General Assembly

Amendment

January Session, 2019

LCO No. 9788

Offered by:
SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.
SEN. FASANO, 34th Dist.
SEN. LESSER, 9th Dist.

To: Senate Bill No. 42  File No. 308  Cal. No. 162

"AN ACT CONCERNING COINSURANCE, COPAYMENTS AND DEDUCTIBLES AND CONTRACTING BY HEALTH CARRIERS."

1 Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (Effective January 1, 2020) (a) Notwithstanding any provision of the general statutes and to the maximum extent permitted by federal law, no individual or group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit in an amount that exceeds the lesser of:

1 (1) The amount paid to the provider or vendor for the covered
benefit, including all discounts, rebates and adjustments, by the insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that delivered, issued for delivery, renewed, amended or continued such policy or an intermediary engaged by such insurer, center, society, corporation or entity;

(2) An amount calculated on the basis of the amount charged for the covered benefit by the provider or vendor, less any discount for such covered benefit and any amount due to, or charged by, an entity if such entity is affiliated with, or owned or controlled by, the insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that delivered, issued for delivery, renewed, amended or continued such policy; or

(3) The amount that the insured would have paid to the provider or vendor for the covered benefit without regard to such policy. If the Insurance Commissioner adopts regulations pursuant to subsection (c) of this section, the commissioner may define such amount in such regulations.

(b) Any violation of subsection (a) of this section shall be deemed an unfair method of competition and unfair and deceptive act or practice in the business of insurance under section 38a-816 of the general statutes, as amended by this act.

(c) The Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 2. Section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies.
Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (A) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (B) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (C) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (D) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (E) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (F) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (G) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (H) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of, any oral or written statement or any pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the
business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive; or making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following: (A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (B) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (C) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (D) refusing to pay claims without conducting a reasonable investigation based upon all available information; (E) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (F) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (G) compelling insureds to institute litigation to recover amounts due.
under an insurance policy by offering substantially less than the
amounts ultimately recovered in actions brought by such insureds; (H)
attempting to settle a claim for less than the amount to which a
reasonable man would have believed he was entitled by reference to
written or printed advertising material accompanying or made part of
an application; (I) attempting to settle claims on the basis of an
application which was altered without notice to, or knowledge or
consent of the insured; (J) making claims payments to insureds or
beneficiaries not accompanied by statements setting forth the coverage
under which the payments are being made; (K) making known to
insureds or claimants a policy of appealing from arbitration awards in
favor of insureds or claimants for the purpose of compelling them to
accept settlements or compromises less than the amount awarded in
arbitration; (L) delaying the investigation or payment of claims by
requiring an insured, claimant, or the physician of either to submit a
preliminary claim report and then requiring the subsequent
submission of formal proof of loss forms, both of which submissions
contain substantially the same information; (M) failing to promptly
settle claims, where liability has become reasonably clear, under one
portion of the insurance policy coverage in order to influence
settlements under other portions of the insurance policy coverage; (N)
failing to promptly provide a reasonable explanation of the basis in the
insurance policy in relation to the facts or applicable law for denial of a
claim or for the offer of a compromise settlement; (O) using as a basis
for cash settlement with a first party automobile insurance claimant an
amount which is less than the amount which the insurer would pay if
repairs were made unless such amount is agreed to by the insured or
provided for by the insurance policy.

(7) Failure to maintain complaint handling procedures. Failure of
any person to maintain complete record of all the complaints which it
has received since the date of its last examination. This record shall
indicate the total number of complaints, their classification by line of
insurance, the nature of each complaint, the disposition of these
complaints, and the time it took to process each complaint. For
purposes of this subsection "complaint" means any written communication primarily expressing a grievance.

(8) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money or other benefit from any insurer, producer or individual.

(9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following practices shall be considered discrimination within the meaning of section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-825: (A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (B) in the case of policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; (C) readjustment of the rate of premium for a group insurance policy based on loss or expense experience, or both, at the end of the first or any subsequent policy year, which may be made retroactive for such policy year.

(10) Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons so licensed.
(11) Favored agent or insurer: Coercion of debtors. (A) No person may (i) require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or producer or group of producers; (ii) unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien; (iii) require directly or indirectly that any borrower, mortgagor, purchaser, insurer or producer pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate or pay a separate charge to substitute the insurance policy of one insurer for that of another; or (iv) use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer or the producer complying with such a requirement.

(B) (i) Subparagraph (A)(iii) of this subdivision shall not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subparagraph (A)(ii) of this subdivision, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this subdivision applies to determine whether such person has violated this subdivision. If a violation of this subdivision is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of section 38a-815,
subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, "person" includes any individual, corporation, limited liability company, association, partnership or other legal entity.

