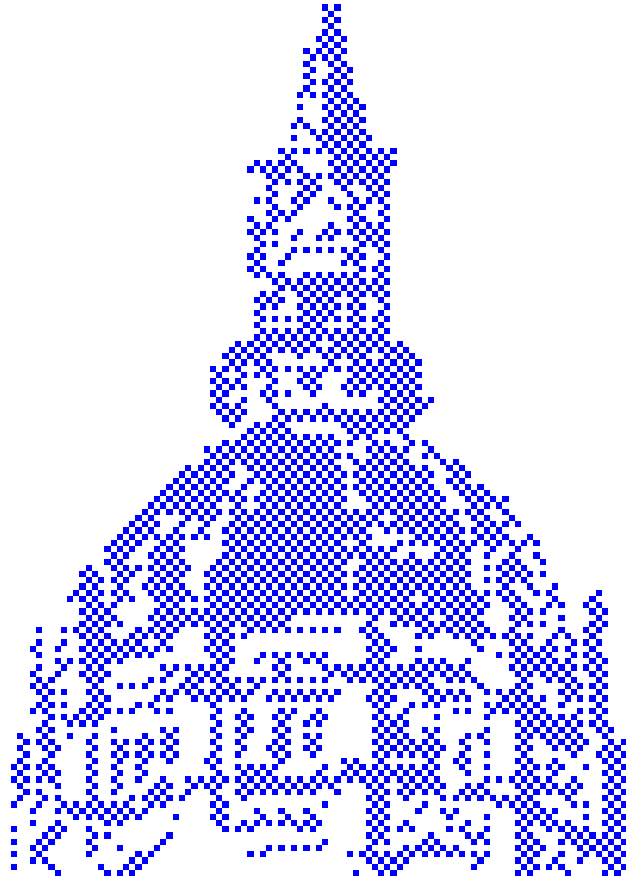




## ACTS AFFECTING INSURANCE



2015-R-0166

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## **NOTICE TO READERS**

This report provides highlights of new laws (public acts) affecting insurance enacted during the 2015 legislative session. It does not include vetoed acts. In each summary, we indicate the public act (PA) number and effective date. In some cases, these acts have other effective dates for provisions not related to insurance.

Not all provisions of the acts are included here. Complete summaries of all 2015 public acts are available on OLR's webpage.

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, House Clerk's Office, or General Assembly's website: <http://www.cga.ct.gov>.

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## **AFFORDABLE CARE ACT**

[PA 15-247, § 17](#) makes numerous changes in the insurance statutes to conform state law to the federal Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). It redefines “small employer” to mean an employer with between one and 100 employees, not including a sole proprietor.

EFFECTIVE DATE: Upon passage

[PA 15-146, § 8](#), requires the insurance commissioner, within available appropriations, to (1) evaluate health insurers', HMOs', fraternal benefit societies', and hospital and medical service corporations' compliance with the ACA and (2) report annually to the Insurance and Real Estate Committee on her findings.

EFFECTIVE DATE: July 1, 2016

## **CONNECTICUT INSURANCE GUARANTY ASSOCIATIONS**

[PA 15-171](#) makes changes in the laws governing the Connecticut Insurance Guaranty Association (CIGA) and Connecticut Life and Health Insurance Guaranty Association (CLHIGA). CIGA and CLHIGA pay certain insurance claims of insolvent insurers that cannot meet their obligations. The act, among other things,

1. requires CIGA to cover certain claims arising from policies an insolvent insurer acquired through a merger or acquisition;
2. specifies that CIGA payments are triggered upon a final order of liquidation with a finding of insolvency;
3. increases the coverage limit for CIGA, from \$400,000 to \$500,000, for claims arising from policies of insurers placed into liquidation with a finding of insolvency; and
4. holds CLHIGA not responsible for claims arising from Medicare Parts C or D policies providing hospital, medical, prescription drug, or other health care benefits.

EFFECTIVE DATE: October 1, 2015

## **DATA SECURITY AND PERSONAL INFORMATION**

[PA 15-142](#) requires each health insurer, HMO, and related entity, by October 1, 2017, to implement and maintain a comprehensive information security program to safeguard the personal information they compile or maintain on insureds and enrollees. It specifies program requirements, requires the program to be updated at least annually, and requires the entities to offer at least one year of free identity theft prevention and mitigation services if a security breach occurs.

