OLR Bill Analysis

sHB 5039

AN ACT CONCERNING MANDATED HEALTH BENEFIT REVIEW AND SURPRISE BILLING.

SUMMARY

This bill modifies the Insurance Department's mandated health benefit review program (§ 3). It authorizes the Insurance and Real Estate Committee, by April 1 annually and by a majority vote of its members, to require the insurance commissioner to review and report on up to 10 proposed mandated health benefits by the next January 1. Under current law, the committee may request a review of any number of existing or proposed benefits by August 1 of each year. By law, unchanged by the bill, the commissioner may assess health carriers (e.g., insurers and HMOs) for the costs of the health benefit review program. Assessments are deposited in the Insurance Fund.

The bill requires the commissioner to submit her mandated health benefit reports to the Insurance and Real Estate and Public Health committees, which must hold a joint informational hearing on each report. It requires her to attend each hearing to take members' questions. It also narrows the definition of "mandated health benefit;" reduces the amount of information the commissioner's reports must include on each benefit; allows, rather than requires, her to contract with the UConn Center for Public Health and Health Policy to conduct a review; and allows her to also contract with an actuarial accounting firm to conduct a review.

The bill also amends the law relating to coverage of emergency services and surprise bills by health carriers (§ 4). It (1) defines facility for the purposes of the law, (2) revises how a health carrier must reimburse a nonparticipating provider for emergency services rendered and extends this to a nonparticipating facility, and (3) requires a health carrier to issue an explanation of benefits (EOB) to an

insured person. The EOB must explain (1) the insured person's payment responsibility for services received and (2) that it is an unfair trade practice for a provider or facility to request payment in excess of his or her responsibility.

The bill makes it an unfair trade practice act violation (see BACKGROUND) for a health care facility to request payment from an insured person, except for a coinsurance, copayment, or deductible, for (1) covered health services or facility fees, (2) covered emergency services rendered by a nonparticipating provider or facility, or (3) a surprise bill (§ 2). By law, it is already an unfair trade practice act violation for a health care provider to request payment in excess of an insured person's applicable coinsurance, copayment, or deductible.

Additionally, the bill requires the insurance commissioner, annually by January 1, to provide the revenue services commissioner a list of each mandated health benefit that applies to health insurance policies delivered or issued in the state (§ 1).

It also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2018 for the provisions concerning the mandated health benefit review program and January 1, 2019 for all other provisions.

§ 3 — MANDATED HEALTH BENEFIT REVIEW PROGRAM

Mandated Health Benefit Definition

The bill narrows the definition of "mandated health benefit." Under the bill, the term means proposed legislation that requires a health carrier offering health insurance policies or benefit plans in the state to offer or provide coverage for (1) a particular type of health care treatment or service or (2) medical equipment, supplies, or drugs used in connection with a health treatment or service.

Under current law, the term also includes:

1. an existing statutory obligation of the carrier to offer or provide coverage;

2. proposed legislation to expand or repeal an existing coverage obligation;

3. an existing obligation or proposed legislation allowing enrollees to obtain treatment or services from a particular type of health care provider; and

4. an existing obligation or proposed legislation to offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition.

Mandated Health Benefit Reports

Under the bill, the insurance commissioner must report to the Insurance and Real Estate and Public Health committees on the proposed mandated health benefits by January 1 following a request. Current law requires her to submit reports only to the Insurance and Real Estate Committee.

The bill reduces the amount of information each report must contain. Under current law, a report must review specified social and financial impacts of mandating the benefit. The bill instead requires a report to evaluate the specified quality and cost impacts of mandating it.

Elements Required. As under existing law, each mandated health benefit report must include the following elements:

1. the extent to which a significant portion of the population uses the treatment, service, equipment, supplies, or drugs;

2. the extent to which the treatment, service, equipment, supplies, or drugs are available under Medicare or through other public programs;

3. the extent to which insurance policies already cover the treatment, service, equipment, supplies, or drugs;

4. the impact of applying the benefit to the state employees' health benefits plan;

5. the extent to which credible scientific evidence published in peer-reviewed medical literature determines the treatment, service, equipment, supplies, or drugs are safe and effective;

6. the extent to which the benefit, over the next five years, may (a) increase or decrease the cost of the treatment, service, equipment, supplies, or drugs and (b) increase the appropriate or inappropriate use of the benefit;

7. the extent to which the treatment, service, equipment, supplies, or drugs are more or less expensive than an existing one determined to be equally safe and effective by credible scientific evidence published in peer-reviewed medical literature;

8. the extent to which the benefit could be an alternative for more or less expensive treatment, service, equipment, supplies, or drugs;

9. the reasonably expected increase or decrease of a policyholder's insurance premiums and administrative expenses;

10. methods that will be implemented to manage the benefit's utilization and costs;

11. the impact on the (a) total cost of health care, including potential savings to insurers and employers resulting from prevention or early detection of disease or illness, and (b) cost of health care for small employers and other employers; and

12. the impact on (a) cost-shifting between private and public payors of health care coverage and (b) the overall cost of the state's health care delivery system.