(12) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of physical disability, mental or nervous condition as set forth in section 38a-488a or intellectual disability, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(13) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. For purposes of this subdivision, "refusal to insure" includes the denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured is blind or partially blind, except that an insurer may exclude from coverage any disability, consisting solely of blindness or partial blindness, when such condition existed at the time the policy was issued. Any individual who is blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons with respect to all other conditions, including the underlying cause of the blindness or partial blindness.

(14) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of exposure to diethylstilbestrol through the female parent.

(15) (A) Failure by an insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, to pay accident and health claims, including, but not limited to,
claims for payment or reimbursement to health care providers, within
the time periods set forth in subparagraph (B) of this subdivision,
unless the Insurance Commissioner determines that a legitimate
dispute exists as to coverage, liability or damages or that the claimant
has fraudulently caused or contributed to the loss. Any insurer, or any
other entity responsible for providing payment to a health care
provider pursuant to an insurance policy, who fails to pay such a claim
or request within the time periods set forth in subparagraph (B) of this
subdivision shall pay the claimant or health care provider the amount
of such claim plus interest at the rate of fifteen per cent per annum, in
addition to any other penalties which may be imposed pursuant to
sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60,
inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to
38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155,
inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-
459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826,
inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due
a claimant or health care provider pursuant to this section is less than
one dollar, the insurer shall deposit such amount in a separate interest-
bearing account in which all such amounts shall be deposited. At the
end of each calendar year each such insurer shall donate such amount
to The University of Connecticut Health Center.

(B) Each insurer or other entity responsible for providing payment
to a health care provider pursuant to an insurance policy subject to this
section, shall pay claims not later than:

(i) For claims filed in paper format, sixty days after receipt by the
insurer of the claimant's proof of loss form or the health care provider's
request for payment filed in accordance with the insurer's practices or
procedures, except that when there is a deficiency in the information
needed for processing a claim, as determined in accordance with
section 38a-477, the insurer shall (I) send written notice to the claimant
or health care provider, as the case may be, of all alleged deficiencies in
information needed for processing a claim not later than thirty days
after the insurer receives a claim for payment or reimbursement under
the contract, and (II) pay claims for payment or reimbursement under
the contract not later than thirty days after the insurer receives the
information requested; and

(ii) For claims filed in electronic format, twenty days after receipt by
the insurer of the claimant's proof of loss form or the health care
provider's request for payment filed in accordance with the insurer's
practices or procedures, except that when there is a deficiency in the
information needed for processing a claim, as determined in
accordance with section 38a-477, the insurer shall (I) notify the
claimant or health care provider, as the case may be, of all alleged
deficiencies in information needed for processing a claim not later than
ten days after the insurer receives a claim for payment or
reimbursement under the contract, and (II) pay claims for payment or
reimbursement under the contract not later than ten days after the
insurer receives the information requested.

(C) As used in this subdivision, "health care provider" means a
person licensed to provide health care services under chapter 368d,
chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a
to 384c, inclusive, or chapter 400j.

(16) Failure to pay, as part of any claim for a damaged motor vehicle
under any automobile insurance policy where the vehicle has been
declared to be a constructive total loss, an amount equal to the sum of
(A) the settlement amount on such vehicle plus, whenever the insurer
takes title to such vehicle, (B) an amount determined by multiplying
such settlement amount by a percentage equivalent to the current sales
tax rate established in section 12-408. For purposes of this subdivision,
"constructive total loss" means the cost to repair or salvage damaged
property, or the cost to both repair and salvage such property, equals
or exceeds the total value of the property at the time of the loss.

(17) Any violation of section 42-260, by an extended warranty
provider subject to the provisions of said section, including, but not
limited to: (A) Failure to include all statements required in subsections
(c) and (f) of section 42-260 in an issued extended warranty; (B) offering an extended warranty without being (i) insured under an adequate extended warranty reimbursement insurance policy or (ii) able to demonstrate that reserves for claims contained in the provider's financial statements are not in excess of one-half the provider's audited net worth; (C) failure to submit a copy of an issued extended warranty form or a copy of such provider's extended warranty reimbursement policy form to the Insurance Commissioner.

(18) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because such individual has been a victim of family violence.

(19) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of genetic information. Genetic information indicating a predisposition to a disease or condition shall not be deemed a preexisting condition in the absence of a diagnosis of such disease or condition that is based on other medical information. An insurance company, hospital service corporation, health care center or fraternal benefit society providing individual health coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be prohibited from refusing to insure or applying a preexisting condition limitation, to the extent permitted by law, to an individual who has been diagnosed with a disease or condition based on medical information other than genetic information and has exhibited
symptoms of such disease or condition. For the purposes of this subsection, "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

(20) Any violation of sections 38a-465 to 38a-465q, inclusive.

(21) With respect to a managed care organization, as defined in section 38a-478, failing to establish a confidentiality procedure for medical record information, as required by section 38a-999.