EFFECTIVE DATE: October 1, 2015

## HEALTH INSURANCE

### ***Connecticut Health Insurance Exchange ("Access Health CT")***

[PA 15-146, §§ 1 & 2](#), requires Access Health CT to establish a consumer health information website with comparative price, quality, and related information.

EFFECTIVE DATE: October 1, 2015

[PA 15-146, § 16](#), requires Access Health CT to encourage health carriers to offer plans with tiered networks and offer those plans through the exchange. A tiered health care provider network plan has different cost-sharing rates for different provider tiers and rewards enrollees with lower copayments, deductibles, or other out-of-pocket expenses for choosing providers in certain tiers.

EFFECTIVE DATE: October 1, 2015

[PA 15-5, June Special Session, § 371](#) requires the Department of Social Services (DSS) commissioner and Access Health CT to ensure that parents or needy caretaker relatives who lose Medicaid eligibility are given an opportunity to enroll in a qualified health plan (QHP) without a gap in coverage. DSS and Access Health CT must report quarterly to the Council on Medical Assistance Program Oversight (MAPOC) on the number of parents and caretaker relatives who lost, gained, or changed their coverage as a result of Medicaid income eligibility changes effective August 1, 2015.

EFFECTIVE DATE: Upon passage

[PA 15-5 June Special Session, §§ 503-505](#), allows Access Health CT to form quasi-public subsidiaries to further the exchange's purposes and make loans to the subsidiaries or assign or transfer to them any of the exchange's rights, money, or other assets. The act also specifies which of the exchange's powers may be exercised by a subsidiary and requires each subsidiary to act through a board of directors.

EFFECTIVE DATE: Upon passage

### ***Coverage Expansions***

[PA 15-93](#) requires the comptroller to offer nonstate public employers and their employees and retirees coverage under the state employee health insurance plan. It also:

1. requires such nonstate employees to be pooled with the state employee plan as long as their employer's application meets the act's requirements and
2. prohibits the comptroller from admitting nonstate employees into the state employee pool unless the State Employees' Bargaining Agent Coalition (SEBAC) consents.

Prior law permitted the comptroller to provide insurance to these same employees and employers under another state plan, known as the partnership plan, but it does not pool them with state employees. The act closes the partnership plan to new

nonstate public employees but specifies that it should not be construed to require any nonstate public employer enrolled in the partnership plan to instead enroll in the state plan. A “nonstate public employer” is a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library.

EFFECTIVE DATE: October 1, 2015, except the sections providing definitions and requiring SEBAC consent are effective upon passage.

**PA 15-226** expands the services certain health insurance policies must cover for mental and nervous conditions. It requires policies to cover, among other things, (1) medically necessary acute treatment and clinical stabilization services (i.e., substance use and post-detoxification treatment); (2) general inpatient hospitalization, including at state-operated facilities; and (3) programs to improve health outcomes for mothers, children, and families. Some effective dates are delayed and coverage requirements expanded by **PA 15-5, June Special Session, §§ 43-46**.

EFFECTIVE DATE: January 1, 2016

**PA 15-5, June Special Session, §§ 347-353**, expands certain individual and group health insurance policies' required coverage of autism spectrum disorder (ASD) services and treatment. It also:

1. expands group policy behavioral therapy coverage requirements for people with ASD and also applies it to individual policies,
2. eliminates maximum coverage limits on the Birth-To-Three program, and
3. requires the insurance commissioner to convene a working group to develop recommendations for uniformly collecting behavioral health data.

EFFECTIVE DATE: January 1, 2016, except for certain provisions, including the working group, which are effective upon passage.

**PA 15-5, June Special Session, §§ 416 & 417**, permits the UConn board of trustees to provide health care coverage for UConn graduate assistants, graduate fellows, postdoctoral trainees, and certain graduate students through the partnership plan, provided the university pays all related premiums and expenses. The partnership plan is the state-administered health insurance plan for nonstate public or nonprofit employers. The act prohibits UConn from charging premiums and expenses to the General Fund.

EFFECTIVE DATE: July 1, 2015

**PA 15-5, June Special Session, §§ 469 & 470**, expands coverage under certain health insurance policies for off-label use of U.S. Food and Drug Administration (FDA) approved drugs. A drug is used “off-label,” when

prescribed to treat a condition other than one for which it has been approved by the FDA. Among other things, the act expands coverage by including peer-reviewed medical literature in the list of sources that can recognize an off-label drug for treatment of a condition and thus require it to be covered.

