OLR Bill Analysis
SB 42 (File 308, as amended by Senate "A")*

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

**SUMMARY**

This bill makes several changes to the insurance, health insurance, and public health statutes. Principally, it limits the maximum out-of-pocket expenses that certain health insurers can charge and makes it an unfair insurance practice for insurers to charge more than this amount (see BACKGROUND) (§§ 1 & 2). It also requires certain health insurance policies to cover medically necessary services to treat emergency conditions (§ 11).

Additionally, the bill:

1. prohibits health carrier contracts from penalizing the disclosure of health care costs or available alternative treatments (§ 3);

2. for managed care organizations (MCOs), requires that deductibles be calculated in the same way that existing law requires of coinsurances and extends this requirement to amounts charged by MCO subcontractors (§ 4);

3. broadens the definition of a surprise health insurance bill by including non-emergency services rendered by an out-of-network clinical laboratory if an insured is referred to it by an in-network provider (§ 5);

4. (a) reduces, from 72 to 48 hours, the maximum time for certain health benefit and adverse determination reviews and (b) creates an exception for weekends (§§ 6-8);

5. prohibits provisions in disability income protection policies that allow insurers discretion to interpret the policy in a way that is
inconsistent with state law (§ 9);

6. requires certain hospitals to report to the Health Systems Planning Unit on trauma activation fee charges (§ 10); and

7. establishes a task force to study high deductible health plans (HDHPs) (§ 12).

“Senate Amendment “A” (1) makes changes to the cost-sharing and out-of-pocket expense provisions, including limiting them to health carriers (instead of carriers and providers), and makes charging more than the limit a Connecticut Unfair Insurance Practices Act (CUIPA), instead of a Connecticut Unfair Trade Practices Act (CUTPA), violation; (2) adds the provisions on surprise billing, adverse determination and benefit reviews, disability income protection policies, hospital reporting, medical necessity coverage, and the HDHP task force; and (3) makes several other minor and other changes, including to the health carrier contracting provisions.

EFFECTIVE DATE: January 1, 2020, except the hospital reporting provisions are effective October 1, 2019, and the task force provisions are effective upon passage.

§§ 1 & 2 — COST SHARING

Under the bill and to the maximum extent allowed by federal law, certain health insurance plans cannot impose a coinsurance, copayment, deductible, or other out-of-pocket expense that exceeds the lesser of:

1. the amount paid to the provider or vendor for the covered benefit, including all discounts, rebates, and adjustments by the insurer, intermediary, or health carrier;

2. an amount calculated based on how much the health service provider or vendor charges after any discount and any amount due to or charged by an entity affiliated with the insurer; or

3. the amount an insured would have paid to the provider or
vendor without using his or her insurance (which the insurance commissioner may define in regulations that the bill permits him to adopt).

The cost-sharing limits apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), these limits do not apply to self-insured benefit plans.

A violation of these provisions constitutes an unfair insurance practice (see BACKGROUND).

§ 3 — HEALTH CARRIER CONTRACTS
The bill prohibits a health carrier contract with another party from containing a provision that prohibits or penalizes, including through increased utilization review, reduced payments, or other financial disincentives, disclosure of certain information to an insured concerning covered benefits. This includes information about (1) a covered benefit’s cost and cash price and (b) the availability, cost, and cash price of any health care service or product that is therapeutically equivalent to a covered benefit.

§ 4 — MANAGED CARE PLANS
Under current law, MCOs must calculate coinsurances based on the lesser of (1) the amount the provider charges for the specific good or service or (2) the amount payable by the MCO for the goods or services. The bill (1) includes in the latter category any amounts payable by an MCO’s subcontractor and (2) requires MCOs to calculate deductibles using the same criteria.

§ 5 — SURPRISE BILLS FOR LABORATORY SERVICES
The bill broadens the definition of a “surprise bill” for health insurance purposes by including a bill for non-emergency services rendered by an out-of-network clinical laboratory if the insured was
referred by an in-network provider. In doing so, it requires health carriers (e.g., insurers and HMOs) to (1) cover any such services resulting in a surprise bill at the in-network level of benefits and (2) include the revised definition of surprise bill in policy documents and on their websites.