(22) Any violation of sections 38a-591d to 38a-591f, inclusive, as amended by this act.

(23) Any violation of section 1 of this act.

Sec. 3. (NEW) (Effective January 1, 2020) Notwithstanding any provision of the general statutes, and to the maximum extent permitted by applicable law, no contract entered into or amended by a health carrier, as defined in section 38a-591a of the general statutes, on or after January 1, 2020, shall contain any provision prohibiting or penalizing, including, but not limited to, through increased utilization review, reduced payments or other financial disincentives, disclosure of any information to a covered person, as defined in section 38a-591a of the general statutes, concerning:

(1) The cost of a covered benefit, including, but not limited to, the cash price of a covered benefit; or

(2) The availability and cost of any health care service or product that is therapeutically equivalent to a covered benefit, including, but not limited to, the cash price of any such health care service or product.

Sec. 4. Section 38a-478j of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

Each managed care plan that requires a deductible or percentage coinsurance payment by the insured shall calculate the insured's
deductible or coinsurance payment on the lesser of the provider's or vendor's charges for the goods or services or the amount payable by the managed care organization or a subcontractor of such managed care organization for such goods or services, except as otherwise required by the laws of a foreign state when applicable to providers, vendors or patients in such foreign state.

Sec. 5. Subsection (a) of section 38a-477aa of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

(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) "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) "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) "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) (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 health care provider, where such services were rendered by (i) such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network 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 provider, or (ii) a clinical laboratory, as defined in section 19a-30, that is an out-of-network provider, upon the referral of an in-network provider.

(B) "Surprise bill" does not include a bill for health care services received by an insured when an in-network 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.

Sec. 6. Subdivision (1) of subsection (c) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

(1) (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than [seventy-two] forty-eight hours after the health carrier receives such request or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the
expiration of the prescribed period of time or number of treatments.

(B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

Sec. 7. Subdivision (1) of subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance;

(C) For expedited review requests, except as specified under subparagraph (D) of this subdivision, [seventy-two] forty-eight hours after the health carrier receives the grievance or seventy-two hours after such health carrier receives such grievance if any portion of such forty-eight-hour period falls on a weekend; and
(D) For expedited review requests of a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, twenty-four hours after the health carrier receives the grievance.

Sec. 8. Subdivision (1) of subsection (i) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, except as specified under subparagraph (D) of this subdivision, as expeditiously as the covered person's medical condition requires, but not later than [seventy-two] forty-eight hours after such organization receives the assignment from the commissioner to conduct such review or seventy-two hours after such organization receives such assignment if any portion of such forty-eight-hour period falls on a weekend;

(D) For expedited external reviews involving a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as expeditiously as the covered person's medical condition requires, but not later than twenty-four
hours after such organization receives the assignment from the
commissioner to conduct such review; and

(E) For expedited external reviews involving a determination that
the recommended or requested health care service or treatment is
experimental or investigational, as expeditiously as the covered
person's medical condition requires, but not later than five calendar
days after such organization receives the assignment from the
commissioner to conduct such review.

Sec. 9. (NEW) (Effective January 1, 2020) No insurer, health care
center, fraternal benefit society, hospital service corporation, medical
service corporation or other entity delivering, issuing for delivery,
renewing, amending or continuing an individual or group health
insurance policy in this state on or after January 1, 2020, providing
coverage of the type specified in subdivision (5) of section 38a-469 of
the general statutes shall include in such policy a provision reserving
discretion to such insurer, center, society, corporation or entity to
interpret the terms of such policy, or provide standards for the
interpretation or review of such policy, that are inconsistent with the
laws of this state.

Sec. 10. Subsection (a) of section 19a-644 of the general statutes is
repealed and the following is substituted in lieu thereof (Effective
October 1, 2019):

(a) On or before February twenty-eighth annually, for the fiscal year
ending on September thirtieth of the immediately preceding year, each
short-term acute care general or children's hospital shall report to the
unit with respect to its operations in such fiscal year, in such form as
the unit may by regulation require. Such report shall include: (1)
Salaries and fringe benefits for the ten highest paid hospital and health
system employees; (2) the name of each joint venture, partnership,
subsidiary and corporation related to the hospital; [and] (3) the salaries
paid to hospital and health system employees by each such joint
venture, partnership, subsidiary and related corporation and by the
hospital to the employees of related corporations; and (4) information
and data prescribed by the Office of Health Strategy concerning
charges for trauma activation fees. For purposes of this subsection,
"health system" has the same meaning as provided in section 33-182aa.

Sec. 11. Section 38a-478r of the general statutes is repealed and the
following is substituted in lieu thereof (Effective January 1, 2020):

(a) Each provider, as defined in section 38a-478, shall code for the
presenting symptoms of all emergency claims and each hospital shall
record such code for such claims on locator 76 on the UB92 form or its
successor.

