General Assembly

**_Governor's Bill No. 5039_**

***February Session, 2018***

LCO No. **403**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
REP. ARESIMOWICZ, 30th Dist.
REP. RITTER M., 1st Dist.
SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.

# *AN ACT PROTECTING HEALTH CARE FAIRNESS AND AFFORDABILITY.*

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective January 1, 2019*) (a) Each individual
2 health insurance policy providing coverage of the type specified in
3 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
4 statutes delivered, issued for delivery, renewed, amended or
5 continued in this state shall, at a minimum, provide coverage, and not
6 impose any cost-sharing requirements, for:

7 (1) Evidence-based items or services that have in effect a rating of
8 "A" or "B" in the current recommendations of the United States
9 Preventive Services Task Force;

10 (2) Immunizations that have in effect a recommendation from the
11 Advisory Committee on Immunization Practices of the Centers for

12 Disease Control and Prevention with respect to the individual
13 involved;

14 (3) With respect to infants, children and adolescents, evidence-
15 informed preventive care and screenings provided for in the
16 comprehensive guidelines supported by the United States Health
17 Resources and Services Administration; and

18 (4) With respect to women, such additional preventive care and
19 screenings not described in subdivision (1) of this subsection as
20 provided for in comprehensive guidelines supported by the United
21 States Health Resources and Services Administration.

22 (b) Nothing in this section shall be construed to prohibit a policy
23 described in subsection (a) of this section, or the issuer of such policy,
24 from providing coverage for services in addition to those services
25 recommended by the United States Preventive Services Task Force or
26 to deny coverage for services that are not recommended by the United
27 States Preventive Services Task Force.

28 (c) Nothing in this section shall be construed to require a policy
29 described in subsection (a) of this section to cover the benefits
30 described in subdivisions (1) to (4), inclusive, of subsection (a) of this
31 section out of network, except if the issuer of such policy does not have
32 an adequate network.

33 (d) Nothing in this section shall be construed to invalidate any other
34 provision of the general statutes.

35 Sec. 2. (NEW) (*Effective January 1, 2019*) (a) Each group health
36 insurance policy providing coverage of the type specified in
37 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
38 statutes delivered, issued for delivery, renewed, amended or
39 continued in this state shall, at a minimum, provide coverage, and not
40 impose any cost-sharing requirements, for:

41 (1) Evidence-based items or services that have in effect a rating of
42 "A" or "B" in the current recommendations of the United States
43 Preventive Services Task Force;

44 (2) Immunizations that have in effect a recommendation from the
45 Advisory Committee on Immunization Practices of the Centers for
46 Disease Control and Prevention with respect to the individual
47 involved;

48 (3) With respect to infants, children and adolescents, evidence-
49 informed preventive care and screenings provided for in the
50 comprehensive guidelines supported by the United States Health
51 Resources and Services Administration; and

52 (4) With respect to women, such additional preventive care and
53 screenings not described in subdivision (1) of this subsection as
54 provided for in comprehensive guidelines supported by the United
55 States Health Resources and Services Administration.

56 (b) Nothing in this section shall be construed to prohibit a policy
57 described in subsection (a) of this section, or the issuer of such policy,
58 from providing coverage for services in addition to those services
59 recommended by the United States Preventive Services Task Force or
60 to deny coverage for services that are not recommended by the United
61 States Preventive Services Task Force.

62 (c) Nothing in this section shall be construed to require a policy
63 described in subsection (a) of this section to cover the benefits
64 described in subdivisions (1) to (4), inclusive, of subsection (a) of this
65 section out of network, except if the issuer of such policy does not have
66 an adequate network.

67 (d) Nothing in this section shall be construed to invalidate any other
68 provision of the general statutes.

69 Sec. 3. (NEW) (*Effective January 1, 2019*) (a) For each calendar month

70 commencing on or after January 1, 2019, each applicable individual
71 shall be liable for a shared responsibility payment in an amount
72 determined in accordance with subsection (b) of this section for each
73 month said individual fails to maintain minimum essential coverage.
74 For purposes of this section, "applicable individual" shall not include
75 any dependent of the individual who is an applicable individual.

