



General Assembly

Substitute Bill No. 5039

February Session, 2018



AN ACT CONCERNING MANDATED HEALTH BENEFIT REVIEW AND SURPRISE BILLING.

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

1 Section 1. (NEW) (*Effective January 1, 2019*) On or before January
2 first, annually, the Insurance Commissioner shall provide to the
3 Commissioner of Revenue Services a list of each mandated health
4 benefit that applies to health insurance policies delivered or issued for
5 delivery in this state.

6 Sec. 2. Subsection (b) of section 20-7f of the general statutes is
7 repealed and the following is substituted in lieu thereof (*Effective*
8 *January 1, 2019*):

9 (b) It shall be an unfair trade practice in violation of chapter 735a for
10 any health care provider or facility to request payment from an
11 enrollee, other than a coinsurance, copayment [] or deductible, [or
12 other out-of-pocket expense,] for (1) health care services or a facility
13 fee, as defined in section 19a-508c, covered under a health care plan, (2)
14 emergency services covered under a health care plan and rendered by
15 [an out-of-network] a nonparticipating health care provider or
16 nonparticipating facility, or (3) a surprise bill, as defined in section 38a-
17 477aa, as amended by this act.

18 Sec. 3. Section 38a-21 of the general statutes is repealed and the
19 following is substituted in lieu thereof (*Effective July 1, 2018*):

20 (a) As used in this section:

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

22 (2) "Mandated health benefit" means [an existing statutory
23 obligation of, or] proposed legislation that would require [] an insurer,
24 health care center, hospital service corporation, medical service
25 corporation, fraternal benefit society or other entity that offers
26 individual or group health insurance or a medical or health care
27 benefits plan in this state to [: (A) Permit an insured or enrollee to
28 obtain health care treatment or services from a particular type of health
29 care provider; (B) offer or provide coverage for the screening,
30 diagnosis or treatment of a particular disease or condition; or (C)] offer
31 or provide coverage for a particular type of health care treatment or
32 service, or for medical equipment, medical supplies or drugs used in
33 connection with a health care treatment or service. ["Mandated health
34 benefit" includes any proposed legislation to expand or repeal an
35 existing statutory obligation relating to health insurance coverage or
36 medical benefits.]

37 (b) (1) There is established within the Insurance Department a
38 health benefit review program for the review and evaluation of any
39 mandated health benefit that is requested by the joint standing
40 committee of the General Assembly having cognizance of matters
41 relating to insurance. Such program shall be funded by the Insurance
42 Fund established under section 38a-52a. The commissioner shall be
43 authorized to make assessments in a manner consistent with the
44 provisions of chapter 698 for the costs of carrying out the requirements
45 of this section. Such assessments shall be in addition to any other taxes,
46 fees and moneys otherwise payable to the state. The commissioner
47 shall deposit all payments made under this section with the State
48 Treasurer. The moneys deposited shall be credited to the Insurance
49 Fund and shall be accounted for as expenses recovered from insurance
50 companies. Such moneys shall be expended by the commissioner to
51 carry out the provisions of this section and section 2 of public act 09-
52 179.

53 (2) The commissioner [shall] may contract with The University of
54 Connecticut Center for Public Health and Health Policy or an actuarial
55 accounting firm to conduct any mandated health benefit review
56 requested pursuant to subsection (c) of this section. [The director of
57 said center may engage the services of an actuary, quality
58 improvement clearinghouse, health policy research organization or
59 any other independent expert, and may engage or consult with any
60 dean, faculty or other personnel said director deems appropriate
61 within The University of Connecticut schools and colleges, including,
62 but not limited to, The University of Connecticut (A) School of
63 Business, (B) School of Dental Medicine, (C) School of Law, (D) School
64 of Medicine, and (E) School of Pharmacy.

65 (c) Not later than August first of each year, the joint standing
66 committee of the General Assembly having cognizance of matters
67 relating to insurance shall submit to the commissioner a list of any
68 mandated health benefits for which said committee is requesting a
69 review. Not later than January first of the succeeding year, the
70 commissioner shall submit a report, in accordance with section 11-4a,
71 of the findings of such review and the information set forth in
72 subsection (d) of this section.

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

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

76 (c) Not later than April first, annually, the joint standing committee
77 of the General Assembly having cognizance of matters relating to
78 insurance may, upon a majority vote of its members, require the
79 commissioner to conduct a review of not more than ten mandated
80 health benefits. The committee shall submit to the commissioner a list
81 of the mandated health benefits to be reviewed.

