General Assembly

Committee Bill No. 42

January Session, 2019

LCO No. **5694**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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

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

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:

(1) A coinsurance or deductible for a covered benefit in an amount that exceeds the lesser of:

(A) An amount calculated on the basis of the amount due and payable for the covered benefit 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;

(B) 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

(C) The amount that the insured would have paid for the covered benefit without regard to such policy; or

(2) A copayment in an amount that the insured would have paid for the covered benefit without regard to such policy.

(b) Any violation of this section shall constitute an unfair trade practice in violation of chapter 735a of the general statutes.

Sec. 2. (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 permit or require any party to such contract to violate the fiduciary duties that the health carrier owes to its insureds.

Sec. 3. Section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) For purposes of this section:

(1) "Request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "This is not a bill".

(2) "Health care provider" means a person licensed to provide health care services under chapters 370 to 373, inclusive, chapters 375 to 383b,

inclusive, chapters 384a to 384c, inclusive, or chapter 400j.

(3) "Enrollee" means a person who has contracted for or who participates in a health care plan for such enrollee or such enrollee's eligible dependents.

(4) **[**"Coinsurance, copayment, deductible or other out-of-pocket expense"**]** "Coinsurance, copayment or deductible" means the portion of a charge for services covered by a health care plan that, under the plan's terms, it is the obligation of the enrollee to pay.

(5) "Health care plan" has the same meaning as provided in subsection (a) of section 38a-477aa.

(6) "Health carrier" has the same meaning as provided in subsection (a) of section 38a-477aa.

(7) "Emergency services" has the same meaning as provided in subsection (a) of section 38a-477aa.

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee: **[**, other**]**

(1) Other than a coinsurance, copayment **[**,**]** or deductible, **[**or other out-of-pocket expense,**]** for **[**(1)**]** (A) health care services or a facility fee, as defined in section 19a-508c, covered under a health care plan, **[**(2)**]** (B) emergency services covered under a health care plan and rendered by an out-of-network health care provider, or **[**(3)**]** (C) a surprise bill, as defined in section 38a-477aa; **[**.**]** or

(2) For a coinsurance, copayment or deductible in an amount that exceeds the amount calculated pursuant to section 1 of this act.

(c) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to report to a credit reporting agency an enrollee's failure to pay a bill for the services, facility fee or surprise bill as set forth in subdivision (1) of subsection (b) of this section, when a

health carrier has primary responsibility for payment of such services, fees or bills.

Sec. 4. Subdivision (3) of subsection (c) of section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(3) No participating provider, or agent, trustee or assignee thereof, may: (A) Maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center; (B) request payment from a subscriber or enrollee for such sums; (C) request payment from a subscriber or enrollee for covered emergency services that are provided by an out-of-network provider; or (D) request payment from a subscriber or enrollee for a surprise bill, as defined in section 38a-477aa, as amended by this act. For purposes of this subdivision "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL". The contract between a health care center and a participating provider shall inform the participating provider that pursuant to section 20-7f, as amended by this act, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from a subscriber or an enrollee, other than a coinsurance, copayment **[**,**]** or deductible, **[**or other out-of-pocket expense,**]** for covered medical or emergency services or facility fees, as defined in section 19a-508c, or surprise bills, or to report to a credit reporting agency an enrollee's failure to pay a bill for such services when a health care center has primary responsibility for payment of such services, fees or bills.

Sec. 5. 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.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	New section
Sec. 2	*January 1, 2020*	New section
Sec. 3	*January 1, 2020*	20-7f
Sec. 4	*January 1, 2020*	38a-193(c)(3)
Sec. 5	*January 1, 2020*	38a-478j

INS *Joint Favorable*

JUD *Joint Favorable*