverage and understand the terms of their coverage,
233 (v) a list of health care provider types, including primary care
234 physicians, nurse practitioners and physician assistants and the types
235 of services each type of health care provider is authorized to provide,
236 (vi) factors consumers should consider when choosing an insurance
237 product or provider group, including provider network, premium,
238 cost-sharing, covered services and tier information, (vii) patient
239 decision aids, (viii) a list of provider services that are physically and
240 programmatically accessible for persons with disabilities, and (ix)
241 descriptions of standard quality measures; (B) be designed to assist
242 consumers and institutional purchasers in making informed decisions
243 regarding their health care and informed choices among health care
244 providers and allows comparisons between prices paid by various
245 health carriers to health care providers; (C) present information in
246 language and a format that is understandable to the average consumer;
247 and (D) be publicized to the general public. All information received
248 by the exchange pursuant to the provisions of this section shall be
249 posted on the Internet web site.

250 (2) Information collected, stored and published by the exchange
251 pursuant to this section is subject to the federal Health Insurance
252 Portability and Accountability Act of 1996, P.L. 104-191, as amended
253 from time to time. Any individually identifiable health information
254 shall be secure, encrypted, as necessary, and shall not be disclosed.

255 (c) Not later than October 1, 2016, and annually thereafter, the
256 Insurance Commissioner and the Commissioner of Public Health shall
257 jointly report to the exchange and make available to the public on the
258 Insurance Department's and Department of Public Health's Internet
259 web sites: (1) The one hundred most frequently provided inpatient
260 admissions in the state, (2) the one hundred most frequently provided
261 outpatient procedures performed in the state, (3) the twenty-five most
262 frequent surgical procedures performed in the state, and (4) the
263 twenty-five most frequent imaging procedures performed in the state.
264 Such lists contained in the report may include bundled episodes of
265 care. At the request of the exchange, such lists may be expanded to
266 include additional admissions and procedures.

267 (d) Not later than January 1, 2016, and annually thereafter, each
268 health carrier shall submit to the exchange the (1) allowed amounts
269 paid to health care providers in the health carrier's network for each
270 admission and procedure included in the report submitted to the
271 exchange by the commissioners pursuant to subsection (c) of this
272 section, and (2) out-of-pocket costs for each such admission and
273 procedure.

274 (e) Not later than January 1, 2016, and annually thereafter, each
275 hospital and outpatient surgical facility shall report to the exchange the
276 following information for each admission and procedure reported in
277 accordance with subsection (c) of this section: (1) The amount to be
278 charged to a patient for each such admission or procedure if all
279 charges are paid in full without a public or private third party paying
280 any portion of the charges, (2) the average negotiated settlement on the
281 amount to be charged to a patient as described in subdivision (1) of
282 this subsection, (3) the amount of Medicaid reimbursement for each
283 such admission or procedure, including claims and pro rata
284 supplement payments, (4) the amount of Medicare reimbursement for
285 each such admission or procedure, and (5) for the five largest health
286 carriers according to the previous year's patient volume, the allowed
287 amount for each such admission or procedure, with the health carriers
288 names and other identifying information redacted. Notwithstanding

289 the provisions of this subsection, a hospital or outpatient surgical
290 facility shall not report information that may reasonably lead to the
291 identification of individuals admitted to, or who receive services from,
292 the hospital or outpatient surgical facility.

293 (f) Each hospital and outpatient surgical facility shall, not later than
294 two business days after scheduling an admission, procedure or service
295 included in the report submitted to the exchange by the Insurance
296 Commissioner and the Commissioner of Public Health pursuant to
297 subsection (c) of this section, provide written notice to the patient that
298 is the subject of the admission or procedure concerning: (1) If the
299 patient is uninsured, the amount to be charged for the admission or
300 procedure if all charges are paid in full without a public or private
301 third party paying any portion of the charges, including the amount of
302 any facility fee, or, if the hospital or outpatient surgical facility is not
303 able to provide a specific amount due to an inability to predict the
304 specific treatment or diagnostic code, the estimated maximum allowed
305 amount or charge for the admission or procedure, including the
306 amount of any facility fee; (2) the Medicare reimbursement amount; (3)
307 if the patient is insured, the allowed amount, the toll-free telephone
308 number and the Internet web site address of the patient's health carrier
309 where the patient can obtain information concerning charges and out-
310 of-pocket expenses; (4) The Joint Commission's composite
311 accountability rating for the hospital or outpatient surgical facility; and
312 (5) the Internet web site addresses for The Joint Commission and the
313 Medicare Hospital Compare tool where the patient may obtain
314 information concerning the hospital or outpatient surgical facility.