82 (d) Not later than January first of the calendar year immediately
83 following the commissioner's receipt of a list described in subsection

84 (c) of this section, the commissioner shall submit a mandated health
85 benefit review report, in accordance with section 11-4a, to the joint
86 standing committees of the General Assembly having cognizance of
87 matters relating to insurance and public health. Such report shall
88 include an evaluation of the quality and cost impacts of mandating
89 each listed benefit, including:

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

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

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

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

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

108 (F) The level of public demand and the level of demand from
109 providers for the treatment, service or equipment, supplies or drugs,
110 as applicable;

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

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

116 (I) The relevant findings of state agencies or other appropriate
117 public organizations relating to the social impact of the mandated
118 health benefit;

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

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

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

127 (M) The impact of the benefit on the availability of other benefits
128 currently offered;

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

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

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

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

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

142 [(B)] (7) The extent to which the mandated health benefit may
143 increase the appropriate or inappropriate use of the treatment, service
144 or equipment, supplies or drugs, as applicable, over the next five
145 years;

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

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

151 [(E)] (10) The extent to which insurance coverage for the treatment,
152 service or equipment, supplies or drugs, as applicable, may be
153 reasonably expected to increase or decrease the insurance premiums
154 and administrative expenses for policyholders;

155 [(F)] (11) The extent to which the treatment, service or equipment,
156 supplies or drugs, as applicable, is more or less expensive than an
157 existing treatment, service or equipment, supplies or drugs, as
158 applicable, that is determined to be equally safe and effective by
159 credible scientific evidence published in peer-reviewed medical
160 literature generally recognized by the relevant medical community;

161 [(G)] (12) The impact of insurance coverage for the treatment,
162 service or equipment, supplies or drugs, as applicable, on the total cost
163 of health care, including potential benefits or savings to insurers and
164 employers resulting from prevention or early detection of disease or
165 illness related to such coverage;

166 [(H)] (13) The impact of the mandated health care benefit on the cost
167 of health care for small employers, as defined in section 38a-564, and
168 for employers other than small employers; and

169 [(I)] (14) The impact of the mandated health benefit on cost-shifting
170 between private and public payors of health care coverage and on the
171 overall cost of the health care delivery system in the state.

172 (e) The joint standing committees of the General Assembly having
173 cognizance of matters relating to insurance and public health shall
174 conduct a joint informational hearing following their receipt of a
175 mandated health benefit review report submitted by the commissioner
176 pursuant to subsection (d) of this section. The commissioner shall
177 attend and be available for questions from the members of the
178 committees at such hearing.

179 Sec. 4. Section 38a-477aa of the general statutes is repealed and the
180 following is substituted in lieu thereof (*Effective January 1, 2019*):

181 (a) As used in this section:

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

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

193 (3) "Facility" means an institution providing health care services on
194 an inpatient basis including, but not limited to, a hospital or other
195 licensed inpatient center, ambulatory surgical or treatment center,
196 skilled nursing center, residential treatment center, diagnostic,
197 laboratory or imaging center, and rehabilitation or other therapeutic
198 health care center;

199 [(3)] (4) "Health care plan" means an individual or a group health
200 insurance policy or health benefit plan that provides coverage of the
201 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
202 469;

203 [(4)] (5) "Health care provider" means an individual licensed to
204 provide health care services under chapters 370 to 373, inclusive,
205 chapters 375 to 383b, inclusive, and chapters 384a to 384c, inclusive;

206 [(5)] (6) "Health carrier" means an insurance company, health care
207 center, hospital service corporation, medical service corporation,
208 fraternal benefit society or other entity that delivers, issues for
209 delivery, renews, amends or continues a health care plan in this state;

210 [(6)] (7) (A) "Surprise bill" means a bill for health care services, other
211 than emergency services, received by an insured for services rendered
212 by [an out-of-network] a nonparticipating health care provider, where
213 such services were rendered by such [out-of-network]
214 nonparticipating provider at [an in-network] a participating facility,
215 during a service or procedure performed by [an in-network] a
216 participating provider or during a service or procedure previously
217 approved or authorized by the health carrier and the insured did not
218 knowingly elect to obtain such services from such [out-of-network]
219 nonparticipating provider.

