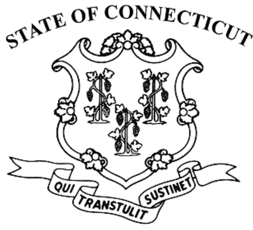

General Assembly

Amendment

January Session, 2017

LCO No. **7774**

Offered by:
SEN. LOONEY, 11th Dist.
SEN. FASANO, 34th Dist.
SEN. GERRATANA, 6th Dist.
SEN. SOMERS, 18th Dist.

To: Subst. Senate Bill No. **445** File No. 519 Cal. No. 295

"AN ACT CONCERNING FAIRNESS IN PHARMACY AND PHARMACY BENEFITS MANAGER CONTRACTS."

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1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective October 1, 2017*) (a) On and after January
4 1, 2018, no contract for pharmacy services entered into in the state
5 between a health carrier, as defined in section 38a-591a of the general
6 statutes, or pharmacy benefits manager, as defined in section 38a-
7 479aaa of the general statutes, and a pharmacy or pharmacist shall
8 contain a provision prohibiting or penalizing, including through
9 increased utilization review, reduced payments or other financial
10 disincentives, a pharmacist's disclosure to an individual purchasing
11 prescription medication of information regarding (1) the cost of the
12 prescription medication to the individual, or (2) the availability of any
13 therapeutically equivalent alternative medications or alternative

14 methods of purchasing the prescription medication, including, but not
15 limited to, paying a cash price, that are less expensive than the cost of
16 the prescription medication to the individual.

17 (b) On and after January 1, 2018, no health carrier or pharmacy
18 benefits manager shall require an individual to make a payment at the
19 point of sale for a covered prescription medication in an amount
20 greater than the lesser of (1) the applicable copayment for such
21 prescription medication, (2) the allowable claim amount for the
22 prescription medication, or (3) the amount an individual would pay
23 for the prescription medication if the individual purchased the
24 prescription medication without using a health benefit plan, as defined
25 in section 38a-591a of the general statutes, or any other source of
26 prescription medication benefits or discounts. For the purposes of this
27 subsection, "allowable claim amount" means the amount the health
28 carrier or pharmacy benefits manager has agreed to pay the pharmacy
29 for the prescription medication.

30 (c) Any provision of a contract that violates the provisions of this
31 section shall be void and unenforceable. Any general business practice
32 that violates the provisions of this section shall constitute an unfair
33 trade practice pursuant to chapter 735a of the general statutes. The
34 invalidity or unenforceability of any contract provision under this
35 subsection shall not affect any other provision of the contract.

36 (d) The Insurance Commissioner may, (1) pursuant to the
37 provisions of chapter 697 of the general statutes, enforce the provisions
38 of this section, and (2) upon request, audit a contract for pharmacy
39 services for compliance with the provisions of this section.

40 Sec. 2. (NEW) (*Effective from passage*) In any action brought under
41 subsection (c) of section 35-32 of the general statutes or seeking treble
42 damages under section 35-35 of the general statutes, a defendant that
43 sells, distributes or otherwise disposes of any drug or device, as
44 defined in 21 USC 321, as amended from time to time:

45 (1) May not assert as a defense that the defendant did not deal

46 directly with the person on whose behalf the action is brought; and

47 (2) May, in order to avoid duplicative liability, prove, as a partial or
48 complete defense against a damage claim, that all or any part of an
49 alleged overcharge for a drug or device ultimately was passed on to
50 another person by a purchaser or a seller in the chain of manufacture,
51 production or distribution of the drug or device that paid the alleged
52 overcharge.

53 Sec. 3. Section 38a-477f of the general statutes is repealed and the
54 following is substituted in lieu thereof (*Effective October 1, 2017*):

55 (a) On and after January 1, 2016, no contract entered into or
56 renewed between a health care provider and a health carrier shall
57 contain a provision prohibiting disclosure of (1) billed or allowed
58 amounts, reimbursement rates or out-of-pocket costs, **[**and**]** or (2) any
59 data to the all-payer claims database program established under
60 section 38a-1091. **[**for the purpose of assisting**]** Information described
61 in subdivisions (1) and (2) of this subsection may be used to assist
62 consumers and institutional purchasers in making informed decisions
63 regarding their health care and informed choices among health care
64 providers and allow comparisons between prices paid by various
65 health carriers to health care providers.

