House of Representatives

General Assembly

File No. 304

February Session, 2018

Substitute House Bill No. 5039

House of Representatives, April 9, 2018

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING MANDATED HEALTH BENEFIT REVIEW AND SURPRISE BILLING.

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

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

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 Subsection (b) of section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider <u>or facility</u> to request payment from an enrollee, other than a coinsurance, copayment **[**,**]** <u>or</u> deductible<u>,</u> **[**or other out-of-pocket expense,**]** for (1) health care services or a facility

fee, as defined in section 19a-508c, covered under a health care plan, (2) emergency services covered under a health care plan and rendered by **[**an out-of-network**]** a nonparticipating health care provider or nonparticipating facility, or (3) a surprise bill, as defined in section 38a-477aa, as amended by this act.

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 Section 38a-21 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner.

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

(b) (1) There is established within the Insurance Department a health benefit review program for the review and evaluation of any mandated health benefit that is requested by the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such program shall be funded by the Insurance Fund established under section 38a-52a. The commissioner shall be authorized to make assessments in a manner consistent with the provisions of chapter 698 for the costs of carrying out the requirements

of this section. Such assessments shall be in addition to any other taxes, fees and moneys otherwise payable to the state. The commissioner shall deposit all payments made under this section with the State Treasurer. The moneys deposited shall be credited to the Insurance Fund and shall be accounted for as expenses recovered from insurance companies. Such moneys shall be expended by the commissioner to carry out the provisions of this section and section 2 of public act 09-179.

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

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

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

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

(c) Not later than April first, annually, the joint standing committee

of the General Assembly having cognizance of matters relating to insurance may, upon a majority vote of its members, require the commissioner to conduct a review of not more than ten mandated health benefits. The committee shall submit to the commissioner a list of the mandated health benefits to be reviewed.

(d) Not later than January first of the calendar year immediately following the commissioner's receipt of a list described in subsection (c) of this section, the commissioner shall submit a mandated health benefit review report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall include an evaluation of the quality and cost impacts of mandating each listed benefit, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(P)**]** (5) The extent to which credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community determines the treatment, service or equipment,

supplies or drugs, as applicable, to be safe and effective; **[**and**]**

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

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

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

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

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

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

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

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

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

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

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

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

(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) "Facility" means an institution providing health care services on an inpatient basis including, but not limited to, a hospital or other licensed 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;

[(3)**]** (4) "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)**]** (5) "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)**]** (6) "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)**]** (7) (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**]** a nonparticipating health care provider, where such services were rendered by such **[**out-of-network**]** nonparticipating provider at **[**an in-network**]** a participating facility, during a service or procedure performed by **[**an in-network**]** a participating provider or 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**]** nonparticipating provider.

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

(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] a nonparticipating health care provider, a coinsurance, copayment [,] or deductible [or other out-of-pocket expense] that is greater than the coinsurance, copayment [,] or deductible [or other out-of-pocket expense] that would be imposed if such emergency services were rendered by [an in-network] a participating 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) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual, customary and reasonable rate for such services; or (iii) the amount Medicare would reimburse for such services. 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.]

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

(4) The health carrier shall issue an explanation of benefits to the insured that explains payment and any payment responsibility of the insured. The health carrier shall include a statement in the explanation of benefits that it is an unfair trade practice in violation of chapter 735a for any health care provider or facility to request payment from an

enrollee, other than a coinsurance, copayment or deductible for (A) health care services or a facility fee, as defined in section 19a-508c, covered under a health care plan, (B) emergency services covered under a health care plan and rendered by a nonparticipating health care provider or nonparticipating facility, or (C) a surprise bill. The explanation of benefits shall include the following statement: "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.".