EFFECTIVE DATE: January 1, 2016

### ***Emergency Services and Surprise Bills***

[PA 15-110](#) requires an ambulance service to make a good faith effort to determine whether a person has health insurance before attempting to collect payment from the person for services provided. If the ambulance service determines that the person is insured, the act prohibits the service from trying to collect payment, other than a coinsurance, copayment, or deductible, from the person for covered medical services, before receiving notice from the insurer that it is not paying for the services. If the insurer has not paid for the service or provided notice that it declines to do so within 60 days after receiving the bill, the ambulance service may attempt to collect payment from the person.

EFFECTIVE DATE: October 1, 2015

[PA 15-146, §§ 9 & 10,](#) requires health carriers to (1) notify insureds about covered benefits, the network status of health care providers, and surprise bills and (2) bill insureds at the in-network level for emergency services

and services that resulted in a surprise bill.

EFFECTIVE DATE: July 1, 2016

### ***Facility Fees and Health Care Costs***

[PA 15-146, §§ 13 & 14,](#) sets certain limits on the copayments insurers can collect for facility fees. 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.

EFFECTIVE DATE: October 1, 2015

[PA 15-146, § 19,](#) requires the insurance commissioner, within available appropriations, to convene a working group to study rising health care costs.

EFFECTIVE DATE: July 1, 2015

### ***Medicare, Medicaid, and the State Children's Health Insurance Program***

[PA 15-5, June Special Session, § 370,](#) reduces HUSKY A coverage by lowering the income limit for non-pregnant adults (i.e., parents or caretakers) to 150% of the federal poverty limit (FPL). Under prior law, the limit was 196% of the FPL. DSS provides Medicaid coverage to children

under age 19 and their parents or caretaker relatives through HUSKY A.

EFFECTIVE DATE: August 1, 2015

**PA 15-5, June Special Session, §§ 373 & 374**, eliminates eligibility for unsubsidized HUSKY B coverage for children with household incomes over 318% of the FPL. HUSKY B provides non-Medicaid health coverage for children in households with incomes over 196% of the FPL, but requires households between 249% of the FPL and 318% of the FPL to pay for coverage on a sliding fee scale (i.e., subsidized coverage).

EFFECTIVE DATE: August 1, 2015

**PA 15-247, §§ 6 & 23** prohibits individual and group health insurance policies from reducing a person's coverage because he or she is eligible for Medicare due to age, disability, or end-stage renal disease. It allows a coverage reduction when a person is actually enrolled in Medicare, but only to the extent Medicare provides coverage.

EFFECTIVE DATE: Upon passage

### ***Peer Conferences***

**PA 15-139** requires health carriers (e.g., insurers or HMOs), after notifying a covered person or his or her authorized representative or health care professional of certain initial adverse determinations, to offer the health care professional the opportunity to confer

with the health carrier's clinical peer. Under the act, health carrier must offer the conference at the request of the health care professional.

EFFECTIVE DATE: October 1, 2015

### ***Preexisting Conditions***

**PA 15-247, § 8**, broadens the prohibition on the inclusion of preexisting condition provisions in individual and group health insurance plans or arrangements issued by insurers, HMOs, fraternal benefit societies, and hospital or medical service corporations. It prohibits their inclusion for anyone, including adults. The law already prohibits their inclusion for children under age 19. Prior law allowed preexisting condition provisions for adults that did not extend beyond the first 12 months of coverage.

EFFECTIVE DATE: Upon passage

### ***Telehealth***

**PA 15-88** (1) requires certain health insurance policies to cover medical advice, diagnosis, care, or treatment provided through telehealth to the extent that they cover those services through in-person visits between an insured person and a health care provider and (2) subjects telehealth coverage to the same terms and conditions that apply to other benefits under the policies. "Telehealth" means delivering health care services through information and communication



technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's physical and mental health.

EFFECTIVE DATE: January 1, 2016

### ***Vision Coverage***

[PA 15-122](#) prohibits a provider contract between an insurer and a licensed optometrist from requiring the optometrist to accept as payment an amount the insurer sets for services or procedures that are not covered benefits under an insurance policy or benefit plan. It also prohibits optometrists from charging patients more than their usual and customary rate for such services or procedures and requires them to post, in a conspicuous place, a notice stating that such services or procedures that are not covered benefits under an insurance policy or plan might not be offered at a discounted rate. Under the act, insurers must (1) include a statement regarding noncovered services on each evidence of coverage document issued for individual or group vision plans and (2) specify the language that must be included in the statement.

