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Connecticut Passes Law Imposing New Burdens on Health Insurance Companies

Public Act 15-146, "An Act Concerning Hospitals, Carriers and Health Care Consumers," was signed into law by Governor Malloy on June 30, 2015 and will have a significant impact on health insurance companies in Connecticut. The new law imposes additional hurdles for insurance companies to acquire physician groups; a practice that has emerged as a recent trend as health insurers attempt to control costs and increase the quality of health care. Many provisions of this Public Act are also intended to help facilitate informed decision-making by health care consumers, while others are intended to prohibit certain billing practices. The following are some highlights of the changes imposed by the Public Act:

CERTIFICATE OF NEED (CON)

The Public Act clarifies that a CON is required for a health insurance company to acquire certain physician group practices. Connecticut General Statutes § 19a-638 was revised to state that a CON is required for a transfer of a "large group practice" to any entity other than a (A) physician or (B) group of two or more physicians legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity.

For these purposes, "large group practice" means, eight or more full-time

equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group.

As a result, group practices that are acquired by a captive professional corporation or other entity affiliated with an insurance company must first obtain approval from the state Office of Health Care Access.

NOTICE TO THE CONNECTICUT DEPARTMENT OF HEALTH (DPH) OF TRANSACTIONS INVOLVING PHYSICIAN GROUPS

Current law already requires that the parties to any transaction that results in a material

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change to the business or corporate structure of a physician group practice submit written notice to the Attorney General. The Public Act additionally requires that, not later than thirty days after the effective date of the transaction, the parties submit written notice to DPH, which will then post a link to the notice on DPH's website. Insurance companies that purchase physician practices will need to consider whether this new notice requirement applies.

A "material change to the business or corporate structure" of the group practice includes the following transactions:

- The merger, consolidation or other affiliation of a group practice with (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system;
- The acquisition of all or substantially all of (A) the properties and assets of a group practice, or (B) the capital stock, membership interests or other equity interests of a group practice by (i) another group practice that results in a group practice comprised of eight or more physicians, or (ii) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system;
- The employment of all or substantially all of the physicians of a group practice by (A) another group practice that results

in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system; and

- The acquisition of one or more insolvent group practices by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system.

CONSUMER HEALTH INFORMATION WEBSITE

Starting January 1, 2017, and annually thereafter, each health insurance company must submit a report to the Connecticut Health Insurance Exchange that lists, by provider, the (1) billed and allowed amounts paid to health care providers in the health insurance company's network for certain diagnoses and procedures, and (2) out-of-pocket costs for certain diagnoses and procedures.

In order to ensure that this information is reported accurately and timely, the Public Act disallows, effective January 1, 2016, any provision in contracts between health care providers and health insurance companies prohibiting disclosure of (1) billed or allowed amounts, reimbursement rates or out-of-pocket costs, and (2) any data to the Connecticut all-payer claims database.

The reported information will then be used by the Connecticut Health Insurance

Exchange to establish a consumer health information website to help consumers make informed decisions concerning their health care and informed choices among health care providers. The website is to be designed to allow comparisons between prices paid by various health insurance companies to health care providers.

CONSUMER NOTIFICATIONS

Effective October 1, 2015, the Public Act requires health insurance companies to ensure that any notice, billing statement, or explanation of benefits submitted to a patient or insured is written in language that is understandable to an average reader. In addition, effective October 1, 2015, each health insurance company must update, not less than monthly, its health care provider directory or directories.

Also, effective January 1, 2016, certain health insurance companies are required to make available to consumers at the time of enrollment and on its website, in an easily readable and understandable format, the following information for each health insurance policy:

- Any coverage exclusions;
- Any restrictions on the use or quantity of a covered benefit, including on prescription drugs or drugs administered in a physician's office or a clinic;
- A specific description of how prescription drugs are included or excluded from any applicable deductible, including a description of other out-of-pocket expenses that apply to such drugs; and

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- The specific dollar amount of any copayment and the percentage of any coinsurance imposed on each covered benefit, including each covered prescription drug.