66 (b) On and after October 1, 2017, no contract entered into between a
67 health care provider, or any agent or vendor retained by the health
68 care provider to provide data or analytical services to evaluate and
69 manage health care services provided to the health carrier's plan
70 participants, and a health carrier shall contain a provision prohibiting
71 disclosure of (1) billed or allowed amounts, reimbursement rates or
72 out-of-pocket costs, or (2) any data to the all-payer claims database
73 program established under section 38a-1091. Information described in
74 subdivisions (1) and (2) of this subsection may be used to assist
75 consumers and institutional purchasers in making informed decisions
76 regarding their health care and informed choices among health care
77 providers and allow comparisons between prices paid by various

78 health carriers to health care providers.

79 (c) If a contract described in subsection (a) or (b) of this section,
80 whichever is applicable, contains a provision prohibited under the
81 applicable subsection, such provision shall be void and unenforceable.
82 The invalidity or unenforceability of any contract provision under this
83 subsection shall not affect any other provision of the contract.

84 Sec. 4. Section 19a-904c of the general statutes is repealed and the
85 following is substituted in lieu thereof (*Effective October 1, 2017*):

86 (a) For purposes of this section:

87 (1) "Bidirectional connectivity" means the ability of a hospital's
88 electronic health record system to electronically send and receive
89 electronic health records;

90 **[**(1)**]** (2) "Electronic health record" means any computerized, digital
91 or other electronic record of individual health-related information that
92 is created, held, managed or consulted by a health care provider and
93 may include, but need not be limited to, continuity of care documents,
94 admission, discharge **[**summaries**]** or transfer records, and other
95 information or data relating to **[**patient**]** a patient's medical history or
96 treatment, including, but not limited to, demographics, **[**medical
97 history,**]** medication, allergies, immunizations, laboratory test results,
98 radiology or other diagnostic images, vital signs and statistics;

99 **[**(2)**]** (3) "Electronic health record system" means a computer-based
100 information system that is used to create, collect, store, manipulate,
101 share, exchange or make available electronic health records for the
102 purpose of the delivery of patient care;

103 **[**(3)**]** (4) "Health care provider" means any individual, corporation,
104 facility or institution licensed by the state to provide health care
105 services; **[**and**]**

106 (5) "Hospital" has the same meaning as in section 19a-490d; and

107 [(4)] (6) "Secure exchange" means the exchange of patient electronic
108 health records between a hospital and a health care provider in a
109 manner that complies with all state and federal privacy requirements,
110 including, but not limited to, the Health Insurance Portability and
111 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from
112 time to time.

113 (b) Each hospital licensed under chapter 368v shall, to the fullest
114 extent practicable [,] (1) use its electronic health records system to
115 enable bidirectional connectivity and provide for the secure exchange
116 of patient electronic health records between the hospital and any other
117 health care provider who [(1)] maintains an electronic health records
118 system capable of exchanging such records [,] and [(2)] provides health
119 care services to a patient whose records are the subject of the exchange,
120 and (2) send or receive an electronic health record in accordance with
121 the provisions of this subsection upon the request of a patient or, with
122 the consent and authorization of the patient, a patient's health care
123 provider, provided the transfer or receipt of the electronic health
124 record constitutes a secure exchange and does not violate any state or
125 federal law or regulation or constitute an identifiable and legitimate
126 security or privacy risk. If the hospital has reason to believe that the
127 transfer of an electronic health record under subdivision (2) of this
128 subsection would violate a state or federal law or regulation or
129 constitute an identifiable and legitimate security or privacy risk, the
130 hospital shall notify the patient or health care provider who made the
131 request.