76 (b) Any applicable individual who fails to maintain minimum
77 essential coverage for one or more months in any taxable year shall be
78 subject to a penalty for each month that such individual fails to
79 maintain minimum essential coverage. The monthly penalty amount
80 shall be one-twelfth of the greater of five hundred dollars or two per
81 cent of such individual's properly reported Connecticut adjusted gross
82 income, as such term is defined in subsection (a) of section 12-701 of
83 the general statutes, for the taxable year that includes such month or
84 months. The total of all monthly penalties imposed shall be the "shared
85 responsibility payment". Any applicable individual who files a joint
86 income tax return for a taxable year in which such individual is liable
87 for a shared responsibility payment shall use the total Connecticut
88 adjusted gross income as properly reported on such joint income tax
89 return for purposes of determining the shared responsibility payment.
90 Each applicable individual's shared responsibility payment shall be
91 calculated separately.

92 (c) Each applicable individual liable for a shared responsibility
93 payment for one or more months during a taxable year shall report
94 such liability on such individual's Connecticut income tax return for
95 the taxable year that includes such month or months and shall remit
96 payment in the amount determined in accordance with subsection (b)
97 of this section for such taxable year to the Commissioner of Revenue
98 Services with such return. If an applicable individual is not otherwise
99 required to file a Connecticut income tax return for a taxable year that
100 such person is liable for a shared responsibility payment, such
101 individual must file a Connecticut income tax return for such taxable
102 year to report the shared responsibility payment. Any applicable

103 individual who is liable for a shared responsibility payment in a
104 taxable year shall not be allowed an earned income tax credit under
105 the provisions of section 12-704e of the general statutes for such
106 taxable year. If an applicable individual files as part of a joint income
107 tax return for a taxable year in which such individual is liable for a
108 shared responsibility payment, neither the applicable individual nor
109 the applicable individual's spouse shall be allowed an earned income
110 tax credit under the provisions of section 12-704e of the general
111 statutes for such taxable year.

112 (d) The shared responsibility payment shall be added to the income
113 tax liability of each applicable individual under chapter 229 of the
114 general statutes and, except as set forth in this section, the provisions
115 of sections 12-728 to 12-737, inclusive, of the general statutes shall
116 apply to the provisions of this section in the same manner and with the
117 same force and effect as if the language of said sections had been
118 incorporated in full into this section and had expressly referred to the
119 shared responsibility payment under this section, except to the extent
120 that any such provision is inconsistent with a provision of this section.
121 The provisions of subsection (c) of section 12-735 of the general
122 statutes shall not apply to this section.

123 (e) The Commissioner of Revenue Services shall deposit into the
124 Health Care Premium Assistance Fund established under section 6 of
125 this act all amounts, including penalties and interest, received by the
126 state under this section.

127 (f) The Commissioner of Revenue Services shall administer the
128 shared responsibility payment consistent with the provisions of the
129 Patient Protection and Affordable Care Act, P.L. 111-148, and the
130 regulations thereunder in effect as of April 15, 2017, to the extent
131 possible and unless otherwise directed by the provisions of this
132 section. Any term used in this section, including "minimum essential
133 coverage", shall have the same meaning as when used in the Patient
134 Protection and Affordable Care Act, P.L. 111-148, and the regulations

135 thereunder in effect as of April 15, 2017, unless a different meaning is
136 set forth in this section or the context indicates another or different
137 meaning or intent.

138 (g) The shared responsibility payment authorized by this section
139 shall only be imposed on an applicable individual in a taxable year
140 when such individual is not subject to a shared responsibility payment
141 under the Patient Protection and Affordable Care Act, P.L. 111-148, or
142 equivalent federal law.