These health insurance companies must also make available to consumers a way to determine accurately:

- Whether a specific prescription drug is available under such policy's drug formulary;
- The coinsurance, copayment, deductible or other out-of-pocket expense applicable to such drug;
- Whether such drug is covered when dispensed by a physician or a clinic;
- Whether such drug requires preauthorization or the use of step therapy;
- Whether specific types of health care specialists are in-network; and
- Whether a specific health care provider or hospital is in-network.

Furthermore, effective July 1, 2016, the Public Act requires insurance companies to inform a covered person or the covered person's health care professional upon request for a prospective or concurrent review of:

- The network status under the covered person's health benefit plan of the health care professional who will be providing the health care service or course of treatment;

- An estimate of the amount the health insurance company will reimburse the health care professional for such service or treatment; and
- How the amount compares to the usual, customary and reasonable charge, as determined by the Centers for Medicare and Medicaid Services, for such service or treatment.

HEALTH INSURANCE COMPANY WEBSITE AND TOLL-FREE NUMBER

By July 1, 2016, each health insurance company must maintain a website and toll-free telephone number that enables consumers to request and obtain information about out-of-network costs for inpatient admissions, health care procedures, and services and in-network costs for inpatient admissions, health care procedures and services, including:

- The allowed amount for, at a minimum, certain admissions and procedures for each health care provider in the state;
- The estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and
- Data or other information concerning quality measures for the health care provider, patient satisfaction, to the extent such information is available, a list of in-network health care providers, whether a health care provider is accepting new patients, and languages spoken by health care providers.

Health insurance companies must also advise consumers when providing the information on out-of-pocket costs, that the amounts are estimates and that the consumer's actual cost may vary due to health care provider contractual changes, the need for unforeseen services that arise out of the proposed admission or procedure, or other circumstances.

OUT-OF-NETWORK SERVICES

Effective July 1, 2016, health insurance companies are prohibited from imposing a coinsurance, copayment, deductible or other out-of-pocket expense for out-of-network emergency services that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if the emergency services were rendered by an in-network health care provider.

If emergency services are rendered by an out-of-network health care provider, the health insurance company must reimburse the health care provider 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; (ii) the usual, customary and reasonable rate for such services, or (iii) the amount Medicare would reimburse for such services.

Also, if services are rendered to an insured by an out-of-network provider and the health insurance company failed to inform the insured of the network status of the provider, the health insurance company may not impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-

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pocket expense that would be imposed if such services were rendered by an in-network provider.

The Public Act categorizes health care services, other than emergency 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 during a service or procedure previously approved or authorized by the health insurance company, where the insured did not knowingly elect to obtain the services from the out-of-network provider, as “surprise bills.” The new law states that in regard to surprise bills, an insured must only be required to pay the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for the services if they were rendered by an in-network provider and the health insurance company must reimburse the out-of-network provider or insured, as applicable, for services rendered at the in-network rate under the insured’s health care plan as payment in full. The new law also requires health insurance companies to include a description of a surprise bill (1) in the insurance policy, certificate of coverage, or handbook given to a covered person and (2) prominently on its website.

FACILITY FEES

Effective October 1, 2015, certain health insurers that reimburse hospitals, health systems, or hospital-based facilities for facility fees for outpatient health care services that are provided at a hospital-based facility located off-site from a hospital campus, may not impose any separate copayment for such fee.

“Facility fee” means any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is: (A) intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee.

TIERED HEALTH CARE PROVIDER NETWORK PLANS

The Public Act requires the Connecticut Health Insurance Exchange to encourage health insurance companies to offer tiered health care provider network plans that have different cost-sharing rates for different health care provider tiers and reward enrollees for choosing low-cost, high-quality health care providers by offering lower copayments, deductibles or other out-of-pocket expenses, and offer any such tiered health care provider network plans through the exchange.

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