132 (c) The requirements of this section apply to [at least the following:
133 (A)] electronic health records that include, but are not limited to: (1)
134 Laboratory and diagnostic tests; [(B)] (2) radiological and other
135 diagnostic imaging; [(C)] (3) continuity of care documents; and [(D)]
136 (4) admission, discharge or transfer notifications and documents.

137 [(c)] (d) Each hospital shall implement the use of any hardware,
138 software, bandwidth or program functions or settings already
139 purchased or available to it to support the secure exchange of

140 electronic health records and information as described in [subsection]
141 subsections (b) and (c) of this section.

142 [(d)] (e) Nothing in this section shall be construed as requiring a
143 hospital to pay for, install, construct or build any new or additional
144 information technology, equipment, hardware or software, including
145 interfaces, where such additional items are necessary to enable such
146 exchange.

147 [(e)] (f) The failure of a hospital to take all reasonable steps to
148 comply with this section shall constitute evidence of health
149 information blocking pursuant to section 19a-904d.

150 [(f)] (g) A hospital that connects to, and actively participates in, the
151 State-wide Health Information Exchange, established pursuant to
152 section 17b-59d shall be deemed to have satisfied the requirements of
153 this section.

154 Sec. 5. Section 19a-508c of the general statutes is repealed and the
155 following is substituted in lieu thereof (*Effective October 1, 2017*):

156 (a) As used in this section:

157 (1) "Affiliated provider" means a provider that is: (A) Employed by
158 a hospital or health system, (B) under a professional services
159 agreement with a hospital or health system that permits such hospital
160 or health system to bill on behalf of such provider, or (C) a clinical
161 faculty member of a medical school, as defined in section 33-182aa,
162 that is affiliated with a hospital or health system in a manner that
163 permits such hospital or health system to bill on behalf of such clinical
164 faculty member;

165 (2) "Campus" means: (A) The physical area immediately adjacent to
166 a hospital's main buildings and other areas and structures that are not
167 strictly contiguous to the main buildings but are located within two
168 hundred fifty yards of the main buildings, or (B) any other area that
169 has been determined on an individual case basis by the Centers for

170 Medicare and Medicaid Services to be part of a hospital's campus;

171 (3) "Facility fee" means any fee charged or billed by a hospital or
172 health system for outpatient **[**hospital**]** services provided in a hospital-
173 based facility that is: (A) Intended to compensate the hospital or health
174 system for the operational expenses of the hospital or health system,
175 and (B) separate and distinct from a professional fee;

176 (4) "Health system" means: (A) A parent corporation of one or more
177 hospitals and any entity affiliated with such parent corporation
178 through ownership, governance, membership or other means, or (B) a
179 hospital and any entity affiliated with such hospital through
180 ownership, governance, membership or other means;

181 (5) "Hospital" has the same meaning as provided in section 19a-490;

182 (6) "Hospital-based facility" means a facility that is owned or
183 operated, in whole or in part, by a hospital or health system <u>and</u> where
184 hospital or professional medical services are provided<u>. For purposes of</u>
185 <u>this subdivision, "facility operated in part by a hospital or health</u>
186 <u>system" includes a facility where outpatient hospital or professional</u>
187 <u>medical services are provided for which the hospital or health system</u>
188 <u>charges a facility fee pursuant to a professional service agreement or</u>
189 <u>other agreement</u>;

190 (7) "Professional fee" means any fee charged or billed by a provider
191 for professional medical services provided in a hospital-based facility;
192 and

193 (8) "Provider" means an individual, entity, corporation or health
194 care provider, whether for profit or nonprofit, whose primary purpose
195 is to provide professional medical services.