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

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

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

234 [(3) (A) If emergency services were rendered to an insured by an
235 out-of-network health care provider, such health care provider may
236 bill the health carrier directly and the health carrier shall reimburse
237 such health care provider the greatest of the following amounts: (i) The
238 amount the insured's health care plan would pay for such services if
239 rendered by an in-network health care provider; (ii) the usual,
240 customary and reasonable rate for such services; or (iii) the amount
241 Medicare would reimburse for such services. As used in this
242 subparagraph, "usual, customary and reasonable rate" means the
243 eightieth percentile of all charges for the particular health care service
244 performed by a health care provider in the same or similar specialty
245 and provided in the same geographical area, as reported in a
246 benchmarking database maintained by a nonprofit organization
247 specified by the Insurance Commissioner. Such organization shall not
248 be affiliated with any health carrier.]

249 (3) If emergency services were rendered to an insured by a
250 nonparticipating health care provider or nonparticipating facility, as
251 applicable, such nonparticipating health care provider or
252 nonparticipating facility shall bill the health carrier directly and the
253 health carrier shall reimburse such nonparticipating health care
254 provider or nonparticipating facility pursuant to Section 2719A of the
255 Public Health Service Act.

256 (4) The health carrier shall issue an explanation of benefits to the
257 insured that explains payment and any payment responsibility of the
258 insured. The health carrier shall include a statement in the explanation
259 of benefits that it is an unfair trade practice in violation of chapter 735a
260 for any health care provider or facility to request payment from an
261 enrollee, other than a coinsurance, copayment or deductible for (A)
262 health care services or a facility fee, as defined in section 19a-508c,
263 covered under a health care plan, (B) emergency services covered
264 under a health care plan and rendered by a nonparticipating health
265 care provider or nonparticipating facility, or (C) a surprise bill. The
266 explanation of benefits shall include the following statement: "Please

267 contact us if you receive a bill from a provider or facility regarding
268 payment for services in excess of your responsibilities pursuant to this
269 explanation of benefits."

270 [(B)] (5) Nothing in this [subdivision] subsection shall be construed
271 to prohibit [such] a health carrier and [out-of-network] a
272 nonparticipating health care provider or facility from agreeing to a
273 greater reimbursement amount for the health care services described in
274 subdivision (2) of this subsection.

275 (c) With respect to a surprise bill:

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

281 (2) A health carrier shall reimburse the [out-of-network] facility,
282 nonparticipating health care provider or insured, as applicable, for
283 health care services rendered at the in-network rate under the
284 insured's health care plan as payment in full, unless such health carrier
285 and facility or health care provider, as the case may be, agree
286 otherwise. The health carrier shall issue an explanation of benefits to
287 the insured that explains payment and any payment responsibility of
288 the insured. The health carrier shall include a statement in the
289 explanation of benefits that it is an unfair trade practice in violation of
290 chapter 735a for any health care provider or facility to request payment
291 from an enrollee, other than a coinsurance, copayment or deductible
292 for (A) health care services or a facility fee, as defined in section 19a-
293 508c, covered under a health care plan, (B) emergency services covered
294 under a health care plan and rendered by a nonparticipating health
295 care provider or nonparticipating facility, or (C) a surprise bill. The
296 explanation of benefits shall include the following statement: "Please
297 contact us if you receive a bill from a provider or facility regarding
298 payment for services in excess of your responsibilities pursuant to this

299 explanation of benefits."

300 (d) If health care services were rendered to an insured by [an out-of-
 301 network] a nonparticipating health care provider and the health carrier
 302 failed to inform such insured, if such insured was required to be
 303 informed, of the network status of such health care provider pursuant
 304 to subdivision (3) of subsection (d) of section 38a-591b, the health
 305 carrier shall not impose a coinsurance, copayment [,] or deductible [or
 306 other out-of-pocket expense] that is greater than the coinsurance,
 307 copayment [,] or deductible [or other out-of-pocket expense] that
 308 would be imposed if such services were rendered by [an in-network] a
 309 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	20-7f(b)
Sec. 3	July 1, 2018	38a-21
Sec. 4	January 1, 2019	38a-477aa

Statement of Legislative Commissioners:

In Section 2, "or nonparticipating facility" was inserted after provider for consistency; in Section 3(c), "annually" was substituted for "of any year" and "a" was substituted for "one" for clarity; in Section 3(d) "first" was deleted and "immediately" was inserted before "following" for consistency; in Section 4(a)(3), "hospital or other" was substituted for "hospital and other", "laboratory or imaging" was substituted for "laboratory and imaging" and "rehabilitation or other" was substituted for "rehabilitation and other" for clarity; in Section 4(a), Subdiv. (4) was deleted for clarity; in Section 4(b)(4) "health" was inserted before "carrier" for consistency and "Please contact us" was moved for clarity; and in Section 4(c)(2), "health" was inserted before "carrier" for consistency and "Please contact us" was moved for clarity.

INS *Joint Favorable Subst.*