



HEALTH INSURANCE TRANSPARENCY QUESTIONS

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ISSUE

Health insurance disclosure issues and related questions.

How do Health Insurers Determine the Medications Used for Treatment?

Health insurers do not determine the medications used to treat a patient, but rather the medications that will be covered. In general, health insurers must cover medically necessary drugs.

The formulary is the list of covered medications. As new drugs become available to consumers or market conditions increase or decrease the price of existing drugs, insurers may update the formulary by adding or removing drugs, or moving drugs between different cost "tiers." Drugs placed in a higher tier may require an insured to (1) pay a higher out-of-pocket cost or (2) try a different, lower-tiered drug first, before insurance covers the higher-tiered drug (a process known as "step-therapy").

The federal Affordable Care Act (ACA) requires certain insurance plans to cover at least the greater of (1) one drug in every United States Pharmacopeial (USP) therapeutic category and class or (2) the same number of drugs in each USP category and class as the state's essential health benefits (EHBs) benchmark plan ([45 C.F.R. 156.122](#)). (The ACA requires states to select a "benchmark plan" that covers at least 10 benefit categories, known as EHBs.) Connecticut's EHB Prescription Drug list is available [here](#).

In practice, insurers use an internal committee or group, often called a pharmacy and therapeutics committee, to review formulary changes. According to the Insurance Department, these committees typically meet quarterly to review new



drugs and, if the drugs are to be covered, determine the drugs' formulary tiers. Although carriers may restrict drugs, both the department and federal law require insurance contract language that creates an exception process based on medical necessity. Any FDA-approved drug that is determined to be medically necessary must be covered. In practice, new drugs may require insureds to obtain preauthorization.

No Connecticut statute or regulation governs how often plans may change formularies or any additional criteria the committees or insurers must consider ([OLR Report 2014-R-0291](#)). According to the Insurance Department, insurers generally describe formulary changes as either negative or positive for the consumer. For example, a negative formulary change may include shrinking the formulary, while a positive change may include adding new drugs on a lower cost-tier. In practice, most insurers in Connecticut change formularies (1) negatively once or twice a year and (2) positively as needed.

Are Health Insurers Required to Publish Contracted Prices?

Insurers are not required to disclose contracted prices for medical services with medical providers and institutions. According to the Insurance Department, as part of the rate review process, the department requires insurers to describe any change in their contracting efforts with providers and how the change impacts costs. However, actual provider contracts are not provided to the department, and the department has no authority over provider reimbursements.

However, [PA 15-146](#) requires insurers to disclose certain information, including reimbursement rates. In addition, it prohibits any contract between a provider and insurer from restricting the disclosure of billed or allowed amounts, reimbursement rates, or out-of-pocket costs.

Under the ACA, health plans on the exchange must make public certain information, including certain payment and claims information ([42 U.S.C. § 18031\(e\)\(3\)](#)).

Are Health Insurers Required to Publish the Formulas Used to Determine Insurance Premiums?

No. However, health insurers must submit rate filings to the Insurance Department. Rate filings include all actuarial information the department needs to determine if an insurer's health insurance rates are inadequate, excessive, or unfairly discriminatory (the three criteria prohibited by law). The filing, which is an actuarial memorandum, and all supporting documentation are publicly available on the department's website.

Two bills proposed this session generally affected health insurer disclosure.

[PA 16-206](#) requires insurers to disclose certain information to the Insurance Department in an annual report, called a Corporate Governance Annual Disclosure report. The act deems the information in the report proprietary, confidential, and exempt from subpoena and disclosure under Connecticut's Freedom of Information Act. The information is not subject to discovery or admissible as evidence in any civil action.

[PA 16-213](#) makes certain examination papers, recorded information, and documents confidential and prohibits anyone, including the insurance commissioner, from making such information public. And the documents and information are not subject to subpoena. The act applies to market conduct examinations, which are different from the rate filings described above.

What Types of Facility Fees May Insurers Charge?

Facility fees are charged by certain health care providers, not insurers. The fees cover overhead costs, such as equipment, space, and support staff.

Connecticut law defines a "facility fee" as any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee. Facilities that charge these fees must provide specified notices to patients ([CGS § 19a-508c](#), as amended by [PA 16-77](#), § 2).

By law, telehealth providers may not charge facility fees for telehealth services ([CGS § 19a-906](#)).

Recent legislation, described below, also sets certain limits on facility fees and related cost-sharing requirements.

Are Health Insurers Required to Report Gifts to Medical Providers, Similar to the Requirements of Pharmaceutical Sunshine Laws?

Broadly, sunshine laws refer to laws requiring disclosure of conflicts of interest. Under the federal [Open Payments](#) program, commonly referred to as the Sunshine Act, certain organizations must report to the Centers for Medicare and Medicaid Services (CMS) any payments, gifts, and other transfers of value to physicians and hospitals. In general, these requirements apply to drug and medical device manufacturers and group purchasing organizations (i.e., organizations that purchase or negotiate covered drugs, devices, or certain other medical supplies).

We found no recent proposed legislation or state or federal law requiring health insurers to disclose payments or gifts to medical providers. However, the American Medical Association (AMA) asks all physicians to decline (1) cash gifts from any entity with a direct interest in treatment recommendations and (2) any gifts for which reciprocity is expected or implied ([Opinion 8.061](#)). It is not clear if this opinion extends to gifts from insurers.

Can a Patient Be Billed for "Unexpected Emotional Behavior"

Unexpected emotional behavior refers to unexpected behavior by a patient during an office or other medical visit that requires additional medical staff or procedures. For example, a patient may schedule an office visit with his or her medical provider for a flu shot, but the patient's unexpected intense fear of injections requires additional medical staffing or treatment of additional symptoms (e.g., hyperventilation).