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

(c) With respect to a surprise bill:

(1) An insured shall only be required to pay the applicable coinsurance, copayment **[**,**]** or 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**]** a participating health care provider; and

(2) A health carrier shall reimburse the **[**out-of-network**]** facility, nonparticipating health care provider or insured, as applicable, for 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 facility or health care provider, as the case may be, agree otherwise. The health carrier shall issue an explanation of benefits to the insured that explains payment and any payment responsibility of the insured. The health carrier shall include a statement in the explanation of benefits that it is an unfair trade practice in violation of chapter 735a for any health care provider or facility to request payment from an enrollee, other than a coinsurance, copayment or deductible for (A) health care services or a facility fee, as defined in section 19a-508c, covered under a health care plan, (B) emergency services covered

under a health care plan and rendered by a nonparticipating health care provider or nonparticipating facility, or (C) a surprise bill. The explanation of benefits shall include the following statement: "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.".

(d) If health care services were rendered to an insured by **[**an out-of-network**]** a nonparticipating 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 **[**,**]** or deductible **[**or other out-of-pocket expense**]** that is greater than the coinsurance, copayment **[**,**]** or deductible **[**or other out-of-pocket expense**]** that would be imposed if such services were rendered by **[**an in-network**]** a 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.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 19 $	FY 20 $
Insurance Dept.	IF - See Below	See Below	See Below
UConn Health Ctr.	Various - Revenue Loss	See Below	See Below
State Comptroller - Fringe Benefits	GF&TF - Potential Savings	See Below	See Below

Note: IF=Insurance Fund; Various=Various; GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 19 $	FY 20 $
Various Municipalities	Potential Savings	See Below	See Below

Explanation

Various provisions of the bill are anticipated to result in potential savings to the state employee, state retiree, and certain municipal health plans, revenue loss to the University of Connecticut (UConn) Health Center, and a potential impact to the Insurance Department. Most fiscal impacts will not begin until midyear FY 19, due to the effective dates associated with the relevant sections of the bill.

Section 1 has no fiscal impact as the Insurance Commissioner has the necessary expertise to provide a list of current mandated health benefits.

Section 2 identifies specific types of facility billing requests as unfair trade practices, which is not anticipated to result in a fiscal impact

associated with unfair trade practices enforcement.

Section 3 permits the Insurance Commissioner to contract with an actuarial accounting firm in addition to The University of Connecticut (UConn) Center for Public Health and Health Policy, part of UConn Health Center, to perform mandated health benefit reviews. To the extent reviews are requested, there is a potential savings to the Insurance Fund to the degree the Insurance Department can reduce costs through competitive bidding. Since the Commissioner assesses health carriers for the cost of any reviews, any savings would be offset by a reduced assessment to carriers. To the extent UConn Health Center reduces contract costs or an actuarial accounting firm performs the review instead, there is a potential revenue loss to the Health Center. No reviews have been performed since 2014.

Section 4 may result in a savings to the state employee and retiree health plan if the bill is interpreted to require a non-participating provider/facility to be reimbursed the in-network rate for emergency services in accordance with section 2719A of the Public Health Service Act (PHSA). Current law conforms to the PHSA's regulations which are contrary to the act. The state employee and retiree health plan currently reimburses non-participating providers/facilities in accordance with current law and PHSA regulation, which is 80% of the usual and customary charge after applicable cost sharing from the insured. There may be similar savings to fully insured municipal plans.

This provision of Section 4 is also anticipated to result in a revenue loss to UConn Health Center. The Health Center typically is reimbursed at the usual and customary charge as described above, which tends to be higher than the in-network rate for services that the health center will receive for emergency services under the bill. The extent of the revenue loss is unknown and depends on the number of patients with a nonparticipating carrier, and the average difference between the: (1) usual and customary rate described above, and (2) in-network rate.

A second provision of Section 4 will result in additional revenue loss to UConn Health Center as it prohibits out-of-network (i.e., nonparticipating) facilities from billing an emergency services patient for the balance remaining after any cost-sharing and carrier payments, i.e., balance billing. The Health Center currently balance bills patients in this manner but does not track resulting revenue, and consequently the extent of the revenue loss is unknown.

For context, UConn Health Center's FY 16 emergency department net revenues (including any revenues from balance billing and out-of-network carriers) were $18.2 million. It is estimated 5 percent of the Health Center's emergency department patients are out-of-network, and payments associated with these patients are affected by the bill.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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)