



General Assembly

January Session, 2015

Committee Bill No. 807

LCO No. 4216



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***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*

PH *Joint Favorable*