196 (b) If a hospital or health system charges a facility fee utilizing a
197 current procedural terminology evaluation and management (CPT
198 E/M) code for outpatient services provided at a hospital-based facility
199 where a professional fee is also expected to be charged, the hospital or

200 health system shall provide the patient with a written notice that
201 includes the following information:

202 (1) That the hospital-based facility is part of a hospital or health
203 system and that the hospital or health system charges a facility fee that
204 is in addition to and separate from the professional fee charged by the
205 provider;

206 (2) (A) The amount of the patient's potential financial liability,
207 including any facility fee likely to be charged, and, where professional
208 medical services are provided by an affiliated provider, any
209 professional fee likely to be charged, or, if the exact type and extent of
210 the professional medical services needed are not known or the terms of
211 a patient's health insurance coverage are not known with reasonable
212 certainty, an estimate of the patient's financial liability based on typical
213 or average charges for visits to the hospital-based facility, including
214 the facility fee, (B) a statement that the patient's actual financial
215 liability will depend on the professional medical services actually
216 provided to the patient, [and] (C) an explanation that the patient may
217 incur financial liability that is greater than the patient would incur if
218 the professional medical services were not provided by a hospital-
219 based facility, and (D) a telephone number the patient may call for
220 additional information regarding such patient's potential financial
221 liability, including an estimate of the facility fee likely to be charged
222 based on the scheduled professional medical services; and

223 (3) That a patient covered by a health insurance policy should
224 contact the health insurer for additional information regarding the
225 hospital's or health system's charges and fees, including the patient's
226 potential financial liability, if any, for such charges and fees.

227 (c) If a hospital or health system charges a facility fee without
228 utilizing a current procedural terminology evaluation and
229 management (CPT E/M) code for outpatient services provided at a
230 hospital-based facility, located outside the hospital campus, the
231 hospital or health system shall provide the patient with a written

232 notice that includes the following information:

233 (1) That the hospital-based facility is part of a hospital or health
234 system and that the hospital or health system charges a facility fee that
235 may be in addition to and separate from the professional fee charged
236 by a provider;

237 (2) (A) A statement that the patient's actual financial liability will
238 depend on the professional medical services actually provided to the
239 patient, **[**and**]** (B) an explanation that the patient may incur financial
240 liability that is greater than the patient would incur if the hospital-
241 based facility was not hospital-based<u>, and (C) a telephone number the</u>
242 <u>patient may call for additional information regarding such patient's</u>
243 <u>potential financial liability, including an estimate of the facility fee</u>
244 <u>likely to be charged based on the scheduled professional medical</u>
245 <u>services</u>; and

246 (3) That a patient covered by a health insurance policy should
247 contact the health insurer for additional information regarding the
248 hospital's or health system's charges and fees, including the patient's
249 potential financial liability, if any, for such charges and fees.

250 (d) On and after January 1, 2016, each initial billing statement that
251 includes a facility fee shall: (1) Clearly identify the fee as a facility fee
252 that is billed in addition to, or separately from, any professional fee
253 billed by the provider; (2) provide the corresponding Medicare facility
254 fee reimbursement rate for the same service as a comparison or, if there
255 is no corresponding Medicare facility fee for such service, (A) the
256 approximate amount Medicare would have paid the hospital for the
257 facility fee on the billing statement, or (B) the percentage of the
258 hospital's charges that Medicare would have paid the hospital for the
259 facility fee; (3) include a statement that the facility fee is intended to
260 cover the hospital's or health system's operational expenses; (4) inform
261 the patient that the patient's financial liability may have been less if the
262 services had been provided at a facility not owned or operated by the
263 hospital or health system; and (5) include written notice of the patient's

264 right to request a reduction in the facility fee or any other portion of
265 the bill and a telephone number that the patient may use to request
266 such a reduction without regard to whether such patient qualifies for,
267 or is likely to be granted, any reduction.

268 (e) The written notice described in subsections (b) to (d), inclusive,
269 and (h) to (j), inclusive, of this section shall be in plain language and in
270 a form that may be reasonably understood by a patient who does not
271 possess special knowledge regarding hospital or health system facility
272 fee charges.

273 (f) (1) For nonemergency care, if a patient's appointment is
274 scheduled to occur ten or more days after the appointment is made,
275 such written notice shall be sent to the patient by first class mail,
276 encrypted electronic mail or a secure patient Internet portal not less
277 than three days after the appointment is made. If an appointment is
278 scheduled to occur less than ten days after the appointment is made or
279 if the patient arrives without an appointment, such notice shall be
280 hand-delivered to the patient when the patient arrives at the hospital-
281 based facility.