By law, an insured person’s bill is already a “surprise bill” if (1) it is for non-emergency health care services rendered by an out-of-network provider at an in-network facility during a service or procedure performed by an in-network provider or previously authorized by the health carrier and (2) the insured person did not knowingly elect to receive the services from the out-of-network provider.

By law, if an insured person receives a surprise bill, he or she has to pay only the coinsurance, copayment, deductible, or other out-of-pocket cost that would apply if the services were rendered by an in-network provider. A health carrier must reimburse an out-of-network provider or the insured person, as applicable, for the services at the in-network rate as payment in full, unless the carrier and provider agree otherwise (CGS § 38a-477aa(c)). The law also requires a health carrier to describe what constitutes a surprise bill (1) in the insurance policy, certificate of coverage, or handbook given to an insured person and (2) prominently on its website (CGS § 38a-591b(d)).

By law, it is a violation of CUTPA (see BACKGROUND) for a health care provider to request payment, except for a copayment, deductible, coinsurance, or other out-of-pocket expense, from an insured person for a surprise bill (CGS § 20-7f).

§§ 6-8 — ADVERSE DETERMINATION REVIEW TIMEFRAMES

Existing law establishes a structure and timeframe for health carriers and independent review organizations (IROs) to conduct benefit reviews and notify the covered individual whether a specific medical service is reimbursable by his or her health insurance plan. This bill shortens, from 72 to 48 hours, the maximum time a health insurer or IRO can take, after receiving all the required health information, to notify an insured or his or her authorized
representative of decisions for one of the following urgent care reviews:

1. initial utilization reviews and benefit determinations,

2. expedited internal adverse determination reviews that are based on medical necessity, and

3. expedited external or final adverse determination reviews.

However, the bill retains the 72 hour requirement if any portion of the 48 hours falls on a weekend.

Existing law, unchanged by the bill, requires that (1) urgent initial utilization reviews be conducted as soon as possible, (2) urgent internal adverse determination reviews be conducted within a reasonable period of time appropriate to the covered person’s condition, and (3) urgent expedited external reviews be conducted as quickly as the covered person's condition requires.

The bill does not apply to urgent care reviews involving substance use disorders and certain mental disorders, which by law must be completed within 24 hours.

§ 9 — DISABILITY INCOME PROTECTION POLICY DISCRETIONARY POLICIES

The bill prohibits certain health carriers from including in a disability income protection policy a provision that allows the carrier discretion to interpret the policy’s terms, or establishes standards for interpreting or reviewing the policy, that are inconsistent with state law. It applies to each insurer, health care center, hospital or medical service corporation, or fraternal benefit society that delivers, issues, renews, amends, or continues in Connecticut a disability income protection policy on or after January 1, 2020.

§ 10 — SHORT TERM ACUTE CARE GENERAL AND CHILDREN’S HOSPITAL REPORTING

The bill requires short term acute care general and children’s hospitals to include in a report they annually send to the Health
Systems Planning Unit information and data the Office of Health Strategy (OHS) prescribes concerning trauma activation fee charges. (By law, the unit is within OHS.)

§ 11 — MEDICAL NECESSITY
The bill requires certain health insurance policies to provide coverage for medically necessary health care services for emergency medical conditions.

Under the bill and existing law:

1. an “emergency medical condition” is a condition that a prudent layperson, acting reasonably, would believe requires emergency medical treatment and

2. “medically necessary health care services” are those that a physician, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose, or treat a condition and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate; and (c) not primarily for the patient’s, physician’s, or other health care provider’s convenience and not more costly than an alternative, therapeutically equivalent service.

