General Assembly

Raised Bill No. 905

January Session, 2019

LCO No. **4328**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING SURPRISE BILLING AND REIMBURSEMENTS FOR EMERGENCY SERVICES PROVIDED BY OUT-OF-NETWORK FACILITY-BASED PROVIDERS.

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

Section 1. Section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):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 **[**,**]** or deductible" **[**or other out-of-pocket expense"**]** 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, as amended by this act.

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

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

(8) "Facility" has the same meaning as provided in section 38a-591a.

(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 health care provider or facility, or (3) a surprise bill, as defined in section 38a-477aa, as amended by this act.

(c) It shall be an unfair trade practice in violation of chapter 735a for any health care provider or facility 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 subsection (b) of this section, when a health carrier has primary responsibility for payment of such services, fees or bills.

Sec. 2. Subsections (a) and (b) of section 38a-477aa of the general statutes are 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) "Facility" has the same meaning as provided in section 38a-591a;

[(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 health care provider, where such services were rendered by 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.

(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.

(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 health care provider or facility, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider or facility.

(3) (A) If emergency services were rendered to an insured by an out-of-network health care provider or facility, such health care provider or facility may bill the health carrier directly and the health carrier shall reimburse such health care provider or facility in 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 or facility; (ii) **[**the usual, customary and reasonable rate for such services**]** the amount the insured's health care plan would pay for such services calculated using the same method such plan uses to calculate payments for out-of-network services, excluding any (I) copayment or coinsurance that such plan would impose on such insured for such services if such services were provided by an in-network provider or facility, or (II) reduction for out-of-network cost-sharing that generally applies under such plan for out-of-network 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.**]** Each health carrier shall disclose, in such health carrier's plan document, the methods such health carrier uses to calculate payments for out-of-network services, including, but not limited to, benchmarking databases and other information sources.

(B) Each out-of-network facility-based provider that renders emergency services to an insured shall: (i) Accept reimbursement for such services from a health carrier in the amount calculated pursuant to subparagraph (A) of this subdivision; or (ii) if such provider is eligible to participate in the mediation program established by the reimbursing health carrier pursuant to subparagraph (C) of this subdivision, refuse to accept reimbursement for such services from such health carrier and notify such health carrier that such provider intends to participate in such program.

(C) (i) Each health carrier shall establish a mediation program for the mediation of disputes concerning reimbursements for emergency services rendered to insureds by out-of-network facility-based providers. Each mediation program established pursuant to this subparagraph shall adhere to generally accepted mediation standards established by:

(I) The National Conference of Commissioners on Uniform State Laws in the Uniform Mediation Act, as amended from time to time;

(II) The American Arbitration Association;

(III) The Association for Conflict Resolution;

(IV) The Section of Dispute Resolution of the American Bar Association; or

(V) An alternative dispute resolution program identified by the judicial branch.

(ii) Except as provided in subparagraph (C)(iii) of this subdivision, each out-of-network facility-based provider shall be eligible to participate in the mediation program established by a health carrier pursuant to subparagraph (C)(i) of this subdivision if: (I) Such provider rendered emergency services to an individual insured by the health carrier; (II) such provider received, but did not accept, reimbursement from the health carrier for such services; (III) such provider's fee for such services exceeds the amount of the reimbursement that such provider received from the health carrier for such services by more than one thousand dollars; and (IV) such provider notifies the health carrier that such provider wishes to participate in such program.

(iii) No mediation program established by a health carrier pursuant to subparagraph (C)(i) of this subdivision shall be used if (I) the health carrier and an out-of-network facility-based provider who is otherwise eligible to participate in such program agree to a payment arrangement outside of such program, or (II) the insured who received emergency services from the out-of-network facility-based provider agrees to pay such provider's fee for such services.

(iv) In performing a mediation pursuant to subparagraph (C) of this subdivision, the mediator shall select, as the reimbursement amount due from the health carrier to the out-of-network facility-based provider, (I) the reimbursement amount issued by such health carrier to such provider pursuant to subparagraph (A) of this subdivision, or (II) such provider's fee for the emergency services that such provider rendered to the insured.

(v) The cost of a mediation performed pursuant to subparagraph (C) of this subdivision shall be borne equally by the health carrier and the out-of-network facility-based provider.

(vi) Each health carrier shall maintain records concerning all notices

submitted to such health carrier pursuant to subparagraph (C)(ii) of this subdivision and all mediations conducted pursuant to subparagraph (C) of this subdivision. Each health carrier shall, upon request from the commissioner, submit to the commissioner, in a form and manner prescribed by the commissioner, a report concerning the records maintained by such health carrier pursuant to this subparagraph.

[(B)**]** (D) Nothing in this subdivision shall be construed to prohibit **[**such**]** a health carrier and out-of-network health care provider from agreeing to a greater reimbursement amount.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	20-7f
Sec. 2	*January 1, 2020*	38a-477aa(a) and (b)

Statement of Purpose:

To: (1) Subject certain bills for emergency services to, and modify the forms of cost-sharing that qualify for protection under, provisions concerning surprise billing; and (2) modify the manner in which reimbursements for emergency services provided by out-of-network facility-based providers are calculated and paid.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]