143 (h) (1) For the purposes of this subsection, "low option benefit
144 design" means a health insurance plan that (A) includes the state's
145 essential health benefits as required under the Patient Protection and
146 Affordable Care Act, P.L. 111-148, (B) includes the state's mandated
147 health benefits, and (C) is in compliance with all state and federal laws,
148 regulations and other administrative guidance, including network
149 adequacy, as described in section 38a-472f of the general statutes, and
150 any associated regulations. A low option benefit design may offer
151 alternative levels of cost-sharing including deductibles, coinsurance
152 and copayments within allowable ranges pursuant to the AV
153 Calculator described in 45 CFR 156.135.

154 (2) Notwithstanding any contrary provision of this section, the
155 provisions of this section shall be effective only when (A) federal tax
156 credits are available pursuant to the Patient Protection and Affordable
157 Care Act, P.L. 111-148, to individuals purchasing insurance through
158 the Connecticut Health Insurance Exchange, established pursuant to
159 section 38a-1080 et seq. of the general statutes, and (B) plans offered
160 through the exchange for plan years beginning on or after January 1,
161 2019, in the bronze and silver metal tiers created under 45 CFR 156.140
162 include at least one low option benefit design.

163 Sec. 4. (NEW) (*Effective January 1, 2019*) On or before January first,
164 annually, the Insurance Commissioner shall provide the
165 Commissioner of Revenue Services with a list of all mandated health

166 benefits that apply to health insurance policies delivered or issued for
167 delivery in this state.

168 Sec. 5. (NEW) (*Effective July 1, 2018*) Notwithstanding any provision
169 of the general statutes, the Connecticut Health Insurance Exchange,
170 established pursuant to section 38a-1080 et seq. of the general statutes,
171 shall not establish any requirements concerning low option benefit
172 design, as defined in section 3 of this act.

173 Sec. 6. (NEW) (*Effective January 1, 2019*) There is established a fund
174 to be known as the "Health Care Premium Assistance Fund" which
175 shall be a separate, nonlapsing fund. The fund shall contain any
176 moneys required by law to be deposited in the fund. Moneys in the
177 fund may be expended by the Insurance Commissioner in connection
178 with the performance of such duties and responsibilities as the
179 commissioner may be required or permitted to perform by state or
180 federal law.

181 Sec. 7. Section 213 of public act 17-2 of the June special session is
182 repealed and the following is substituted in lieu thereof (*Effective from*
183 *passage*):

184 The Commissioner of Social Services, in administering the **[**state**]**
185 medical assistance program, may offset any federal funding reductions
186 for providers or recipients of services described in 42 USC
187 1396d(a)(4)(C)<u>.</u> **[**, provided (1) the General Assembly approves such
188 use of state funds in a vote scheduled not later than ninety days
189 following notice of such federal funding reduction by the
190 commissioner, (2)**]** <u>In order to receive state funding,</u> such services **[**are**]**
191 <u>must be</u> otherwise covered by the medical assistance program, and
192 **[**(3)**]** providers <u>must</u> otherwise meet the requirements of the
193 Department of Social Services for participation and enrollment in the
194 medical assistance program.

195 Sec. 8. Subsection (b) of section 20-7f of the general statutes is
196 repealed and the following is substituted in lieu thereof (*Effective*

197 *January 1, 2019*):

198 (b) It shall be an unfair trade practice in violation of chapter 735a for
199 any health care provider or facility to request payment from an
200 enrollee, other than a coinsurance, copayment [,] or deductible, [or
201 other out-of-pocket expense,] for (1) health care services or a facility
202 fee, as defined in section 19a-508c, covered under a health care plan, (2)
203 emergency services covered under a health care plan and rendered by
204 [an out-of-network] a nonparticipating health care provider, or (3) a
205 surprise bill, as defined in section 38a-477aa, as amended by this act.

206 Sec. 9. Section 38a-21 of the general statutes is repealed and the
207 following is substituted in lieu thereof (*Effective July 1, 2018*):

208 (a) As used in this section:

209 (1) "Commissioner" means the Insurance Commissioner.

