Testimony Concerning and Supporting
House Bill 6015: An Act Protecting Patients Against Surprise Out-of-Network Medical Bills
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February 17, 2017

Universal Health Care Foundation of Connecticut is submitting this testimony concerning and supporting House Bill 6015: An Act Protecting Patients Against Surprise Out-of-Network Medical Bills.

First, a little background information on why people end up with surprise out-of-network medical bills. Most insurance coverage requires patients to see providers within their network to access discounted rates for co-pays, co-insurance and other cost-sharing. In-network providers have existing contracts with insurers to accept their payment arrangements. Out-of-network providers do not have these contracts, and if an insurance plan member gets care from an out-of-network provider, they will pay more for their services.

So why would a person go to an out-of-network provider and be surprised when they get the bill? *Because they did not know the provider was out-of-network*. Surprise out-of-network bills occur in two instances:

- Someone required emergency medical care and are routed to the closest hospital – regardless of whether that hospital is an in-network or out-of-network hospital. In emergencies, the patient may not even be conscious – and even if they are, during a medical emergency, providers are focused on delivering care as quickly as possible. During that type of crisis, there is little time for a person to whip out their insurance card and ensure they are receiving in-network care.
- Surprise out-of-network bills also occur during routine procedures where a patient has secured in-network care at an in-network facility – and then somewhere during the procedure, an out-of-network provider delivered care. This can happen when the patient is unconscious, or not even in the room.

In both these instances, patients should be protected against out-of-network bills. As I testified this year at an Insurance & Real Estate Committee public hearing, on Senate Bill 426: An Act Protecting Patients from Inappropriate Billing Practices[i] (The written testimony can be found at the CGA site here), we support that bill's requirement that all providers at an in-network hospital or facility to be paid in-network rates. This would prevent surprise bills by essentially banning the practice of providers at an in-network hospital being out-of-network.

Public Act 15-146[ii] (SB 811 in 2015) included protections against surprise medical bills. Insured people are only required to pay the in-network cost-sharing rate:

- In the event of a medical emergency
- If an insured receives a surprise bill, which is when an insured did not knowingly select an out-of-network provider
- If an insured receives services from an out-of-network provider, after the insured or the provider has requested information about the provider's network status, and the insurance plan fails to inform the person or provider that the provider is out-of-network

For more detail, please see attached for the PA 15-146 summary pages pertaining to surprise medical bills.

One important note: while the state has the authority to regulate individual, small group and large group insurance plans in the state, self-insured plans are regulated at the federal level. See the attached infographic.

The bill I am writing on today, House Bill 6015: An Act Protecting Patients Against Surprise Out-of-Network Medical Bills, focuses more on ensuring that consumers have access to information about what their care may cost for a routine procedure. While we support this measure, we don't think the onus should be on the consumer to avoid out-of-network surprise medical bills.

A consumer *should*, though, be able to easily determine what providers are in-network. As this bill is working to increase the transparency and ease of identifying in-network providers, we support the measures proposed. These measures should not supersede the existing protections in Public Act 15-146.

There is no one easy solution for making health care more affordable. There are many players, many stakeholders, and many factors affecting our health. Affordable health care requires a coordinated approach with interconnected measures. This is one such measure, enabling consumers access to information to make informed decisions about from which providers to seek care.

We have to remember that health care affordability isn't just about lowering costs in the larger system – it's also about consumers getting the high-quality health care they need, at a price they can afford.

Universal Health Care Foundation of Connecticut's mission is to serve as a catalyst that engages residents and communities in shaping a democratic health system that provides universal access to quality, affordable health care and promotes health in Connecticut. We believe that health care is a fundamental right and that our work is part of a broader movement for social and economic justice.

SURPRISE Medical Bills

Are you protected from surprise medical bills?

FULLY

- ✓ Medicare
- ✓ Medicaid
- ✓ VA healthcare
- ✓ Tricare

POTENTIALLY

- ✓ Fully insured employer plan
- ✓ ACA exchange and other individual market plans

1/4 of states have taken some action to protect their insured.

