STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony
Insurance and Real Estate Committee
February 7, 2017

Senate Bill No. 426 An Act Protecting Patients from Inappropriate Billing Practices.

House Bill No. 6436 An Act Concerning An Arbitration Process for Surprise Bills and Bills for Emergency Services.

Committee Chairs, Co-Chairs, Ranking Member, and Members of the Insurance and Real Estate Committee, the Insurance Department appreciates the opportunity to submit written testimony on **Senate Bill No. 426 An Act Protecting Patients from Inappropriate Billing Practices and House Bill No. 6436 An Act Concerning An Arbitration Process for Surprise Bills and Bills for Emergency Services.** Generally, S.B. 426 requires carriers to only charge a patient who received health care services from a health care provider at a hospital that is in-network a cost that is level with the in-network level of cost-sharing by all health care providers who provide services at such hospital and H.B. 5962 requires the Connecticut Insurance Department to operate an arbitration process by which a dispute over a bill for emergency services or a surprise bill for health care services rendered under certain circumstances may be resolved.

Last year, the Department was instrumental in its support of P.A. 16-205 regarding network adequacy. This legislation was based on the NAIC model, but changed slightly to accommodate for the requirements in P.A. 15-146 regarding surprise billing. This NAIC model was developed through a collaborative process with consumer, provider, and industry input. In the NAIC model, but not included in P.A. 16-205, is section 7. Section 7 covers billing for non-participating providers in participating facilities in both emergency and non-emergency situations and sets up a provider mediation process to discern appropriate billing amounts. The Department would like to lend its support to this legislation and request that these bills be drafted in line with section 7 of the NAIC model act on Health Benefit Plan Network Access and Adequacy of 2015. The Department is happy to be a partner and provide any technical assistance it can on this topic.

The Department's mission is to ensure consumers receive the coverage required under the law and in their contracts. The Department's Consumer Affairs Division stands ready to assist any consumer or provider who feels as though medically necessary treatment has not been covered appropriately and has been successful in recovering payment on behalf of insureds in many circumstances.

The Department thanks the members of the Insurance and Real Estate Committee for the opportunity to submit testimony in support of S.B. 426 and H.B. 6436 and looks forward to being part of the discussion should these bills move forward.

About the Connecticut Insurance Department: The mission of the Connecticut Insurance Department is to protect consumers through regulation of the industry, outreach, education and advocacy. The Department recovers an average of more than $4 million yearly on behalf of consumers and regulates the industry by ensuring carriers adhere to state insurance laws and regulations and are financially solvent to pay claims. The Department's annual budget is funded through assessments from the insurance industry. For every dollar of direct expense, the Department brings in about $7.45 to the state in revenues. Each year, the Department returns more than $215 million in assessments, fees and penalties to the state's General Fund.

HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Health Benefit Plan Network Access and Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to:

A. Establish standards for the creation and maintenance of networks by health carriers; and

B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered services to covered persons; and

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Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section 11 of this Act in order to determine if the provisions in the contract defining what is to be considered timely notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section, Section 11 of this Act or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of provider contracting issues.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

Section 7. Requirements for Participating Facilities with Non-Participating Facility-Based Providers

A. For purposes of this section, "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility's general business operations, and a covered person or the covered person's health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.

Drafting Note: States should carefully review the definition of "facility-based provider" above to make sure it includes any provider who may bill separately from the facility for health care services provided at the in-patient or ambulatory facility.

B. Non-emergency out-of-network services.

(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

(a) That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

(b) That those facility-based providers may not have contracts with the covered person's health carrier and are therefore considered to be out-of-network;

(c) That the service(s) therefore will be provided on an out-of-network basis;

(d) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;

(e) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person's health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and

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(f) A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

Drafting Note: The notice required in this subsection could replace the notice in Section 8B of this Act.

(2) At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility shall provide the covered person with the written disclosure, as outlined in Paragraph (1), and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

C. Out-of-network emergency services.

(1) For out-of-network emergency services, the non-participating facility-based provider shall include a statement on any billing notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan's allowable amount is more than [$500.00].

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by a non-participating provider, which permit a non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit a non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph (1) above, the state should review their laws or regulations that may be equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act* (#73) and revise them accordingly.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on balance billing covered persons.

(1) In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice in Paragraph (2).

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan's allowable amount is more than [$500.00], you may

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send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by [this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process described in Subsection E.

(4) Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in Paragraph (2), may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network facility-based provider payments.

(1) Health carriers shall develop a program for payment of non-participating facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in Subsection F.

(3) Non-participating facility-based providers who object to the payment(s) made in Paragraph (2) may elect the Provider Mediation Process described in Subsection G.

(4) This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

F. Benchmark for non-participating facility-based provider payments. Payments to non-participating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F and others such as: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in Subsection F.

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(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

Drafting Note: Some states have included a provider mediation process in an independent dispute resolution process. The intent and effect is similar to this process.

(3) Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

(4) A health carrier provider mediation process may not be used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

(5) A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report to the commissioner in the format specified by the commissioner.

Drafting Note: In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

I. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insurance department] shall be responsible for enforcement of the requirements of this section.

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare,

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Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

Drafting Note: This section is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of the services, to obtain health care services from a non-participating facility-based provider.

K. Regulations. The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Disclosure and Notice Requirements

A. (1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. The disclosure or notice also shall inform the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

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