315 (g) The Commissioner of Public Health, in consultation with the
316 Insurance Commissioner and the Healthcare Advocate, shall (1)
317 develop quality measures for health carriers to include when
318 providing information to patients concerning the costs of health care
319 services, and (2) determine quality measures to be reported by health
320 carriers and health care providers to the exchange. In developing such
321 measures, said commissioners and the Healthcare Advocate shall
322 consider those quality measures recommended by the National

323 Quality Forum's Measures Applications Partnership and the National
324 Priorities Partnership.

325 (h) The Commissioner of Social Services shall submit to the
326 exchange all Medicaid data requested for the all-payer claims
327 database, established pursuant to section 38a-1091 of the general
328 statutes.

329 Sec. 3. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
330 section, "health care provider" means any person, corporation, facility
331 or institution licensed by this state to provide health care services.

332 (b) Each health care provider shall, at the time such health care
333 provider schedules an admission or procedure for a patient, determine
334 whether the patient is covered under a health insurance policy. If the
335 patient is determined to be covered under a health insurance policy,
336 the health care provider shall notify the patient, in writing, as to
337 whether the health care provider is in-network or out-of-network
338 under such policy and provide the toll-free telephone number and
339 Internet web site address of the patient's health carrier. If the patient is
340 determined not to have health insurance coverage or the patient's
341 health care provider is out-of-network, the health care provider shall
342 notify the patient in writing (1) of the actual charges for the admission
343 or procedure, and (2) that such patient may be charged, and is
344 responsible for payment for unforeseen services that may arise out of
345 the proposed admission or procedure. Nothing in this subsection shall
346 prevent a health care provider from charging a patient for such
347 unforeseen services.

348 (c) Each health care provider that refers a patient to another health
349 care provider that is part of, or represented by, the same provider
350 organization shall notify the patient, in writing, that the health care
351 providers are part of, or represented by, the same provider
352 organization.

353 (d) Each health care provider and health carrier shall ensure that
354 any billing statement or explanation of benefits submitted to a patient

355 or insured is written in language that is understandable to an average
356 reader.

357 Sec. 4. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
358 section, (1) "health care provider" means any individual, corporation,
359 facility or institution licensed by this state to provide health care
360 services, and (2) "health carrier" means any insurer, health care center,
361 hospital service corporation, medical service corporation or other
362 entity delivering, issuing for delivery, renewing, amending or
363 continuing any individual or group health insurance policy in this
364 state providing coverage of the type specified in subdivisions (1), (2),
365 (4), (11) and (12) of section 38a-469 of the general statutes.

366 (b) On and after October 1, 2015, no contract entered into, or
367 renewed, between a health care provider and a health carrier shall
368 contain a provision prohibiting disclosure of negotiated pricing
369 information, including, but not limited to, pricing information relating
370 to out-of-pocket expenses.

371 Sec. 5. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
372 section:

373 (1) "Allowed amount" means the maximum reimbursement dollar
374 amount that an insured's health insurance policy allows for a specific
375 procedure or service;

376 (2) "Health care provider" means any individual, corporation,
377 facility or institution licensed by this state to provide health care
378 services;

379 (3) "Health carrier" means any insurer, health care center, hospital
380 service corporation, medical service corporation or other entity
381 delivering, issuing for delivery, renewing, amending or continuing any
382 individual or group health insurance policy in this state providing
383 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
384 of section 38a-469 of the general statutes; and

385 (4) "Out-of-pocket cost" means costs that are not reimbursed by a

386 health insurance policy and includes deductibles, coinsurance and
387 copayments for covered services and other costs to the consumer
388 associated with a procedure or service.

389 (b) Each health carrier shall develop and publish an Internet web
390 site and institute the use of a mobile device application and toll-free
391 telephone number that enables consumers to request and obtain: (1)
392 Information on in-network costs for inpatient admissions, health care
393 procedures and services, including (A) the allowed amount for (i) at a
394 minimum, admissions and procedures reported to the Connecticut
395 Health Insurance Exchange pursuant to section 2 of this act for each
396 health care provider in the state, and (ii) prescribed drugs and durable
397 medical equipment; (B) the estimated out-of-pocket cost that the
398 consumer would be responsible for paying for any such admission or
399 procedure that is medically necessary, including any facility fee,
400 copayment, deductible, coinsurance or other expense; and (C) data or
401 other information concerning (i) quality measures for the health care
402 provider, as such measures are determined by the Commissioner of
403 Public Health in accordance with subsection (g) of section 2 of this act,
404 (ii) patient satisfaction, (iii) whether a health care provider is accepting
405 new patients, (iv) credentials of health care providers, (v) languages
406 spoken by health care providers, and (vi) network status of health care
407 providers; and (2) information on out-of-network costs for inpatient
408 admissions, health care procedures and services. Each health carrier
409 shall use on its Internet web site the defined terms established by the
410 Insurance Commissioner pursuant to section 6 of this act.