NOT

- ✓ Self-funded employer plan

Only the federal government can regulate these plans, but there's been little federal action to-date.

B | Center for Health Policy at BROOKINGS

USC Schaeffer Leonard D. Schaeffer Center for Health Policy & Economics

Source: http://healthaffairs.org/blog/2017/02/01/stopping-surprise-medical-bills-federal-action-is-needed/

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[i] Universal Health Care Foundation of Connecticut's testimony in support of Senate Bill 426: An Act Protecting Patients from Inappropriate Billing Practices https://www.cga.ct.gov/2017/insdata/tmy/2017SB-00023-R000207-Universal%20Health%20Care-TMY.PDF

[ii] Public Act 15-146: https://www.cga.ct.gov/2015/ACT/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf

5. whether specific health care providers, hospitals, or types of specialists are in the policy's provider network.

The act requires Access Health CT to post links on its website to the carriers' information for each qualified health plan offered or sold through the exchange. It also requires the insurance commissioner to post links on the Insurance Department's website to any online tools or calculators available to help consumers compare and evaluate health insurance policies and plans. By law, the department must already post certain tools on its website, including the annual *Consumer Report Card on Health Insurance Carriers in Connecticut.*

EFFECTIVE DATE: January 1, 2016

§ 8 - INSURANCE COMMISSIONER TO EVALUATE COMPLIANCE WITH THE AFFORDABLE CARE ACT

The act requires the insurance commissioner to, within available appropriations, (1) evaluate health insurers', HMOs', fraternal benefit societies', and hospital and medical service corporations' compliance with the federal Affordable Care Act (ACA) and (2) report her findings annually to the Insurance and Real Estate Committee on her findings. It requires the carriers to give the commissioner, upon request, the following information for a specific health insurance policy or plan:

1. the benefits covered under each category of the essential health benefits package, as defined by the U.S. Health and Human Services secretary;

2. any coverage exclusions or restrictions on covered benefits, including prescription drug benefits;

3. any prescription drug formulary used, the tier structure of the formulary (tiers generally relate to the applicable copayments), and a list of each covered prescription drug and its tier placement;

4. the applicable coinsurance, copayment, deductible, or other out-of-pocket expense for each covered benefit; and

5. any other information the commissioner deems necessary to evaluate the entity's ACA compliance.

By law, the commissioner may adopt regulations to implement these provisions.

EFFECTIVE DATE: July 1, 2016

§§ 9-12 - BILLS FOR EMERGENCY SERVICES, SURPRISE BILLS, AND UNFAIR BILLING PRACTICES

§ 9 - Emergency Services

The act prohibits health carriers from requiring prior authorization for emergency services. It also prohibits health carriers from charging an insured a coinsurance, copayment, deductible, or other out-of-pocket expense for emergency services performed by an out-of-network health care provider that is greater than that charged when performed by an in-network provider.

The act requires health carriers to reimburse out-of-network providers who perform emergency services for insureds the greatest of the: (1) amount the health care plan would pay if the services were rendered by an in-network provider; (2) usual, customary, and reasonable rate; or (3) amount Medicare reimburses for those services. A health carrier and an out-of-network provider may agree to a greater reimbursement amount. The health care provider may bill the carrier directly.

Under the act, "usual, customary, and reasonable rate" means the 80th percentile of all charges for the 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. That organization must not be affiliated with a health carrier.

As used in this section, "health carriers" include health insurers, HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that issue health care plans in Connecticut. "Emergency services" are medical screenings to evaluate an emergency condition and examinations and treatment to stabilize the patient.

§§ 9 & 10 - Network Status Notification

The act requires each health carrier to tell a covered person or his or her health care professional, when the person or professional requests a prospective or concurrent benefit review:

1. the professional's network status under the person's health benefit plan;

2. the estimated amount the health carrier will reimburse the professional; and

3. how that amount compares to the usual, customary, and reasonable charge, as determined by the federal Center for Medicare and Medicaid Services.