(b) The presenting symptoms, as coded by the provider and
recorded by the hospital on the UB92 form or its successor, or the final
diagnosis, whichever reasonably indicates an emergency medical
condition, shall be the basis for reimbursement or coverage, provided
such symptoms reasonably indicated an emergency medical condition.

(c) For the purposes of this section, in accordance with the National
Committee for Quality Assurance, an emergency medical condition is
a condition such that a prudent layperson, acting reasonably, would
have believed that emergency medical treatment is needed.

(d) The Insurance Commissioner may develop and disseminate to
hospitals in this state a claims form system that will ensure that all
hospitals consistently code for the presenting and diagnosis symptoms
on all emergency claims.

(e) Each health insurance policy providing coverage of the type
specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
delivered, issued for delivery, renewed, amended or continued in this
state shall provide coverage for health care services that are medically
necessary, as defined in section 38a-482a or 38a-513c, as applicable, for
an emergency medical condition described in subsection (c) of this
section.
Sec. 12. (Effective from passage) (a) For the purposes of this section, "high deductible health plan" means a high deductible health plan within the meaning of Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, that is not used to establish a medical savings account or an Archer MSA pursuant to said Section 220 or a health savings account pursuant to said Section 223.

(b) There is established a task force to study the structure of high deductible health plans and the impact of such plans on enrollees in this state. The task force shall make recommendations concerning:

(1) Measures to ensure access to affordable health care services under high deductible health plans;

(2) The financial impact that high deductible health plans have on enrollees and their families;

(3) The use of health savings accounts, and the impact that alternative payment structures would have on such accounts, including, but not limited to, the status of such accounts under the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(4) Measures to ensure that each cost-sharing payment due under a high deductible health plan and paid by an enrollee at the time of service accurately reflects the enrollee's cost-sharing obligation for such service under such plan;

(5) Measures to ensure the prompt payment of a refund to an enrollee for any cost-sharing payments under a high deductible health plan that exceeds the enrollee's cost-sharing obligation under such plan;

(6) Measures to enhance enrollee knowledge regarding how enrollee
payments are applied to deductibles under high deductible health plans; and

(7) Payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

(c) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of the Connecticut College of Emergency Physicians and one of whom shall be a representative of a small employer in this state sponsoring a high deductible health plan;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be an insurance producer licensed in this state and knowledgeable regarding high deductible health plans and one of whom shall be an enrollee in a high deductible health plan in this state;

(3) One appointed by the majority leader of the House of Representatives, who shall be a primary care physician who participates in one or more high deductible health plans;

(4) One appointed by the majority leader of the Senate, who shall be an emergency room physician;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the Connecticut Association of Health Plans;

(6) One appointed by the minority leader of the Senate, who shall be a representative of the Connecticut State Medical Society;

(7) The Healthcare Advocate, or the Healthcare Advocate's designee; and

(8) Three persons appointed by the Governor, one of whom shall be a representative of the Connecticut Hospital Association, one of whom shall be a representative of a health plan issuing high deductible health
plans and one of whom shall be a tax attorney knowledgeable regarding health savings accounts.

(d) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The members of the task force shall elect two chairpersons of the task force from among the members of the task force. The Healthcare Advocate shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the task force.

(g) Not later than February 1, 2020, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or December 1, 2020, whichever is later."

This act shall take effect as follows and shall amend the following sections:

<table>
<thead>
<tr>
<th>Section</th>
<th>Effective Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>Sec. 1</td>
<td>January 1, 2020</td>
<td>New section</td>
</tr>
<tr>
<td>Sec. 2</td>
<td>January 1, 2020</td>
<td>38a-816</td>
</tr>
<tr>
<td>Sec. 3</td>
<td>January 1, 2020</td>
<td>New section</td>
</tr>
<tr>
<td>Sec. 4</td>
<td>January 1, 2020</td>
<td>38a-478j</td>
</tr>
<tr>
<td>Sec. 5</td>
<td>January 1, 2020</td>
<td>38a-477aa(a)</td>
</tr>
<tr>
<td>Sec. 6</td>
<td>January 1, 2020</td>
<td>38a-591d(c)(1)</td>
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<tr>
<td>Sec. 7</td>
<td>January 1, 2020</td>
<td>38a-591e(d)(1)</td>
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<td>Sec. 8</td>
<td>January 1, 2020</td>
<td>38a-591g(i)(1)</td>
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<td>Sec. 9</td>
<td>January 1, 2020</td>
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</tr>
<tr>
<td>Sec. 10</td>
<td>October 1, 2019</td>
<td>19a-644(a)</td>
</tr>
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<td>Sec. 11</td>
<td>January 1, 2020</td>
<td>38a-478r</td>
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<td>Sec. 12</td>
<td>from passage</td>
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