Proposed Substitute Bill No. 5039

LCO No. **2917**

AN ACT PROTECTING HEALTH CARE FAIRNESS AND AFFORDABILITY.

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 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 Subsection (b) of section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):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 or facility to request payment from an enrollee, other than a coinsurance, copayment **[**,**]** or deductible, **[**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 (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 Section 38a-21 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):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 of any year, 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 one 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 first calendar year 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 and other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing center, residential treatment center, diagnostic, laboratory and imaging center, and rehabilitation and other therapeutic health care center;

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

[(3)**]** (5) "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)**]** (6) "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)**]** (7) "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)**]** (8) (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 Services Act.

(4) The carrier shall issue an explanation of benefits to the insured that explains payment and any payment responsibility of the insured. The 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: "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 please contact us.".

[(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 carrier shall issue an explanation of benefits to the insured that explains payment and any payment responsibility of the insured. The 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: "In the event that you receive a bill from a provider or facility regarding payment for services in excess of your responsibilities pursuant to this

explanation of benefits please contact us.".

(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