210 (2) "Mandated health benefit" means [an existing statutory
211 obligation of, or] proposed legislation that would require [,] an insurer,
212 health care center, hospital service corporation, medical service
213 corporation, fraternal benefit society or other entity that offers
214 individual or group health insurance or a medical or health care
215 benefits plan in this state to [: (A) Permit an insured or enrollee to
216 obtain health care treatment or services from a particular type of health
217 care provider; (B) offer or provide coverage for the screening,
218 diagnosis or treatment of a particular disease or condition; or (C)] offer
219 or provide coverage for a particular type of health care treatment or
220 service, or for medical equipment, medical supplies or drugs used in
221 connection with a health care treatment or service. ["Mandated health
222 benefit" includes any proposed legislation to expand or repeal an
223 existing statutory obligation relating to health insurance coverage or
224 medical benefits.]

225 (b) (1) There is established within the Insurance Department a
226 health benefit review program for the review and evaluation of any

227 mandated health benefit that is requested by the joint standing
228 committee of the General Assembly having cognizance of matters
229 relating to insurance. Such program shall be funded by the Insurance
230 Fund established under section 38a-52a. The commissioner shall be
231 authorized to make assessments in a manner consistent with the
232 provisions of chapter 698 for the costs of carrying out the requirements
233 of this section. Such assessments shall be in addition to any other taxes,
234 fees and moneys otherwise payable to the state. The commissioner
235 shall deposit all payments made under this section with the State
236 Treasurer. The moneys deposited shall be credited to the Insurance
237 Fund and shall be accounted for as expenses recovered from insurance
238 companies. Such moneys shall be expended by the commissioner to
239 carry out the provisions of this section and section 2 of public act 09-
240 179.

241 (2) The commissioner **[**shall**]** <u>may</u> contract with The University of
242 Connecticut Center for Public Health and Health Policy <u>or an actuarial</u>
243 <u>accounting firm</u> to conduct any mandated health benefit review
244 requested pursuant to subsection (c) of this section. **[**The director of
245 said center may engage the services of an actuary, quality
246 improvement clearinghouse, health policy research organization or
247 any other independent expert, and may engage or consult with any
248 dean, faculty or other personnel said director deems appropriate
249 within The University of Connecticut schools and colleges, including,
250 but not limited to, The University of Connecticut (A) School of
251 Business, (B) School of Dental Medicine, (C) School of Law, (D) School
252 of Medicine, and (E) School of Pharmacy.

253 (c) Not later than August first of each year, the joint standing
254 committee of the General Assembly having cognizance of matters
255 relating to insurance shall submit to the commissioner a list of any
256 mandated health benefits for which said committee is requesting a
257 review. Not later than January first of the succeeding year, the
258 commissioner shall submit a report, in accordance with section 11-4a,
259 of the findings of such review and the information set forth in

260 subsection (d) of this section.

261 (d) The review report shall include at least the following, to the
262 extent information is available:

263 (1) The social impact of mandating the benefit, including:]

264 (c) Not later than April first of any year, the joint standing
265 committee of the General Assembly having cognizance of matters
266 relating to insurance may, upon a majority vote of its members, require
267 the commissioner to conduct one review of not more than ten
268 mandated health benefits. The committee shall submit to the
269 commissioner a list of the mandated health benefits to be reviewed.

270 (d) Not later than January first of the first calendar year following a
271 request for review made under subsection (c) of this section, the
272 commissioner shall submit a mandated health benefit review report, in
273 accordance with section 11-4a, to the joint standing committees of the
274 General Assembly having cognizance of matters relating to insurance
275 and public health. Such report shall include an evaluation of the
276 quality and cost impacts of mandating the benefit including:

277 [(A)] (1) The extent to which the treatment, service or equipment,
278 supplies or drugs, as applicable, is utilized by a significant portion of
279 the population;

280 [(B)] (2) The extent to which the treatment, service or equipment,
281 supplies or drugs, as applicable, is currently available to the
282 population, including, but not limited to, coverage under Medicare, or
283 through public programs administered by charities, public schools, the
284 Department of Public Health, municipal health departments or health
285 districts or the Department of Social Services;