282 (2) For emergency care, such written notice shall be provided to the
283 patient as soon as practicable after the patient is stabilized in
284 accordance with the federal Emergency Medical Treatment and Active
285 Labor Act, 42 USC 1395dd, as amended from time to time, or is
286 determined not to have an emergency medical condition and before
287 the patient leaves the hospital-based facility. If the patient is
288 unconscious, under great duress or for any other reason unable to read
289 the notice and understand and act on his or her rights, the notice shall
290 be provided to the patient's representative as soon as practicable.

291 (g) Subsections (b) to (f), inclusive, and (k) of this section shall not
292 apply if a patient is insured by Medicare or Medicaid or is receiving
293 services under a workers' compensation plan established to provide
294 medical services pursuant to chapter 568.

295 (h) A hospital-based facility shall prominently display written

296 notice in locations that are readily accessible to and visible by patients,
297 including patient waiting areas, stating: [that: (1) The] (1) That the
298 hospital-based facility is part of a hospital or health system, [and] (2)
299 the name of the hospital or health system, and (3) that if the hospital-
300 based facility charges a facility fee, the patient may incur a financial
301 liability greater than the patient would incur if the hospital-based
302 facility was not hospital-based.

303 (i) A hospital-based facility shall clearly hold itself out to the public
304 and payers as being hospital-based, including, at a minimum, by
305 stating the name of the hospital or health system in its signage,
306 marketing materials, Internet web sites and stationery.

307 (j) A hospital-based facility shall, when scheduling services for
308 which a facility fee may be charged, inform the patient (1) that the
309 hospital-based facility is part of a hospital or health system, (2) the
310 name of the hospital or health system, (3) the hospital or health system
311 may charge a facility fee in addition to and separate from the
312 professional fee charged by the provider, and (4) a patient covered by a
313 health insurance policy may contact the health insurer for additional
314 information regarding the hospital's or health system's charges and
315 fees, including the patient's potential liability, if any, for such charges
316 and fees.

317 [(j)] (k) (1) On and after January 1, 2016, if any transaction, as
318 described in subsection (c) of section 19a-486i, results in the
319 establishment of a hospital-based facility at which facility fees will
320 likely be billed, the hospital or health system, that is the purchaser in
321 such transaction shall, not later than thirty days after such transaction,
322 provide written notice, by first class mail, of the transaction to each
323 patient served within the previous three years by the health care
324 facility that has been purchased as part of such transaction.

325 (2) Such notice shall include the following information:

326 (A) A statement that the health care facility is now a hospital-based
327 facility and is part of a hospital or health system;

328 (B) The name, business address and phone number of the hospital
329 or health system that is the purchaser of the health care facility;

330 (C) A statement that the hospital-based facility bills, or is likely to
331 bill, patients a facility fee that may be in addition to, and separate
332 from, any professional fee billed by a health care provider at the
333 hospital-based facility;

334 (D) (i) A statement that the patient's actual financial liability will
335 depend on the professional medical services actually provided to the
336 patient, and (ii) an explanation that the patient may incur financial
337 liability that is greater than the patient would incur if the hospital-
338 based facility were not a hospital-based facility;

339 (E) The estimated amount or range of amounts the hospital-based
340 facility may bill for a facility fee or an example of the average facility
341 fee billed at such hospital-based facility for the most common services
342 provided at such hospital-based facility; and

343 (F) A statement that, prior to seeking services at such hospital-based
344 facility, a patient covered by a health insurance policy should contact
345 the patient's health insurer for additional information regarding the
346 hospital-based facility fees, including the patient's potential financial
347 liability, if any, for such fees.

348 (3) A copy of the written notice provided to patients in accordance
349 with this subsection shall be filed with the Office of Health Care
350 Access. Said office shall post a link to such notice on its Internet web
351 site.

