General Assembly

Amendment

January Session, 2017

LCO No. **7599**

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."

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

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

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

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

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

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

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

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

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

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

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

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

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

health carriers to health care providers.

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

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

(a) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. Section 17b-59e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) For purposes of this section:

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

(2) "Electronic health record system" means a computer-based information system that is used to create, collect, store, manipulate, share, exchange or make available electronic health records for the purposes of the delivery of patient care.

(3) "Local or regional health information exchange" means an entity that administers a computerized, digital or electronic system designed to send and receive patient electronic health records between health care providers within a region, health system or other provider organization or network for the purposes of providing coordinated care. "Local or regional health information exchange" does not include

private contractual agreements for the provision of data collection, processing or analysis services; and

(4) "Electronic health record" has the same meaning as provided in section 19a-904c.

(b) Not later than one year after commencement of the operation of the State-wide Health Information Exchange, each hospital licensed under chapter 368v and clinical laboratory licensed under section 19a-30 shall maintain an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

(c) Not later than one year after commencement of the operation of the State-wide Health Information Exchange or six months after commencing operation in the state as a local or regional health information exchange, whichever occurs later, any local or regional health information exchange operating in the state shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

[(c)**]** (d) Not later than two years after commencement of the operation of the State-wide Health Information Exchange, (1) each health care provider with an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange, and (2) each health care provider without an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall be capable of sending and receiving secure messages that comply with the Direct Project specifications published by the federal Office of the National Coordinator for Health Information Technology.

(e) The Health Information Technology Officer designated under section 19a-755 may request information from any hospital, health care

provider or local or regional health information exchange regarding such hospital's, provider's or exchange's electronic health record system and health information exchange activities for the purposes of establishing the State-wide Health Information Exchange pursuant to section 17b-59 and otherwise carrying out said officer's statutory duties. Such information may include general operational and performance data, but shall not include individual patient health records, patient identifying information or other information protected from disclosure by the federal Health Insurance Portability and Accountability Act of 1996, (P.L. 104.191) (HIPAA), as amended from time to time.

Sec. 6. Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section:

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

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

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient **[**hospital**]** services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system,

and (B) separate and distinct from a professional fee;

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

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

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

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

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

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

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

provider;

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

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

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:

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

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

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

(d) On and after January 1, 2016, each initial billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the corresponding Medicare facility fee reimbursement rate for the same service as a comparison or, if there is no corresponding Medicare facility fee for such service, (A) the approximate amount Medicare would have paid the hospital for the facility fee on the billing statement, or (B) the percentage of the hospital's charges that Medicare would have paid the hospital for the facility fee; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction.

(e) The written notice described in subsections (b) to (d), inclusive, and (h) to (j), inclusive, of this section shall be in plain language and in

a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges.

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

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

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

(h) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting areas, stating: **[**that: (1) The**]** (1) That the hospital-based facility is part of a hospital or health system, **[**and**]** (2) the name of the hospital or health system, and (3) that if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based

facility was not hospital-based.

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

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

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

(2) Such notice shall include the following information:

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

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

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate

from, any professional fee billed by a health care provider at the hospital-based facility;

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

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

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

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

(4) A hospital, health system or hospital-based facility shall not collect a facility fee for services provided at a hospital-based facility that is subject to the provisions of this subsection from the date of the transaction until at least thirty days after the written notice required pursuant to this subsection is mailed to the patient or a copy of such notice is filed with the Office of Health Care Access, whichever is later. A violation of this subsection shall be considered an unfair trade practice pursuant to section 42-110b.

[(k)**]** (l) Notwithstanding the provisions of this section, **[**on and after January 1, 2017,**]** no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use

a current procedural terminology evaluation and management (CPT E/M) code and are provided at a hospital-based facility located off-site from a hospital campus, other than a hospital emergency department, **[**located off-site from a hospital campus**]** operated as a provider-based entity, as defined in 42 CFR 413.65, that is authorized under Medicare rules to bill for emergency procedures, or (2) outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, and operated as a provider-based entity, as defined in 42 CFR 413.65, that is authorized under Medicare rules to bill for emergency procedures, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.

[(l)**]** (m) (1) Each hospital and health system shall report not later than July 1, 2016, and annually thereafter to the Commissioner of Public Health concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and location of each facility **[**owned or operated by the hospital or health system**]** that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by Medicare, Medicaid or under private insurance policies, (D) for each facility, the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee revenue and, for each such procedure or service, the total amount of revenue received by the

hospital or health system derived from facility fees, and (G) the top ten procedures for which facility fees are charged based on patient volume. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

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

Sec. 7. Section 38a-477aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) As used in this section:

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

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

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

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

(5) "Health carrier" means an insurance company, health care center,

hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health care plan in this state;

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

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

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

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

(3) **[**(A)**]** If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall reimburse

such health care provider the greatest of the following amounts: **[**(i)**]** (A) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; **[**(ii)**]** (B) the usual, customary and reasonable rate for such services; or **[**(iii)**]** (C) the amount Medicare would reimburse for such services. Nothing in this subdivision shall be construed to prohibit such health carrier and out-of-network health care provider from agreeing to a different reimbursement amount. As used in this subparagraph, "usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier.

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

(c) With respect to a surprise bill:

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

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

(d) If health care services were rendered to an insured by an out-of-network health care provider and the health carrier failed to inform such insured, if such insured was required to be informed, of the network status of such health care provider pursuant to subdivision (3)

of subsection (d) of section 38a-591b, the health carrier shall not impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such services were 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*	17b-59e
Sec. 6	*October 1, 2017*	19a-508c
Sec. 7	*January 1, 2018*	38a-477aa