286 [(C)] (3) The extent to which insurance coverage is already available
287 for the treatment, service or equipment, supplies or drugs, as
288 applicable;

289 [(D) If the coverage is not generally available, the extent to which
290 such lack of coverage results in persons being unable to obtain
291 necessary health care treatment;

292 (E) If the coverage is not generally available, the extent to which
293 such lack of coverage results in unreasonable financial hardships on
294 those persons needing treatment;

295 (F) The level of public demand and the level of demand from
296 providers for the treatment, service or equipment, supplies or drugs,
297 as applicable;

298 (G) The level of public demand and the level of demand from
299 providers for insurance coverage for the treatment, service or
300 equipment, supplies or drugs, as applicable;

301 (H) The likelihood of achieving the objectives of meeting a
302 consumer need as evidenced by the experience of other states;

303 (I) The relevant findings of state agencies or other appropriate
304 public organizations relating to the social impact of the mandated
305 health benefit;

306 (J) The alternatives to meeting the identified need, including, but
307 not limited to, other treatments, methods or procedures;

308 (K) Whether the benefit is a medical or a broader social need and
309 whether it is consistent with the role of health insurance and the
310 concept of managed care;

311 (L) The potential social implications of the coverage with respect to
312 the direct or specific creation of a comparable mandated benefit for
313 similar diseases, illnesses or conditions;

314 (M) The impact of the benefit on the availability of other benefits
315 currently offered;

316 (N) The impact of the benefit as it relates to employers shifting to
317 self-insured plans and the extent to which the benefit is currently being
318 offered by employers with self-insured plans;**]**

319 **[**(O)**]** (4) The impact of making the benefit applicable to the state
320 employee health insurance or health benefits plan; **[**and**]**

321 **[**(P)**]** (5) The extent to which credible scientific evidence published in
322 peer-reviewed medical literature generally recognized by the relevant
323 medical community determines the treatment, service or equipment,
324 supplies or drugs, as applicable, to be safe and effective; **[**and**]**

325 **[**(2) The financial impact of mandating the benefit, including:**]**

326 **[**(A)**]** (6) The extent to which the mandated health benefit may
327 increase or decrease the cost of the treatment, service or equipment,
328 supplies or drugs, as applicable, over the next five years;

329 **[**(B)**]** (7) The extent to which the mandated health benefit may
330 increase the appropriate or inappropriate use of the treatment, service
331 or equipment, supplies or drugs, as applicable, over the next five
332 years;

333 **[**(C)**]** (8) The extent to which the mandated health benefit may serve
334 as an alternative for more expensive or less expensive treatment,
335 service or equipment, supplies or drugs, as applicable;

336 **[**(D)**]** (9) The methods that will be implemented to manage the
337 utilization and costs of the mandated health benefit;

338 **[**(E)**]** (10) The extent to which insurance coverage for the treatment,
339 service or equipment, supplies or drugs, as applicable, may be
340 reasonably expected to increase or decrease the insurance premiums
341 and administrative expenses for policyholders;

342 **[**(F)**]** (11) The extent to which the treatment, service or equipment,
343 supplies or drugs, as applicable, is more or less expensive than an

344 existing treatment, service or equipment, supplies or drugs, as
345 applicable, that is determined to be equally safe and effective by
346 credible scientific evidence published in peer-reviewed medical
347 literature generally recognized by the relevant medical community;

348 **[**(G)**]** <u>(12)</u> The impact of insurance coverage for the treatment,
349 service or equipment, supplies or drugs, as applicable, on the total cost
350 of health care, including potential benefits or savings to insurers and
351 employers resulting from prevention or early detection of disease or
352 illness related to such coverage;

353 **[**(H)**]** <u>(13)</u> The impact of the mandated health care benefit on the cost
354 of health care for small employers, as defined in section 38a-564, and
355 for employers other than small employers; and

356 **[**(I)**]** <u>(14)</u> The impact of the mandated health benefit on cost-shifting
357 between private and public payors of health care coverage and on the
358 overall cost of the health care delivery system in the state.

