Insurance and Real Estate Committee
JOINT FAVORABLE REPORT

Bill No.: HB-5039
Title: AN ACT PROTECTING HEALTH CARE FAIRNESS AND AFFORDABILITY.
Vote Date: 3/20/2018
Vote Action: Joint Favorable Substitute
PH Date: 3/8/2018
File No.:

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SPONSORS OF BILL:

Insurance and Real Estate Committee

Rep. Joe Aresimowicz, 30th Dist.
Rep. Matthew Ritter, 1St Dist.
Sen. Martin M. Looney, 11th Dist.
Sen. Bob Duff, 25th Dist.
Rep. Geraldo. C. Reyes, 75th Dist.
Rep. Michael D'Agostino, 91st Dist.
Rep. Josh Elliott, 88th Dist.

REASONS FOR BILL:

To implement the Governor's budget recommendations

JFS LANGUAGE

The substitute bill omits provisions that would have(1) Imposed and individual mandate; (2) establish a Health Care Premium Assistance Fund; (3) established several new mandated health benefits; (4) authorized low-option benefit design plans; and (5) modified the state medical assistance program. The substitute bill retains provisions concerning mandated health benefit review and surprise billing.

RESPONSE FROM ADMINISTRATION/AGENCY:

State of Connecticut Insurance Department testified on the bill. This bill continues the good work already being done in Connecticut and the comprehensive approach will preserve our progress. The bill will help stabilize our individual health insurance market and give consumers more choice of affordable plans. The important provisions are
Individual Mandate/Low Option Benefit Designs

Covered Benefits for Women, Children and Adolescents
Balance Billing for Services
Mandate Benefit Review.
Also included in the testimony are various proposed Amendments to Sections 1,2,5,8 and 10.

Governor Dannel P. Malloy provided testimony. The Affordable Care Act (ACA) makes healthcare more economical and accessible for millions. This proposal seeks to ensure that (ACA) will remain protected in the event Washington, D.C. dismantles health care. The bill will take systemic action to ensure stability in the marketplace, allow women affordable access to reproductive health care, provide finding for Planned Parenthood and maintain a diverse and robust risk pool, while addressing some of the major cost drivers.

Comptroller Kevin Lembo, State of Connecticut testified on the bill. Federal repeal efforts on the Affordable Care Act remind us that we cannot depend on federal protections to ensure Connecticut residents have access to affordable health insurance. This bill and HB 5379 seeks to codify in state statue the essential health benefit requirements that are not required under federal law. This bill attempts to address the issue of out-of-control premiums by requiring new "low-option" insurance designs at each tier of insurance products. We need broader systemic changes to lower premiums. At least three states have implemented state-level reinsurance pools to reduce premiums.

Senator Martin M. Looney 11th District expressed concerns regarding the bill. My biggest objection to this legislation is that it would allow any short term insurance plan that was permitted by the federal government. This bill deletes the sections that set the rates that insurers are reimbursed for out of network emergency department, claims to provide new patient protections on surprise billing and does not, eliminates the reimbursement framework by reverting to the federal statue therefor leaving UCR undefined. I do not support the low benefit plan design because I believe they should be designed by the Health Insurance Exchange.

Senator Leonard A. Fasano 34th District testified on the bill. I opposed Section 10 because as drafted is would reduce our existing patient protections. Under the current law an insured patient who goes to any network facility cannot be balanced billed by that provider. This bill will treat that as an ordinary in network bill and the patient is responsible for the copayment or other out of pocket costs. Subsection (a) of Section 10 will create two new defined terms that would severely alter and reduce the current consumer protections. Subsection (b) is really the heart of the bill and addresses the provider reimbursement framework out of network bills for emergency services. So the changed proposed in this subsection come down to how much insurers pat of out of network emergency services and who decides. The new language in Section 10, (b)(4) and (c)(2) requiring insurers to provide a better explanation of benefits (EOB) while informative is not necessary because there is nothing prohibiting insurer from providing such statements currently

NATURE AND SOURCES OF SUPPORT:

Brian Flaherty, Connecticut Business and Industry Association testified that there are two aspects that are of concern to our members. We applaud Section 9 which changes how

the General Assembly enacts new health care mandates by reviewing up to 10 mandated health benefits and reporting back to the General Assembly the following year. Section10 helps to correct an unintended result of legislation passed in 2015 that protected consumers from the impact of surprise bills. We urge passage of this section.

Frances G. Padilla, President Universal Health Care Foundation of Connecticut spoke on HB 5093 and HB5379. If the state pursues and individual mandate it must include some critical provisions: Preservation of quality health care, a ban on sub-par plans, a method for utilizing penalty dollars and a health care premium assistance fund. Universal Health Care Foundation of Connecticut envisions a state everyone has access to quality, affordable health care and it is time to quit fighting the same old battles and start making progress to universal, affordable, quality coverage.

Zack Cooper, PhD Yale University testified that if Connecticut fails to introduce an insurance responsibility fee (mandate) and increased premiums there will be a jump in the amount of uncompensated care delivered by Connecticut Hospitals. The cost will fall primarily on non-profit hospitals and ultimately the taxpayers. The choice the state is facing is whether the cost of this uncompensated care is borne by taxpayers and hospitals in Connecticut or by the federal government. I would recommend with some modest modifications the approach taken in HB 5379 preserves individual choice and reduces free riding.