Neither the Insurance nor Public Health department regulates how providers bill a patient's insurance in such a scenario. According to the Insurance Department, a provider may bill for additional services in accordance with his or her contract with the insurer and his or her office policies.

Are Pharmacy Benefit Managers (PBMS) Subject to Price Transparency or Other State Laws?

PBMs manage prescription drug, prescription device, or pharmacist services for health insurance plan sponsors (e.g., self-insured employers, insurance companies, labor unions, or health care centers). They act as fiscal intermediaries that specialize in the administration and management of prescription drug benefit programs.

PBMs aim to provide high-quality pharmaceutical care at the lowest possible cost. To do this, they employ a number of methods to reduce prescription drug costs, including negotiated prices, generic substitution, manufacturer rebates, copayment and coinsurance cost sharing, and formularies.

No state law requires PBMs to disclose prescription drug or device pricing or contracting information. PBMs must be registered with the insurance commissioner, who may suspend or revoke registration for, among other things, unfair or deceptive business practices ([CGS § 38a-479ccc\(b\)](#)). In addition to registering, PBMs must generally pay claims in a timely fashion, are subject to investigation by the insurance commissioner, and may initiate audits of pharmacies with whom they work ([CGS § 38a-479aaa et seq.](#) and [Conn. Agencies Regs. § 38a-479aaa-1 et seq.](#)).

RECENT LEGISLATION INCREASING HEALTH INSURANCE TRANSPARENCY

[PA 15-146](#) made several changes that increase the transparency of medical costs, contracted prices, and medical provider reimbursement rates. The act requires certain disclosures by Access Health CT, health carriers and health carrier contracts, health care providers, and hospitals. The act also limits facility fees.

Access Health CT

The act requires Access Health CT, within available resources, to establish and maintain a consumer health information website that includes health carrier reimbursement amounts to providers. The website must include comparative price and cost information for the (1) 50 most frequent inpatient primary diagnoses and procedures, (2) 50 most frequent outpatient procedures, (3) 25 most frequent surgical procedures, and (4) 25 most frequent imaging procedures. The information must be categorized by payer and listed by provider.

Health Carriers

Under the act, health carriers must annually submit to Access Health CT a report listing, by provider, the (1) billed and allowed amounts (i.e., maximum reimbursements) paid to in-network providers for certain prominent diagnoses and procedures and (2) out-of-pocket costs for each such diagnosis and procedure (i.e., unreimbursed costs such as deductibles, coinsurance, and copayments).

Health carriers must also maintain a website and toll-free telephone number that allows consumers to request and obtain information on in-network and out-of-network costs for health care procedures, services, and inpatient admissions.

The act requires health carriers to disclose certain information to consumers at enrollment and post the information on their websites. This includes:

1. any coverage exclusions;
2. any restrictions on the use or quantity of a covered benefit, including prescription drugs;
3. a description of the deductible and other out-of-pocket expenses that apply to prescription drugs; and
4. the applicable copayment and coinsurance percentage for each covered benefit, including each covered prescription drug.

Health carriers must also provide a way for consumers to accurately determine:

1. whether a prescription drug is covered under the policy's drug formulary;
2. the coinsurance, copayment, deductible, or other out-of-pocket expense applicable to a prescription drug;
3. whether a prescription drug is covered when a physician or clinic dispenses it;
4. whether a prescription drug requires preauthorization or the use of step-therapy (i.e., a protocol establishing the sequence for prescribing drugs for a specific medical condition); and
5. whether specific health care providers, hospitals, or specialists are in-network.

Health Carrier Contracts

The act prohibits contracts between providers and carriers from restricting certain disclosures. Among other things, contracts cannot restrict the disclosure of (1) billed or allowed amounts, reimbursement rates, or out-of-pocket costs or (2) any data to Connecticut's All Payer Claims Database.

Health Care Providers

The act requires licensed health care providers, before any scheduled nonemergency admission, procedure, or service, 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 charges for the admission, procedure, or service. An out-of-network provider must also notify the patient that (1) he or she may be charged for unforeseen services that may arise and is responsible for these charges and (2) the admission, service, or procedure will likely be deemed out-of-network and out-of-network rates may apply.

Hospitals

Under the act, hospitals must notify patients at the time they schedule certain common nonemergency diagnoses or procedures of their right to request related cost and quality information.

Facility Fees

Starting January 1, 2017, the law generally prohibits hospitals, health systems, and hospital-based facilities from collecting any facility fee for outpatient services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department,

that is off-site from a hospital campus. It also prohibits them from collecting from uninsured patients a facility fee for outpatient services, other than for services provided in off-site emergency departments, that exceeds the Medicare rate.

This year, another act provides that these restrictions do not apply to Medicare or Medicaid patients or patients receiving services under a workers' compensation plan ([PA 16-77](#)).

[PA 15-146](#) also set limits on patient cost-sharing requirements for facility fees for outpatient services provided off-site from a hospital campus. It prohibits health insurers and similar entities that reimburse hospitals, health systems, or hospital-based facilities for such facility fees from imposing a separate copayment for these fees. If an insured person has not satisfied his or her deductible, the hospital or other facility may not collect from the person a facility fee exceeding the agreed-upon reimbursement rate under the applicable contract.

The act also makes it an unfair trade practice for a health care provider to request payment from a health care plan enrollee, except for a copayment, deductible, coinsurance, or other out-of-pocket expense, for covered health care services or facility fees.

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