411 (c) A health carrier shall not require a consumer to pay a higher
412 amount for an inpatient admission, health care procedure or service
413 than that disclosed to the consumer pursuant to subsection (b) of this
414 section, provided a health carrier may impose additional cost-sharing
415 requirements for unforeseen services that arise out of the proposed
416 admission or procedure if (1) such requirements are disclosed in the
417 health benefit plan, and (2) the health carrier advised the consumer
418 when providing the cost-sharing information that the amounts are
419 estimates and that the consumer's actual cost may vary due to the need

420 for unforeseen services that arise out of the proposed admission or
421 procedure.

422 (d) Each health carrier shall submit to the Insurance Commissioner
423 not later than July 1, 2016, and annually thereafter, a detailed
424 description of (1) the manner in which cost-sharing information is
425 communicated to consumers, as required pursuant to subsection (b) of
426 this section, (2) any marketing efforts undertaken to inform consumers
427 of the information available pursuant to the provisions of this section,
428 (3) any surveys of consumers conducted to determine consumer
429 satisfaction with the manner in which cost-sharing information is
430 communicated, and (4) the tools used to provide cost-sharing
431 information to consumers.

432 (e) Not later than thirty days after the date that a health care
433 provider stops accepting patients who are enrolled in an insurance
434 plan, such health care provider shall notify, in writing, the applicable
435 health carrier.

436 Sec. 6. (NEW) (*Effective October 1, 2015*) The Insurance
437 Commissioner shall establish standard terms with definitions to be
438 used by health carriers and health care providers for the purposes of
439 complying with sections 2, 3 and 5 of this act, to ensure consumers
440 obtain accurate, relevant and complete price information.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2015</i>	38a-1084
Sec. 2	<i>October 1, 2015</i>	New section
Sec. 3	<i>October 1, 2015</i>	New section
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>	New section

Statement of Legislative Commissioners:

In Section 2(c) "said department's" was changed to "the Insurance Department's and Department of Public Health's" for clarity.

PH *Joint Favorable Subst. -LCO*

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:

Agency Affected	Fund-Effect	FY 16 \$	FY 17 \$
Insurance Department	IF - Potential Cost	Up to \$45,000	Up to \$60,000
UConn Health Center	SF - Cost	Up to \$110,000	\$82,400

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

Municipal Impact: None

Explanation

The bill will result in costs of up to \$110,000 in FY 16 and \$82,400 in FY 17 for the UConn Health Center (UCHC). The bill requires hospitals to identify and provide certain information to patients. UCHC would incur a one-time cost of up to \$50,000 to develop the necessary data system to collate information and produce the required documents. Additionally, one full time position in the patient access department would be required to identify patients and provide the written reports. This position would result in additional salary and fringe benefit costs of \$60,000 in FY 16 and \$80,000 in FY 17.

The bill also results in a potential cost to the Department of Insurance (DOI) related to the requirement to annually post certain information and to develop standard terms for provisions of the bill. The bill does not specify where the information to be posted is to be acquired. Should this information not be readily available from other sources, such as the All-Payer Claims Database, DOI may have to annually survey insurance carriers and analyze the data. Likewise, should DOI not be able to utilize existing information to develop

standardized terms, a one-time administrative cost may result. It is assumed that the potential combined administrative costs would not exceed the equivalent of a half time position, with annualized salary and fringe benefit costs of approximately \$60,000.

The bill also requires the Connecticut Health Insurance Exchange to create a consumer health information website. This does not result in a fiscal impact to the state. As a quasi-public state agency, the Exchange is responsible to charge assessments or fees as necessary to carry out its duties.

The Out Years

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

OLR Bill Analysis**sSB 813*****AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.*****SUMMARY:**

This bill contains various provisions on health care cost and quality information available to consumers. It requires the Connecticut Health Insurance Exchange (i.e., Access Health CT) to create a consumer health information website. Among other things, the website must contain comparative price, cost, and quality information for the most common health care services. The bill creates several annual reporting requirements to provide data for the website, including reporting by the public health (DPH) and insurance commissioners, health carriers (e.g., insurers), hospitals, and outpatient surgical facilities.

The bill requires providers, when scheduling any admission or procedure, to determine whether the patient is insured. If the patient is uninsured or the provider is out of network, the provider must notify the patient of the actual charges and that the patient may be charged more for unforeseen services that may arise.