The provision applies to health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

§ 12 — HDHP TASK FORCE
The bill establishes an HDHP task force to study the structure and impact of HDHPs on enrollees in Connecticut and report its findings to the Insurance and Real Estate Committee by February 1, 2020. The task force must make recommendations about:

1. measures to ensure access to affordable health care services under HDHPs;
2. the financial impact of HDHPs on enrollees and their families;

3. the use of health savings accounts (HSAs) and the impact of alternative payment structures on HSAs, including the status of the accounts under the federal tax code;

4. measures to ensure that each cost-sharing payment due and paid under an HDHP accurately reflects the enrollee’s cost-sharing obligation for his or her specific plan;

5. measures to ensure prompt payment of refunds for enrollees who overpay;

6. measures to enhance enrollee knowledge of how payments are applied to deductibles; and

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

The task force consists of the healthcare advocate or his or her designee and the following appointed members:

<table>
<thead>
<tr>
<th>Appointing Authority</th>
<th>Number of Appointments</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>House speaker</td>
<td>2</td>
<td>One who represents the Connecticut College of Emergency Physicians and one who represents a small employer sponsoring an HDHP</td>
</tr>
<tr>
<td>Senate president pro tempore</td>
<td>2</td>
<td>One who is an insurance producer with knowledge of HDHPs, and one who is an HDHP enrollee</td>
</tr>
<tr>
<td>House majority leader</td>
<td>1</td>
<td>Primary care physician participating in an HDHP</td>
</tr>
<tr>
<td>Senate majority leader</td>
<td>1</td>
<td>Emergency room physician</td>
</tr>
<tr>
<td>House minority leader</td>
<td>1</td>
<td>Represents the Connecticut Association of Health Plans</td>
</tr>
<tr>
<td>Senate minority leader</td>
<td>1</td>
<td>Represents the Connecticut State Medical Society</td>
</tr>
</tbody>
</table>
Governor | 3 | One who represents the Connecticut Hospital Association, one who represents a health plan issuing HDHPs, and one who is a tax attorney knowledgeable about HSAs

Under the bill, task force appointments must be made within 30 days of the bill’s passage, and vacancies are filled by the appointing authority. The members must elect two chairpersons. The healthcare advocate must schedule the first meeting within 60 days of the bill’s passage.

The bill requires the Insurance and Real Estate Committee administrative staff to serve as such for the task force. The task force terminates when it submits its report or December 1, 2020, whichever is later.

BACKGROUND

*Connecticut Unfair Insurance Practices Act (CUIPA)*

The law prohibits engaging in unfair or deceptive acts or practices in the insurance business. It authorizes the insurance commissioner to conduct investigations and hearings, issue cease and desist orders, impose fines, revoke or suspend licenses, and order restitution for per se violations (i.e., violations specifically listed in statute). The law also allows the commissioner to ask the attorney general to seek injunctive relief in Superior Court if he believes someone is engaging in other unfair or deceptive acts not specifically defined in statute.

Fines may be up to (1) $5,000 per violation to a $50,000 maximum or (2) $25,000 per violation to a $250,000 maximum in any six-month period if the violation was knowingly committed. The law also imposes a fine of up to $50,000, in addition to or in lieu of a license suspension or revocation, for violating a cease and desist order (CGS § 38a-815 et seq.)

*Connecticut Unfair Trade Practice Act*

CUTPA 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 up to $25,000 for a restraining order violation (CGS § 42-110b).

Health Benefit Review Timeframes

Generally, reviews have up to three steps: (1) an initial review to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is conducted when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the insurance department. External reviews, also called final adverse determination reviews, are conducted by an IRO assigned by the insurance department.

Urgent and Non-Urgent Care Reviews

By law, an initial utilization review may be determined urgent by a health care professional with knowledge of the covered person's medical condition. Other benefit requests may be determined urgent if the time period for a non-urgent care review:

1. could, in the judgment of an individual acting on behalf of the health carrier and applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine, seriously jeopardize the life or health of the covered person or his or her ability to regain maximum function or

2. would, in the opinion of a health care professional with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be otherwise adequately managed without the requested treatment or service
(CGS § 38a-591a et seq.).

**Related Bills**

SB 31 (File 306), reported favorably by the Insurance and Real Estate Committee, contains identical surprise billing provisions.

SB 38 (File 359), reported favorably by the Insurance and Real Estate Committee, contains substantially similar adverse determination and benefit review provisions.

SB 87 (File 309), reported favorably by the Insurance and Real Estate Committee, contains identical disability income protection policy provisions.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable
Yea 16 Nay 4 (03/14/2019)

Judiciary Committee

Joint Favorable
Yea 27 Nay 11 (04/30/2019)