352 (4) A hospital, health system or hospital-based facility shall not
353 collect a facility fee for services provided at a hospital-based facility
354 that is subject to the provisions of this subsection from the date of the
355 transaction until at least thirty days after the written notice required
356 pursuant to this subsection is mailed to the patient or a copy of such
357 notice is filed with the Office of Health Care Access, whichever is later.
358 A violation of this subsection shall be considered an unfair trade

359 practice pursuant to section 42-110b.

360 [(k)] (l) Notwithstanding the provisions of this section, [on and after
361 January 1, 2017,] no hospital, health system or hospital-based facility
362 shall collect a facility fee for (1) outpatient health care services that use
363 a current procedural terminology evaluation and management (CPT
364 E/M) code and are provided at a hospital-based facility located off-site
365 from a hospital campus, other than a hospital emergency department,
366 [located off-site from a hospital campus] operated as a provider-based
367 entity, as defined in 42 CFR 413.65, that is authorized under Medicare
368 rules to bill for emergency procedures, or (2) outpatient health care
369 services, other than those provided in an emergency department
370 located off-site from a hospital campus, and operated as a provider-
371 based entity, as defined in 42 CFR 413.65, that is authorized under
372 Medicare rules to bill for emergency procedures, received by a patient
373 who is uninsured of more than the Medicare rate. Notwithstanding the
374 provisions of this subsection, in circumstances when an insurance
375 contract that is in effect on July 1, 2016, provides reimbursement for
376 facility fees prohibited under the provisions of this section, a hospital
377 or health system may continue to collect reimbursement from the
378 health insurer for such facility fees until the date of expiration of such
379 contract. A violation of this subsection shall be considered an unfair
380 trade practice pursuant to chapter 735a.

381 [(l)] (m) (1) Each hospital and health system shall report not later
382 than July 1, 2016, and annually thereafter to the Commissioner of
383 Public Health concerning facility fees charged or billed during the
384 preceding calendar year. Such report shall include (A) the name and
385 location of each facility [owned or operated by the hospital or health
386 system] that provides services for which a facility fee is charged or
387 billed, (B) the number of patient visits at each such facility for which a
388 facility fee was charged or billed, (C) the number, total amount and
389 range of allowable facility fees paid at each such facility by Medicare,
390 Medicaid or under private insurance policies, (D) for each facility, the
391 total amount of revenue received by the hospital or health system
392 derived from facility fees, (E) the total amount of revenue received by

393 the hospital or health system from all facilities derived from facility
394 fees, (F) a description of the ten procedures or services that generated
395 the greatest amount of facility fee revenue and, for each such
396 procedure or service, the total amount of revenue received by the
397 hospital or health system derived from facility fees, and (G) the top ten
398 procedures for which facility fees are charged based on patient
399 volume. For purposes of this subsection, "facility" means a hospital-
400 based facility that is located outside a hospital campus.

401 (2) The commissioner shall publish the information reported
402 pursuant to subdivision (1) of this subsection, or post a link to such
403 information, on the Internet web site of the Office of Health Care
404 Access.

405 Sec. 6. Section 38a-477aa of the general statutes is repealed and the
406 following is substituted in lieu thereof (*Effective January 1, 2018*):

407 (a) As used in this section:

408 (1) "Emergency condition" has the same meaning as "emergency
409 medical condition", as provided in section 38a-591a;

410 (2) "Emergency services" means, with respect to an emergency
411 condition, (A) a medical screening examination as required under
412 Section 1867 of the Social Security Act, as amended from time to time,
413 that is within the capability of a hospital emergency department,
414 including ancillary services routinely available to such department to
415 evaluate such condition, and (B) such further medical examinations
416 and treatment required under said Section 1867 to stabilize such
417 individual, that are within the capability of the hospital staff and
418 facilities;

419 (3) "Health care plan" means an individual or a group health
420 insurance policy or health benefit plan that provides coverage of the
421 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
422 469;

423 (4) "Health care provider" means an individual licensed to provide
424 health care services under chapters 370 to 373, inclusive, chapters 375
425 to 383b, inclusive, and chapters 384a to 384c, inclusive;