Under the act, if an out-of-network provider renders services to an insured and the health carrier did not inform the insured of the provider's network status, the health carrier is prohibited from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense that is more than what would be imposed if an in-network provider rendered services.

§§ 9 & 10 - Surprise Bills

Under the act, if an insured receives a surprise bill, the insured is only required to pay the coinsurance, copayment, deductible, or other out-of-pocket expense that would apply if the services had been rendered by an in-network provider. A health carrier must reimburse an out-of-network provider or insured, as applicable, for the services at the in-network rate under the plan as payment in full, unless the carrier and provider agree otherwise.

The act requires a health carrier to include a description of what constitutes a surprise bill (1) in the insurance policy, certificate of coverage, or handbook given to a covered person and (2) prominently on its website.

Under the act, a "surprise bill" is a bill for non-emergency health care services received by an insured for services rendered by an out-of-network provider at an in-network facility during a service or procedure that was performed by an in-network provider or previously approved by the health carrier, and the insured did not knowingly elect to receive the services from the out-of-network provider. A bill is not a surprise bill if an in-network provider is available but an insured knowingly elects to receive services from an out-of-network provider.

§§ 11 & 12 - Unfair Billing Practices by Health Care Providers

The act expands what constitutes an unfair trade practice by a health care provider (CUTPA, see BACKGROUND). Under prior law, it was an unfair trade practice for a health care provider to request payment from a managed care plan enrollee for covered services, except for a copayment or deductible.

The act instead makes it an unfair trade practice for a health care provider to request payment from a health care plan enrollee, except for a copayment, deductible, coinsurance, or other out-of-pocket expense, for:

1. covered health care services or facility fees,

2. covered emergency services rendered by an out-of-network provider, or

3. a surprise bill.

The act also makes it an unfair trade practice for a health care provider to report to a credit reporting agency an enrollee's failure to pay a bill for the above listed items when a health carrier has primary responsibility for paying. Under prior law, it was an unfair trade practice to report to a credit reporting agency an enrollee's failure to pay a bill for medical services that a managed care organization had primary responsibility for paying.

The act requires contracts between HMOs and participating providers to reflect what constitutes an unfair trade practice, as described above. It also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2016

§§ 13 & 14 - FACILITY FEES

Limits on Allowable Fees

By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee.

On and after January 1, 2017, the act places certain limits on facility fees collected by hospitals, health systems, and hospital-based facilities. It prohibits them from collecting a facility fee for outpatient services that (1) use a current procedural terminology evaluation and management code and (2) are provided at a hospital-based facility, other than a hospital emergency department, that is not on a hospital campus. It prohibits them from collecting a facility fee from uninsured patients for outpatient services, other than those provided in off-site emergency departments, that exceeds the Medicare facility fee rate. A violation is an unfair trade practice.

If an insurance contract in effect on July 1, 2016 provides reimbursement for facility fees that are prohibited by these provisions, the hospital or health system may continue to collect reimbursement from insurers for these fees until the contract expires.

Billing Statement Notice

Beginning January 1, 2016, the act requires each billing statement that includes a facility fee to:

1. clearly identify the fee as a facility fee that is in addition to, or separate from, the provider's professional fee, if any;

2. provide the comparable Medicare facility fee reimbursement rate for the same service;

3. include a statement that the fee is intended to cover the hospital's or health system's operational expenses;

4. inform the patient that his or her financial liability might have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and

5. include notice of the patient's right to request a reduction in the facility fee, or any portion of the bill, and a telephone number that the patient may use to make thisrequest.

These requirements do not apply to billing statements for Medicare or Medicaid patients or those receiving services under a workers' compensation plan.

Notice of Transaction Resulting in Hospital-Based Facility; Stay on Collecting Facility Fees

Under the act, on and after January 1, 2016, if a transaction materially changes the business or corporate structure of a physician group practice and establishes a hospital-based facility at which facility fees will likely be billed, the hospital or health system purchasing the practice must notify each patient the practice served in the previous three years. The purchaser must send the notice by first class mail, within 30 days after the transaction.