359 <u>(e) The joint standing committees of the General Assembly having</u>
360 <u>cognizance of matters relating to insurance and public health shall</u>
361 <u>conduct a joint informational hearing following their receipt of a</u>
362 <u>mandated health benefit review report submitted by the commissioner</u>
363 <u>pursuant to subsection (d) of this section. The commissioner shall</u>
364 <u>attend and be available for questions from the members of the</u>
365 <u>committees at such hearing.</u>

366 Sec. 10. Section 38a-477aa of the general statutes is repealed and the
367 following is substituted in lieu thereof (*Effective January 1, 2019*):

368 (a) As used in this section:

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

371 (2) "Emergency services" means, with respect to an emergency
372 condition, (A) a medical screening examination as required under

373 Section 1867 of the Social Security Act, as amended from time to time,
374 that is within the capability of a hospital emergency department,
375 including ancillary services routinely available to such department to
376 evaluate such condition, and (B) such further medical examinations
377 and treatment required under said Section 1867 to stabilize such
378 individual, that are within the capability of the hospital staff and
379 facilities;

380 (3) "Facility" means an institution providing health care services on
381 an inpatient basis including, but not limited to, a hospital and other
382 licensed inpatient center, ambulatory surgical or treatment center,
383 skilled nursing center, residential treatment center, diagnostic,
384 laboratory and imaging center, and rehabilitation and other
385 therapeutic health care center;

386 (4) "Facility-based provider" means a health care provider who
387 provides health care services, including, but not limited to, pathology,
388 anesthesiology, emergency room care, radiology and laboratory
389 services, in an inpatient or ambulatory facility setting and arranged by
390 such facility by contract or agreement with the health care provider as
391 part of the facility's general business operations;

392 **[**(3)**]** (5) "Health care plan" means an individual or a group health
393 insurance policy or health benefit plan that provides coverage of the
394 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
395 469;

396 **[**(4)**]** (6) "Health care provider" means an individual licensed to
397 provide health care services under chapters 370 to 373, inclusive,
398 chapters 375 to 383b, inclusive, and chapters 384a to 384c, inclusive;

399 **[**(5)**]** (7) "Health carrier" means an insurance company, health care
400 center, hospital service corporation, medical service corporation,
401 fraternal benefit society or other entity that delivers, issues for
402 delivery, renews, amends or continues a health care plan in this state;

403 [(6)] (8) (A) "Surprise bill" means a bill for health care services, other
404 than emergency services, received by an insured for services rendered
405 by [an out-of-network] a nonparticipating health care provider, where
406 such services were rendered by such [out-of-network]
407 nonparticipating provider at [an in-network] a participating facility,
408 during a service or procedure performed by [an in-network] a
409 participating provider or during a service or procedure previously
410 approved or authorized by the health carrier and the insured did not
411 knowingly elect to obtain such services from such [out-of-network]
412 nonparticipating provider.

413 (B) "Surprise bill" does not include a bill for health care services
414 received by an insured when [an in-network] a participating health
415 care provider was available to render such services and the insured
416 knowingly elected to obtain such services from another health care
417 provider who was [out-of-network] nonparticipating.

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

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

427 [(3) (A) If emergency services were rendered to an insured by an
428 out-of-network health care provider, such health care provider may
429 bill the health carrier directly and the health carrier shall reimburse
430 such health care provider the greatest of the following amounts: (i) The
431 amount the insured's health care plan would pay for such services if
432 rendered by an in-network health care provider; (ii) the usual,
433 customary and reasonable rate for such services; or (iii) the amount

434 Medicare would reimburse for such services. As used in this
435 subparagraph, "usual, customary and reasonable rate" means the
436 eightieth percentile of all charges for the particular health care service
437 performed by a health care provider in the same or similar specialty
438 and provided in the same geographical area, as reported in a
439 benchmarking database maintained by a nonprofit organization
440 specified by the Insurance Commissioner. Such organization shall not
441 be affiliated with any health carrier.]

