



General Assembly

January Session, 2015

Committee Bill No. 813

LCO No. 5901



Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

**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 Section 38a-1084 of the general statutes is repealed and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 said
258 departments' Internet web sites: (1) The one hundred most frequently
259 provided inpatient admissions in the state, (2) the one hundred most
260 frequently provided outpatient procedures performed in the state, (3)
261 the twenty-five most frequent surgical procedures performed in the
262 state, and (4) the twenty-five most frequent imaging procedures
263 performed in the state. Such lists contained in the report may include
264 bundled episodes of care. At the request of the exchange, such lists
265 may be expanded to include additional admissions and procedures.

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

273 (e) Not later than January 1, 2016, and annually thereafter, each
274 hospital and outpatient surgical facility shall report to the exchange the
275 following information for each admission and procedure reported in
276 accordance with subsection (c) of this section: (1) The amount to be
277 charged to a patient for each such admission or procedure if all
278 charges are paid in full without a public or private third party paying
279 any portion of the charges, (2) the average negotiated settlement on the
280 amount to be charged to a patient as described in subdivision (1) of
281 this subsection, (3) the amount of Medicaid reimbursement for each
282 such admission or procedure, including claims and pro rata

283 supplement payments, (4) the amount of Medicare reimbursement for
284 each such admission or procedure, and (5) for the five largest health
285 carriers according to the previous year's patient volume, the allowed
286 amount for each such admission or procedure, with the health carriers
287 names and other identifying information redacted. Notwithstanding
288 the provisions of this subsection, a hospital or outpatient surgical
289 facility shall not report information that may reasonably lead to the
290 identification of individuals admitted to, or who receive services from,
291 the hospital or outpatient surgical facility.

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

314 (g) The Commissioner of Public Health, in consultation with the
315 Insurance Commissioner and the Healthcare Advocate, shall (1)

316 develop quality measures for health carriers to include when
317 providing information to patients concerning the costs of health care
318 services, and (2) determine quality measures to be reported by health
319 carriers and health care providers to the exchange. In developing such
320 measures, said commissioners and the Healthcare Advocate shall
321 consider those quality measures recommended by the National
322 Quality Forum's Measures Applications Partnership and the National
323 Priorities Partnership.

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

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

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

347 (c) Each health care provider that refers a patient to another health

348 care provider that is part of, or represented by, the same provider
349 organization shall notify the patient, in writing, that the health care
350 providers are part of, or represented by, the same provider
351 organization.

352 (d) Each health care provider and health carrier shall ensure that
353 any billing statement or explanation of benefits submitted to a patient
354 or insured is written in language that is understandable to an average
355 reader.

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

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

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

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

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

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

384 (4) "Out-of-pocket cost" means costs that are not reimbursed by a
385 health insurance policy and includes deductibles, coinsurance and
386 copayments for covered services and other costs to the consumer
387 associated with a procedure or service.

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

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

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

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

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

To promote health care cost and quality transparency in a consumer-friendly manner that empowers consumers to make informed decisions regarding their care.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. FASANO, 34th Dist.
REP. CONROY, 105th Dist.

S.B. 813