The bill requires hospitals and outpatient surgical facilities, within two business days after scheduling common procedures or admissions, to provide the patient with related cost and quality information.

It requires carriers to develop websites allowing consumers to obtain cost and quality information, and make the same information available through phone applications and toll-free numbers. The bill prohibits carriers from requiring consumers to pay higher amounts than those disclosed, except for unforeseen services. It requires carriers to annually report to the insurance commissioner on how they communicate cost-sharing information to consumers and related

matters.

The bill requires providers to send written notice to the applicable carrier within 30 days after they stop accepting patients enrolled in an insurance plan (§ 5).

Among other things, the bill also:

1. requires the insurance commissioner to establish standard terms with definitions to be used by carriers and providers to comply with the provisions described above, to ensure consumers obtain accurate, relevant, and complete price information (§ 6) and
2. prohibits contracts between providers and carriers from restricting the disclosure of negotiated pricing information, including information on out-of-pocket expenses (§ 4).

EFFECTIVE DATE: October 1, 2015

§§ 1 & 2 – CONSUMER HEALTH INFORMATION WEBSITE

The bill requires the Connecticut Health Insurance Exchange to establish and maintain a consumer health information website. The website must be designed to help consumers and institutional purchasers make informed decisions about their health care and choice of health care providers.

Website Contents and Format

Under the bill, the website must contain information comparing the quality, price, and cost of health care services. This must include, to the extent practicable:

1. comparative price and cost information for the most common referrals or prescribed services, categorized by payer and listed by facility, health care provider, and provider organization;
2. comparative quality information for these services or service categories, listed by facility, provider, provider organization, or

- any other provider grouping;
3. data on health care-associated infections and serious reportable events;
 4. definitions of common health insurance and medical terms, as determined by the insurance commissioner, so consumers may compare health coverage and understand coverage terms;
 5. a list of health care provider types, including primary care physicians, nurse practitioners, and physician assistants, and the types of services each is authorized to provide;
 6. factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost-sharing, covered services, and tier information;
 7. patient decision aids;
 8. a list of provider services accessible for people with disabilities; and
 9. descriptions of standard quality measures.

The website also must allow comparisons of health carrier reimbursement to providers.

It must present information in a language and format understandable to the average consumer. The exchange must publicize the website to the general public.

Data Submission and Reporting Requirements

The bill establishes several data submission and reporting requirements to collect data for the consumer website. The exchange must post all such information on the website.

The bill provides that all information the exchange collects, stores, and publishes under these provisions is subject to the federal Health Insurance Portability and Accountability Act. Any individually

identifiable health information must be secure, encrypted as necessary, and not disclosed.

Insurance and Public Health Commissioners. The bill requires the insurance and DPH commissioners, by October 1, 2016 and annually after that, to jointly report to the exchange and make available on their departments' websites, the following information on health procedures in the state: (1) the 100 most frequent inpatient admissions and outpatient procedures and (2) the 25 most frequent surgical procedures and imaging procedures. The lists may include bundled episodes of care (all health care services related to the treatment).

The bill allows the exchange to expand this requirement to include more admissions and procedures.

Health Carriers. The bill requires health carriers, by January 1, 2016 and annually after that, to submit to the exchange:

1. the allowed amounts (i.e., maximum reimbursements) paid to in-network providers for each admission and procedure included in the commissioners' report (e.g., the 100 most frequent admissions) and
2. out-of-pocket costs for each such admission and procedure (i.e., unreimbursed costs such as deductibles, coinsurance, and copayments).

Under the bill, "health carriers" are insurers, HMOs, hospital or medical service corporations, or other entities delivering, issuing, renewing, amending, or continuing individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

Hospitals and Outpatient Surgical Facilities. The bill requires hospitals and outpatient surgical facilities, by January 1, 2016 and annually thereafter, to report to the exchange the following

information for each admission and procedure in the commissioners' report described above:

1. the amount they charge patients if all charges are paid in full without a third party (e.g., public or private insurer) paying any portion;
2. the average negotiated settlement on these charges;
3. the Medicaid reimbursement amount, including claims and pro rata supplement payments;
4. the Medicare reimbursement amount; and
5. the allowed amounts for the five largest carriers according to the previous year's patient volume, with the carriers' names and other identifying information redacted.

Despite these requirements, the bill prohibits a hospital or outpatient surgical facility from reporting information that may reasonably lead to the identification of specific patients.

Social Services Commissioner. The bill requires the social services commissioner to submit to the exchange all Medicaid data it requests for the all-payer claims database (which the exchange administers).