442 (3) If emergency services were rendered to an insured by a
443 nonparticipating health care provider or nonparticipating facility, as
444 applicable, such nonparticipating health care provider or
445 nonparticipating facility shall bill the health carrier directly and the
446 health carrier shall reimburse such nonparticipating health care
447 provider or nonparticipating facility pursuant to Section 2719A of the
448 Public Health Services Act.

449 (4) The carrier shall issue an explanation of benefits to the insured
450 that explains payment and any payment responsibility of the insured.
451 The carrier shall include a statement in the explanation of benefits that
452 it is an unfair trade practice in violation of chapter 735a for any health
453 care provider or facility to request payment from an enrollee, other
454 than a coinsurance, copayment or deductible for (A) health care
455 services or a facility fee, as defined in section 19a-508c, covered under
456 a health care plan, (B) emergency services covered under a health care
457 plan and rendered by a nonparticipating health care provider or
458 nonparticipating facility, or (C) a surprise bill. The explanation of
459 benefits shall include the following statement: "In the event that you
460 receive a bill from a provider or facility regarding payment for services
461 in excess of your responsibilities pursuant to this explanation of
462 benefits please contact us.".

463 [(B)] (5) Nothing in this [subdivision] subsection shall be construed
464 to prohibit [such] a health carrier and [out-of-network] a
465 nonparticipating health care provider or facility from agreeing to a

466 greater reimbursement amount for the health care services described in
467 subdivision (2) of this subsection.

468 (c) With respect to a surprise bill:

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

474 (2) A health carrier shall reimburse the [out-of-network] facility,
475 nonparticipating health care provider or insured, as applicable, for
476 health care services rendered at the in-network rate under the
477 insured's health care plan as payment in full, unless such health carrier
478 and facility or health care provider, as the case may be, agree
479 otherwise. The carrier shall issue an explanation of benefits to the
480 insured that explains payment and any payment responsibility of the
481 insured. The carrier shall include a statement in the explanation of
482 benefits that it is an unfair trade practice in violation of chapter 735a
483 for any health care provider or facility to request payment from an
484 enrollee, other than a coinsurance, copayment or deductible for (A)
485 health care services or a facility fee, as defined in section 19a-508c,
486 covered under a health care plan, (B) emergency services covered
487 under a health care plan and rendered by a nonparticipating health
488 care provider or nonparticipating facility, or (C) a surprise bill. The
489 explanation of benefits shall include the following statement: "In the
490 event that you receive a bill from a provider or facility regarding
491 payment for services in excess of your responsibilities pursuant to this
492 explanation of benefits please contact us.".

493 (d) If health care services were rendered to an insured by [an out-of-
494 network] a nonparticipating health care provider and the health carrier
495 failed to inform such insured, if such insured was required to be
496 informed, of the network status of such health care provider pursuant

497 to subdivision (3) of subsection (d) of section 38a-591b, the health
498 carrier shall not impose a coinsurance, copayment [,] or deductible [or
499 other out-of-pocket expense] that is greater than the coinsurance,
500 copayment [,] or deductible [or other out-of-pocket expense] that
501 would be imposed if such services were rendered by [an in-network] a
502 participating health care provider.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *January 1, 2019* | New section |
| Sec. 2 | *January 1, 2019* | New section |
| Sec. 3 | *January 1, 2019* | New section |
| Sec. 4 | *January 1, 2019* | New section |
| Sec. 5 | *July 1, 2018* | New section |
| Sec. 6 | *January 1, 2019* | New section |
| Sec. 7 | *from passage* | PA 17-2 of the June Sp. Sess., Sec. 213 |
| Sec. 8 | *January 1, 2019* | 20-7f(b) |
| Sec. 9 | *July 1, 2018* | 38a-21 |
| Sec. 10 | *January 1, 2019* | 38a-477aa |

***Statement of Purpose:***
To implement the Governor's budget recommendations.

***[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]***