EFFECTIVE DATE: January 1, 2016

### **LIFE INSURANCE AND GROUP ANNUITY CONTRACTS**

[PA 15-70](#) prohibits an insurer from issuing or delivering to any service member a life insurance or annuity that eliminates or otherwise reduces an insurer's liability if the insured's death is

related to military service. Under the act, a life insurance or annuity policy, contract, and any related application, rider, or endorsement issued to a known U.S. Armed Forces or National Guard member cannot exclude coverage if the insured's death is related to (1) a declared or undeclared war or (2) military service, except accidental death coverage such as double indemnity may be excluded (i.e., paying a multiple of the policy's value if death results from an accident). Existing Insurance Department regulations prohibit such actions but do not cover National Guard members.

EFFECTIVE DATE: October 1, 2015

[PA 15-167](#) extends protection from creditors to certain allocated and unallocated group annuity contracts. By law, creditors cannot claim interests in and payments from certain accounts, including certain retirement accounts, simplified employee pension plans, and medical savings accounts. Under the act, a group annuity contract qualifies for protection from creditors if it is issued to an employer or pension plan to provide employees or retirees with defined retirement benefits and the original retirement benefits were protected under the federal Employee Retirement Income Security Act or Pension Benefit Guaranty Corporation but the new group annuity contract is not.

EFFECTIVE DATE: October 1, 2015

[PA 15-236](#) prohibits someone convicted of 1<sup>st</sup> or 2<sup>nd</sup> degree larceny or 1<sup>st</sup> degree abuse of an elderly, blind, or disabled person or person with intellectual disabilities from receiving, among other things, insurance benefits from his or her deceased victim. It makes changes in the disposition of certain types of jointly owned personal property when one owner is convicted of one of these or certain other crimes against another owner.

EFFECTIVE DATE: October 1, 2015

### **MISCELLANEOUS**

[PA 15-118](#) makes a number of unrelated changes in insurance laws and related provisions. Among other things, it:

1. repeals a provision, declared unconstitutional by a federal appellate court, requiring auto insurers to provide certain information to insureds about glass repair;
2. ensures that a ban on denying uninsured motorist coverage to certain named insureds or relatives continues to apply on and after October 1, 2015; and
3. repeals, for certain individual and group health insurance policies, provisions relating to coverage determinations and notice requirements. (The repealed provisions are superseded by provisions in compliance with the ACA.)

EFFECTIVE DATE: October 1, 2015

[PA 15-144](#) makes several changes in the insurance statutes. Among other changes, it:

1. requires the insurance commissioner, after completing a financial examination of an insurer, HMO, or similar entity, to give a final report of the examination to the entity's board of directors for review;
2. allows the commissioner to extend the due date for insurers and HMOs to file their quarterly and annual financial statements under certain circumstances;
3. prohibits anyone from making confidential examination workpapers and related information public but allows the commissioner to disclose the information to other insurance regulatory officials, law enforcement officials, and government agencies that agree to keep it confidential; and
4. allows the commissioner to order an HMO to turn over books and records necessary for her to conduct a financial examination of the company, which she is authorized by law to conduct, and requires the HMO to pay for the examination.

EFFECTIVE DATE: July 1, 2015

[PA 15-187](#) makes several unrelated changes in insurance statutes. Among other changes, it:

1. makes a portable electronics insurance license valid until

January 31 of even-numbered years;

2. extends the insurance commissioner's authority to suspend or revoke an insurance producer's license if the producer submits to the Insurance Department any form of payment, instead of just checks, that is dishonored;
3. allows the commissioner to share an insurer's Own Risk and Solvency Assessment summary report and related documents with other regulatory officials and the National Association of Insurance Commissioners without the insurer's written consent; and
4. incorporates the third-party administrator (TPA) annual reporting requirement into the annual TPA license renewal process.