Elements No Longer Required. The bill eliminates the following elements from a mandated health benefit report:

1. if coverage of the benefit is not generally available, the extent to which this results in (a) people being unable to obtain necessary treatment and (b) unreasonable financial hardships on those

needing treatment;

2. the level of demand from the public and health care providers for (a) the treatment, service, equipment, supplies, or drugs and (b) insurance coverage for these;

3. the likelihood of meeting a consumer need based on other states' experiences;

4. relevant findings of state agencies or other appropriate public organizations relating to the benefit's social impact;

5. alternatives to meeting the identified need, including other treatments, methods, or procedures;

6. whether the benefit is (a) a medical or broader social need and (b) consistent with the role of health insurance and managed care concepts;

7. potential social implications regarding the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses, or conditions;

8. the benefit's impact on (a) the availability of other benefits already offered and (b) employers shifting to self-insured plans; and

9. the extent to which employers with self-insured plans offer the benefit.

§ 4 — EMERGENCY SERVICES AND SURPRISE BILLS

Emergency Services

The bill revises how a health carrier must reimburse a nonparticipating health care provider for emergency services rendered and applies this to a nonparticipating facility, as well.

Under the bill, a "facility" is an institution providing inpatient health care services and includes a licensed hospital or other inpatient center; ambulatory surgical or treatment center; skilled nursing center;

residential treatment center; diagnostic, laboratory, or imaging center; and rehabilitation or other therapeutic health care center.

Under the bill, if a nonparticipating health care provider or facility renders emergency services to an insured person, the health carrier must reimburse the provider or facility, as applicable, pursuant to Section 2719A of the federal Public Health Services Act. That act requires out-of-network emergency services to be covered as if they were in-network services. Under current state law, a health carrier must reimburse an out-of-network provider who performs emergency services for an insured person the greatest of the (1) amount the health care plan would pay if the services were rendered by an in-network provider; (2) usual, customary, and reasonable rate; or (3) amount Medicare reimburses for those services.

Existing law allows a health carrier and an out-of-network health care provider to agree to a greater reimbursement amount. The bill allows a carrier and a nonparticipating facility to do the same.

The bill also requires a nonparticipating health care provider or facility that renders emergency services to an insured person to bill the health carrier directly. Current law allows an out-of-network provider to do so.

Surprise Bills

By law, if an insured person receives a surprise bill for health care services, the health carrier must reimburse the provider or insured person, as applicable, at the in-network rate as payment in full, unless the carrier and provider agree otherwise. The bill extends this reimbursement provision to a facility. Thus, under the bill, a carrier must reimburse a facility, nonparticipating provider, or insured person, as applicable, for the services resulting in a surprise bill at the in-network rate as payment in full, unless the carrier and provider or facility agree otherwise.

By law, a "surprise bill" is a bill for non-emergency health care services received by an insured person for services rendered by an out-

of-network provider at an in-network facility during a service or procedure that was performed by an in-network provider or previously approved by the health carrier, and the insured person did not knowingly elect to receive the services from the out-of-network provider.

The bill makes technical changes to replace the terms "out-of-network" and "in-network" with "nonparticipating" and "participating."

Explanation of Benefits (EOB)

The bill requires a health carrier to issue an EOB to an insured person explaining (1) his or her payment responsibility, if any, and (2) the carrier's payment. The EOB must include a statement that it is an unfair trade practice act violation for any health care provider or facility to request a payment from the person that exceeds his or her coinsurance, copayment, or deductible for the following:

1. covered health care services or facility fees,
2. covered emergency services rendered by a nonparticipating provider or facility, or
3. a surprise bill.

The carrier must also include the following statement in the EOB: "Please contact us if you receive a bill from a provider or facility regarding payment for services in excess of your responsibilities pursuant to this explanation of benefits."

BACKGROUND

Unfair Trade Practice Act Violation

The Connecticut Unfair Trade Practices Act prohibits businesses from engaging in unfair and deceptive acts or practices. It allows the consumer protection commissioner to issue regulations defining what constitutes an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $10,000, enter into consent agreements, ask the attorney general to seek

injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for violation of a restraining order.

Related Bill

sSB 210, reported favorably by the Insurance and Real Estate Committee, also amends the surprise billing law. It expands the definition of surprise bill to include a bill for non-emergency services rendered by an out-of-network clinical laboratory upon the referral of an in-network provider.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 21 Nay 0 (03/20/2018)