Connecticut Association of Health Plans has serious reservations regarding passing a mandate at this time. We do support Section 9 and lend our strong support to Section 10.

Karen Siegel, Health Policy Fellow, Connecticut Voices for Children appreciates the continued positive impact that this legislation mandates. A state-level penalty for failing to enroll in health insurance may encourage healthy adults to remain covered and prevent premium increases. The right to claim the state EITC should remain so as not to penalize families who find the minimum penalty burdensome.

Linda Ross, Christian Science Committee spoke in favor of the bill the amendment that addresses an unfairness regarding bills that hold sincere religious beliefs opposed to maintaining minimum creditable coverage as defined in the Affordable Care Act (ACA). These bills incorporate the religious exemption available under the ACA but is overly narrow and only applies to groups that have doctrinal beliefs that oppose private or public insurance benefits but not Christian Scientists. I am asking this committee to consider amendment language that was successfully implemented in Massachusetts is attached for your benefit.

Ted Guetlius submitted testimony in support of the amendment to the bill. We as Christian Scientists have had healings of diseases, stroke, broken bones and shared it with our children. We pay for religious nonmedical health care services and we also pay the penalty under the Federal ACA thus we are paying twice. There are no individual health plans available thru the Connecticut exchange that covers religious nonmedical health care. If this bill is not amended we will again be paying twice.

The Radiological Society of Connecticut offered brief comments with their concern with surprise billing in Section 10. The current statute is appropriate for determining payments and is a fair way to handle the matter.

Susan L. Yolen, Vice President, Planned Parenthood of Southern New England, supports the bill. Planned Parenthood appreciates the inclusion of language that allows the Commissioner of Social Services to offset federal funding. Planned Parenthood continues to be the object of persistent ideological attacks and the language in Section 7 could prove vital to our ability to provide preventive care to nearly 30,000 women (and men) annually using Medicaid as their source of coverage.

Elaine M. Dove strongly supports the bill. We Americans need this affordable health care.

NATURE AND SOURCES OF OPPOSITION:

The Connecticut Conference of Municipalities has concerns that the mandated expansions may cause increases in the premiums paid by municipal employers. CCM does support language in the bill that allows the Insurance & Real Estate Committee to request the Commissioner of the Department of Insurance to conduct one review of up to 10 mandated health benefits per year with a majority vote of the Committee.

Daniel Freess MD Connecticut College of Emergency Physicians strongly opposes the bill CCEP objects to the deletion of the language in Section 10, lines 427 to 441 and the replacement with the new language beginning on line 442. We urge you to reconsider the language and either defeat it or at least return to the original language.

William G. Frederick, President, Connecticut Society of Pathologists opposes legislation that adversely alters the out-or-network payment formula for emergency services. Do not allow the insurance industry and opportunity to unwind this market-based method for calculating physician payment.

Witold Waberski, President, Connecticut State Society of Anesthesiologists, Inc. opposes the bill. Out-or-network billing has often been with facility-based providers including radiologists, pathologists, physician anesthesiologists, and emergency room physicians that patients assumed would be covered in their in-network surgeon and hospital. Surprise bills would disappear if insurance companies adhered to a fair payment and maintained an adequate network for all providers.

Shareef Jandali MD opposes the bill. This bill would significantly impact plastic surgery coverage of emergency services and limit access for patients. The new bill deletes the statutory reference to the usual and customary rate for in-network and out-or-network and forces physicians to accept the greatest of (1) median amount negotiated, (2) the amount for emergency services calculated and (3) the amount that would be paid under Medicare for the emergency services.

David Passaretti MD opposes the bill because it purports to fix a problem that we do not have in Connecticut. Patients have access to highly qualified and compassionate physicians and there is already legislation on the books that protects patients against surprise billing and other predatory practices.

Boris E. Goldman MD opposes the bill. Removing the "fair and usual" clause from statute is unfair to the provider of the service. Insurance carriers should be required to pay the out-of-network providers full fee for their services.

Connecticut State Medical Society strongly opposes the bill. Section 10-(B)(3) would likely eviscerate patient protections that provide medical benefits to the citizens of Connecticut. Section 10 further removes any incentive for health insurers to enter into or even offer fair contracts or fair payment for services rendered to physicians.

Anya Kishinevsky MD and Alan Babigian MD, The American Society of Plastic Surgeron (ASPS) testified in opposition to the bill. The American Society of Plastic Surgeons (ASPS) opposes the bill and their detailed analysis focus on ways to ensure that patients are properly informed about the cost and removed from patient disputes. Also included in the testimony is ASPS official position statement on out of network billing.

Joseph B. O'Connell MD opposes the bill. This bill will lower the quality of care in our state and deny patients access to the care they need. To protect our patients it is vital that out-or-network care be reimbursed at the current usual and customary rate. This bill provides a scenario where a provider is at the mercy of a payor utilizing their own non-transparent data to determine reimbursement. Their goal is to pay as little as possible.

Reported by: Pamela Bianca **Date: 04/02/2018**