EFFECTIVE DATE: October 1, 2015

[PA 15-198, § 7](#), adds pharmacists to the definition of "healing arts" in the HMO statutes. Various provisions in the HMO statutes refer to healing arts, including provisions on:

1. training provided under the direction of people licensed to practice a healing art (CGS §§ 38a-176 and -177),
2. required representation for healing arts practitioners on the boards of HMOs organized as nonprofit corporations (CGS § 38a-179), and
3. allowing (a) healing arts practitioners to be employed by

and participate in HMOs and (b) patients to choose healing arts practitioners in the HMO (CGS § 38a-180).

Pharmacists are not included in the more general statutory definition of healing arts (CGS § 20-1).

EFFECTIVE DATE: Upon passage

[PA 15-242, § 25](#), adds the insurance commissioner, or her designee, to the 14-member Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute Neuropsychiatric Syndrome (PANS). The council advises the DPH commissioner on research, diagnosis, treatment, and education relating to these conditions and must report annually to the Public Health Committee.

EFFECTIVE DATE: October 1, 2015

[PA 15-5, June Special Session, § 51](#), requires the insurance commissioner to select a group-wide supervisor for certain internationally active insurance groups that are also active in Connecticut. The act specifies the (1) factors the commissioner must consider when selecting a group-wide supervisor and (2) commissioner's powers and responsibilities when selected to serve in that capacity. It allows the commissioner to adopt regulations to implement its provisions.

EFFECTIVE DATE: October 1, 2015

[PA 15-5, June Special Session, § 345](#), transfers funding for certain Department of Public Health (DPH) programs from the General Fund to the Insurance Fund, including (1) the needle and syringe exchange, (2) AIDS services, and (3) breast and cervical cancer detection and treatment. By September 1 annually, the Office of Policy and Management (OPM) secretary, in consultation with the DPH commissioner, must determine the amounts appropriated for the programs and inform the insurance commissioner.

EFFECTIVE DATE: July 1, 2015

## **MOTOR VEHICLE INSURANCE**

[PA 15-5, June Special Session, §§ 229-232](#), requires the Department of Motor Vehicles (DMV) to establish an online insurance verification system in order to, among other things, confirm that a vehicle owner or operator obtains and continuously maintains the insurance coverage required by law and reduce the number of uninsured motor vehicles in the state. Insurers must submit certain motor vehicle insurance records to DMV, and DMV must, at least monthly, use the records to (1) update the system's database, (2) match with DMV's vehicle and owner information, and (3) compare against all current vehicle registrations.

EFFECTIVE DATE: Upon passage

## **POWERS OF ATTORNEY**

[PA 15-240](#) authorizes a person chosen to determine incapacity in a

power of attorney (POA) to act as the principal's personal representative under the federal Health Insurance Portability and Accountability Act and regulations to access health care information and communicate with health care providers. The act allows an agent granted authority by a POA over insurance matters to complete general tasks on behalf of the principal individual. This includes paying premiums and making changes to insurance contracts and annuities, acquiring loans based on an insurance or annuity contract, exercising elections and investment powers, determining payments from insurance contracts or annuities, and paying related taxes.

EFFECTIVE DATE: July 1, 2016

## **RATES AND FILINGS**

[PA 15-185](#) extends the sunset date for the "flex rating" law for personal risk insurance (e.g., home, auto, marine, or umbrella) from July 1, 2015 to July 1, 2017. The flex rating law permits property and casualty insurers, until the law sunsets, to file new personal risk insurance rates with the insurance commissioner and begin using them immediately without prior approval under certain circumstances.

EFFECTIVE DATE: June 30, 2015

[PA 15-247, § 7](#), requires health insurers to file small employer group health insurance premium rates with the insurance commissioner and prohibits them from issuing or

delivering policies or certificates in Connecticut to small employers unless the commissioner approves the rates.

EFFECTIVE DATE: Upon passage

**PA 15-247, §§ 1, 3, 5, & 7,**

requires insurers, HMOs, and hospital and medical service corporations to include in their rate filings an actuarial memorandum, including pricing assumptions, claims experience, and premium rates and loss ratios from the policy or contract inception. "Loss ratio" is the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

EFFECTIVE DATE: Upon passage

**REQUIRED NOTIFICATIONS AND DISCLOSURES**

**PA 15-146, § 15,** requires health care providers to notify patients when they refer them to an affiliated provider. The notification must be in writing and (1) inform them that they are not required to see the affiliated provider and may choose their own provider and (2) provide them with the website and toll-free telephone number of their health carrier to obtain information on in-network health care providers and estimated out-of-pocket costs for the referred services. The act applies to providers referring patients to another provider with whom they are affiliated but who is not a member of the same partnership, professional corporation, or limited liability company as the original

referring provider. The act exempts healthcare providers who provide a substantially similar notice under federal law.