Quality Measures

The bill requires the DPH commissioner, in consultation with the insurance commissioner and healthcare advocate, to:

1. develop quality measures for carriers to include when providing information to patients about the costs of health care services and
2. determine quality measures to be reported by carriers and providers to the exchange.

In developing these measures, they must consider

recommendations by the National Quality Forum's Measures Applications Partnership and the National Priorities Partnership (see BACKGROUND).

§§ 2 & 3 – NOTICES TO PATIENTS

All Providers

The bill requires all licensed health care providers in the state, when scheduling an admission or procedure, to determine whether the patient is insured. If yes, the provider must notify the patient, in writing, as to whether the provider is in-network under the patient's policy and provide the carrier's toll-free telephone number and website.

If the patient is uninsured or the provider is out-of-network, the provider must notify the patient in writing (1) of the actual charges for the admission or procedure and (2) that the patient may be charged for unforeseen services arising out of the admission or procedure and is responsible for these charges. The bill specifies that these provisions do not prevent a provider from charging for unforeseen services.

Under the bill, if a provider refers a patient to another provider that is part of, or represented by, the same provider organization, the provider must notify the patient, in writing, of this connection.

Providers and Carriers

The bill requires providers and carriers to ensure that any billing statement or explanation of benefits they submit to a patient or insured is written in language understandable to an average reader.

Hospitals and Outpatient Surgical Facilities

Under the bill, hospitals and outpatient surgical facilities must provide written notice to patients within two business days after scheduling an admission, procedure, or service included in the DPH and insurance commissioners' report described above (e.g., the 100 most frequent outpatient procedures). The notice must include the following information:

1. for uninsured patients, (a) the amount to be charged if all charges are paid in full without a third party paying any portion, including any facility fee, or (b) if the hospital or facility cannot predict the specific treatment or diagnostic code and is thus unable to provide a specific amount to be charged, the estimated maximum allowed amount or charge, including any facility fee;
2. the Medicare reimbursement amount;
3. for insured patients, the allowed amount, toll-free telephone number, and website of the patient's health carrier where the patient can obtain information on charges and out-of-pocket expenses;
4. The Joint Commission's composite accountability rating for the hospital or facility; and
5. the websites for The Joint Commission and the Medicare Hospital Compare tool where the patient may obtain information on the hospital or facility.

The Joint Commission is an independent, nonprofit organization that accredits and certifies many categories of health care organizations and programs in the United States.

§ 5 – CARRIER COSTS, WEBSITE, AND INFORMATION

The bill requires each health carrier to publish a website and begin using a mobile device application and toll-free telephone number allowing consumers to request and obtain information on in-network and out-of-network costs for health care procedures, services, and inpatient admissions.

The in-network information must include:

1. the allowed amount for at least the admissions and procedures reported to the exchange under the bill, for each provider in the state;

2. the allowed amount for prescribed drugs and durable medical equipment;
3. the estimated out-of-pocket cost (including facility fees) that the consumer would be responsible for paying for these admissions or procedures that are medically necessary; and
4. data or other information on (a) quality measures for the provider, as determined by the DPH commissioner under the bill; (b) patient satisfaction; (c) whether a provider is accepting new patients; and (d) health care providers' credentials, languages spoken, and network status.

On their websites, carriers must use the defined terms established by the insurance commissioner under the bill.

The bill generally prohibits carriers from requiring consumers to pay a higher amount for health care procedures, services, and inpatient admissions than the amounts disclosed to the consumer as set forth above. The carrier may impose additional cost-sharing requirements for related unforeseen services if (1) these requirements are disclosed in the benefit plan and (2) the carrier advised the consumer when providing the cost-sharing information that the amounts are estimates and the consumer's actual cost may vary due to the need for unforeseen services.

The bill requires each carrier, by July 1, 2016 and annually after that, to submit to the insurance commissioner a detailed description of:

1. how it communicates cost-sharing information to consumers, as required under the bill;
2. its marketing efforts, if any, to inform consumers of the information available under these provisions;
3. any consumer surveys the carrier has conducted to determine consumer satisfaction with how it communicates cost-sharing information; and

4. the tools it uses to provide cost-sharing information.

BACKGROUND

National Quality Forum and National Priorities Partnership

The National Quality Forum (NQF) is a nonprofit membership organization that works to improve health care quality management and reporting. The National Priorities Partnership, convened by the NQF, is a partnership of over 50 organizations that, among other things, provides input to the Health and Human Services secretary on the National Quality Strategy (a blueprint to improve health care quality).

COMMITTEE ACTION

Public Health Committee

Joint Favorable

Yea 25 Nay 0 (03/30/2015)