426 (5) "Health carrier" means an insurance company, health care center,
427 hospital service corporation, medical service corporation, fraternal
428 benefit society or other entity that delivers, issues for delivery, renews,
429 amends or continues a health care plan in this state;

430 (6) (A) "Surprise bill" means a bill for health care services, other than
431 emergency services, received by an insured for services rendered by an
432 out-of-network health care provider, where such services were
433 rendered by such out-of-network provider (i) at an in-network facility,
434 (ii) during a service or procedure performed by an in-network
435 provider, [or] (iii) during a service or procedure previously approved
436 or authorized by the health carrier, [and the insured did not knowingly
437 elect to obtain such services from such out-of-network provider] or (iv)
438 upon the referral of an in-network provider to a clinical laboratory, as
439 defined in section 19a-30, that is an out-of-network provider.

440 (B) "Surprise bill" does not include a bill for health care services
441 received by an insured when (i) an in-network health care provider
442 was available or made available to the insured to render such services,
443 [and] (ii) the insured knowingly [elected] and voluntarily consented, in
444 writing, to obtain such services from [another] an out-of-network
445 health care provider [who was out-of-network] and acknowledged, in
446 writing, that such services might result in costs not covered by the
447 health care plan.

448 (b) (1) No health carrier shall require prior authorization for
449 rendering emergency services to an insured.

450 (2) No health carrier shall impose, for emergency services rendered
451 to an insured by an out-of-network health care provider, a
452 coinsurance, copayment, deductible or other out-of-pocket expense
453 that is greater than the coinsurance, copayment, deductible or other
454 out-of-pocket expense that would be imposed if such emergency

455 services were rendered by an in-network health care provider.

456 (3) [(A)] If emergency services were rendered to an insured by an
457 out-of-network health care provider, such health care provider may
458 bill the health carrier directly and the health carrier shall reimburse
459 such health care provider the greatest of the following amounts: [(i)]
460 (A) The amount the insured's health care plan would pay for such
461 services if rendered by an in-network health care provider; [(ii)] (B) the
462 usual, customary and reasonable rate for such services; or [(iii)] (C) the
463 amount Medicare would reimburse for such services. Nothing in this
464 subdivision shall be construed to prohibit such health carrier and out-
465 of-network health care provider from agreeing to a different
466 reimbursement amount. As used in this subparagraph, "usual,
467 customary and reasonable rate" means the eightieth percentile of all
468 charges for the particular health care service performed by a health
469 care provider in the same or similar specialty and provided in the
470 same geographical area, as reported in a benchmarking database
471 maintained by a nonprofit organization specified by the Insurance
472 Commissioner. Such organization shall not be affiliated with any
473 health carrier.

474 [(B) Nothing in this subdivision shall be construed to prohibit such
475 health carrier and out-of-network health care provider from agreeing
476 to a greater reimbursement amount.]

477 (c) With respect to a surprise bill:

478 (1) An insured shall only be required to pay the applicable
479 coinsurance, copayment, deductible or other out-of-pocket expense
480 that would be imposed for such health care services if such services
481 were rendered by an in-network health care provider; and

482 (2) A health carrier shall reimburse the out-of-network health care
483 provider or insured, as applicable, for the health care services rendered
484 at the in-network rate under the insured's health care plan as payment
485 in full, unless such health carrier and health care provider agree
486 otherwise.

487 (d) If health care services were rendered to an insured by an out-of-
488 network health care provider and the health carrier failed to inform
489 such insured, if such insured was required to be informed, of the
490 network status of such health care provider pursuant to subdivision (3)
491 of subsection (d) of section 38a-591b, the health carrier shall not impose
492 a coinsurance, copayment, deductible or other out-of-pocket expense
493 that is greater than the coinsurance, copayment, deductible or other
494 out-of-pocket expense that would be imposed if such services were
495 rendered by an in-network health care provider."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2017*	New section
Sec. 2	*from passage*	New section
Sec. 3	*October 1, 2017*	38a-477f
Sec. 4	*October 1, 2017*	19a-904c
Sec. 5	*October 1, 2017*	19a-508c
Sec. 6	*January 1, 2018*	38a-477aa