EFFECTIVE DATE: October 1, 2015

**PA 15-146, § 5,** requires each health carrier to maintain a website and toll-free telephone number allowing consumers to obtain information on in- and out-of-network costs.

EFFECTIVE DATE: October 1, 2015

**PA 15-146, § 7,** requires health insurers, HMOs, fraternal benefit societies, and hospital and medical service corporations to disclose specified information to consumers at enrollment and post the information on their websites. This includes:

1. any coverage exclusions;
2. any restrictions on the use or quantity of a covered benefit, including prescription drugs;
3. description of the deductible and other out-of-pocket expenses that apply to prescription drugs; and
4. the applicable copayment and coinsurance percentage for each covered benefit, including each covered prescription drug.

EFFECTIVE DATE: January 1, 2016

## **STATE INSURANCE AND RISK MANAGEMENT BOARD**

[PA 15-123, § 4](#), transfers, from the comptroller to the State Insurance and Risk Management Board, responsibility for obtaining fire and casualty insurance coverage for the Connecticut building at the Eastern States Exposition (Big E).

EFFECTIVE DATE: July 1, 2015

[PA 15-5, June Special Session, § 491](#), makes changes to the State Insurance and Risk Management Board, which determines how the state insures itself against losses and purchases insurance to obtain the broadest coverage at the most reasonable cost. The act (1) adds a gubernatorial appointee to the board, bringing its total membership to 13; (2) requires that eight, rather than seven, members be qualified by training and experience; (3) increases, from six to eight, the maximum number of members who may belong to the same political party; and (4) removes the prohibition on members serving more than two consecutive terms.

EFFECTIVE DATE: Upon passage

## **TAX CREDITS**

[PA 15-244, § 85](#), extends, to 2015 and 2016, the temporary cap on the maximum insurance premium tax liability that an insurer may offset through tax credits.

EFFECTIVE DATE: Upon passage and applicable to calendar years

commencing on or after January 1, 2015.

[PA 15-244, § 171](#), makes several changes in the Insurance Reinvestment Act program, including increasing the aggregate cap on Insurance Reinvestment Act tax credits by \$150 million, from \$200 million to \$350 million. It does not change the program's \$40 million annual cap. The credits apply to the insurance premium tax, and insurers qualify for them by investing in eligible businesses through state-certified business investment funds, called "Invest CT Funds." (Prior law named them "Insurance Investment Funds.")

EFFECTIVE DATE July 1, 2015

## **UNAUTHORIZED INSURERS AND SURPLUS LINES INSURANCE**

[PA 15-166](#) specifies that the Unauthorized Insurers Act allows nonadmitted or unauthorized insurers to open an office in Connecticut to transact surplus lines insurance. By law, a nonadmitted or unauthorized insurer is one that has not been granted a certificate of authority by the insurance commissioner to transact insurance business in Connecticut. Surplus lines insurance is property and casualty insurance coverage that is unavailable from Connecticut-licensed insurers (i.e., admitted insurers) and must therefore be purchased from a nonadmitted insurer.

EFFECTIVE DATE: October 1, 2015

## **WORKERS' COMPENSATION**

**PA 15-5, June Special Session, § 52**, requires an employer who uses an approved medical provider list to provide a copy of it to an injured employee within two business days after the employee reports a work-related injury or condition to the employer.

EFFECTIVE DATE: July 1, 2015

**PA 15-5, June Special Session, § 459**, requires certain workers' compensation-related hospital charges to be determined according to the hospital's actual costs of treating an injured worker, as determined by a workers' compensation commissioner and not according to the Office of Health Care Access (OHCA) statutes. (In March 2015, the state Supreme Court upheld a compensation commissioner's decision that a workers' compensation payor must pay a hospital's billed charges because the law's requirement to pay actual costs had been superseded by hospital deregulation laws in the OHCA statutes.)

The act also creates a one-year deadline for filing disputes over a hospital's workers' compensation-related charges, unless an applicable law or rule requires a shorter timeframe.

EFFECTIVE DATE: Upon passage

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