



Substitute House Bill No. 6655

Public Act No. 05-238

**AN ACT CONCERNING GROUPS COVERED UNDER THE STATE
EMPLOYEE HEALTH PLAN AND ASSOCIATION GROUP PLANS.**

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

Section 1. Subsection (i) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(i) The Comptroller may provide for coverage of employees of municipalities, nonprofit corporations, community action agencies and small employers and individuals eligible for a health coverage tax credit, retired members or members of an association for personal care assistants under the plan or plans procured under subsection (a) of this section, provided: (1) Participation by each municipality, nonprofit corporation, community action agency, [or] small employer, [or] eligible individual, retired member or association for personal care assistants shall be on a voluntary basis; (2) where an employee organization represents employees of a municipality, nonprofit corporation, community action agency or small employer, participation in a plan or plans to be procured under subsection (a) of this section shall be by mutual agreement of the municipality, nonprofit corporation, community action agency or small employer and the employee organization only and neither party may submit the

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issue of participation to binding arbitration except by mutual agreement if such binding arbitration is available; (3) no group of employees shall be refused entry into the plan by reason of past or future health care costs or claim experience; (4) rates paid by the state for its employees under subsection (a) of this section are not adversely affected by this subsection; (5) administrative costs to the plan or plans provided under this subsection shall not be paid by the state; (6) participation in the plan or plans in an amount determined by the state shall be for the duration of the period of the plan or plans, or for such other period as mutually agreed by the municipality, nonprofit corporation, community action agency, small employer, retired member or association for personal care assistants and the Comptroller; and (7) nothing in [public act 03-6 of the June 30 special session*] this section or section 12-202a, as amended by this act, 38a-551, 38a-553 or 38a-556 shall be construed as requiring a participating insurer or health care center to issue individual policies to individuals eligible for a health coverage tax credit. The coverage provided under this section may be referred to as the "Municipal Employee Health Insurance Plan". The Comptroller may arrange and procure for the employees and eligible individuals under this subsection health benefit plans that vary from the plan or plans procured under subsection (a) of this section. Notwithstanding any provision of [law] part V of chapter 700c, the coverage provided under this subsection may be offered [to employees] on either a fully underwritten or risk-pooled basis at the discretion of the Comptroller. [, except that coverage offered to small employers shall be fully underwritten in accordance with part V of chapter 700c.] For the purposes of this subsection, (A) "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, regional emergency telecommunications center, tourism district established under section 32-302, flood commission or

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authority established by special act, regional planning agency, transit district formed under chapter 103a, or the Children's Center established by number 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a nonprofit corporation organized under 26 USC [501(c)(3)] 501 that has a contract with the state or receives a portion of its funding from a municipality, the state or the federal government, or (ii) an organization that is tax exempt pursuant to 26 USC 501(c)(5); (C) "community action agency" means a community action agency, as defined in section 17b-885; (D) "small employer" means a small employer, as defined in subparagraph (A) of subdivision (4) of section 38a-564, as amended by this act; (E) "eligible individuals" or "individuals eligible for a health coverage tax credit" means [persons] individuals who are eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210); [and] (F) "association for personal care assistants" means an organization composed of personal care attendants who are employed by recipients of service (i) under the home-care program for the elderly under section 17b-342, (ii) under the personal care assistance program under section 17b-605a, (iii) in an independent living center pursuant to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for individuals with acquired brain injury as described in section 17b-260a; and (G) "retired members" means individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system.

Sec. 2. Section 12-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005, and applicable to income years commencing on or after January 1, 2005*):

(a) Each health care center, as defined in section 38a-175, that is

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governed by sections 38a-175 to 38a-192, inclusive, shall pay a tax to the Commissioner of Revenue Services for the calendar year commencing on January 1, 1995, and annually thereafter, at the rate of one and three-quarters per cent of the total net direct subscriber charges received by such health care center during each such calendar year on any new or renewal contract or policy approved by the Insurance Commissioner under section 38a-183. Such payment shall be in addition to any other payment required under section 38a-48.

(b) Notwithstanding the provisions of subsection (a) of this section, the tax shall not apply to:

(1) Any new or renewal contract or policy entered into with the state on or after July 1, 1997, to provide health care coverage to state employees, retirees and their dependents;

(2) [any] Any subscriber charges received from the federal government to provide coverage for Medicare patients;

(3) [any] Any subscriber charges received under a contract or policy entered into with the state to provide health care coverage to Medicaid recipients under the Medicaid managed care program established pursuant to section 17b-28, which charges are attributable to a period on or after January 1, 1998;

(4) [any] Any new or renewal contract or policy entered into with the state on or after April 1, 1998, to provide health care coverage to eligible beneficiaries under the HUSKY Medicaid Plan Part A, HUSKY Part B, or the HUSKY Plus programs, each as defined in section 17b-290;

(5) [any] Any new or renewal contract or policy entered into with the state on or after April 1, 1998, to provide health care coverage to recipients of state-administered general assistance pursuant to section 17b-192;

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(6) [any] Any new or renewal contract or policy entered into with the state on or after February 1, 2000, to provide health care coverage to retired teachers, spouses or surviving spouses covered by plans offered by the state teachers' retirement system;

(7) [any] Any new or renewal contract or policy entered into on or after July 1, 2001, to provide health care coverage to employees of a municipality and their dependents under a plan procured pursuant to section 5-259, as amended by this act;

(8) [any] Any new or renewal contract or policy entered into on or after July 1, 2001, to provide health care coverage to employees of nonprofit organizations and their dependents under a plan procured pursuant to section 5-259, as amended by this act; [or]

(9) [any] Any new or renewal contract or policy entered into on or after July 1, 2003, to provide health care coverage to individuals eligible for a health coverage tax credit and their dependents under a plan procured pursuant to section 5-259, as amended by this act;

(10) Any new or renewal contract or policy entered into on or after July 1, 2005, to provide health care coverage to employees of community action agencies and their dependents under a plan procured pursuant to section 5-259, as amended by this act; or

(11) Any new or renewal contract or policy entered into on or after July 1, 2005, to provide health care coverage to retired members and their dependents under a plan procured pursuant to section 5-259, as amended by this act.

(c) The provisions of this chapter pertaining to the filing of returns, declarations, installment payments, assessments and collection of taxes, penalties, administrative hearings and appeals imposed on domestic insurance companies shall apply with respect to the charge imposed under this section.

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Sec. 3. Subdivision (4) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(4) (A) "Small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual. In determining the number of eligible employees, companies which are affiliated companies, as defined in section 33-840, or which are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer. Eligible employees shall not include employees covered through the employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act. Except as otherwise specifically provided, provisions of sections 12-201, 12-211, 12-212a and 38a-564 to 38a-572, inclusive, as amended by this act, which apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(B) "Small employer" does not include [(A)] (i) a municipality procuring health insurance pursuant to section 5-259, as amended by this act, [(B)] (ii) a private school in this state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, [(C)] (iii) a nonprofit organization procuring health insurance pursuant to section 5-259, as amended by this act, unless the Secretary of the Office of Policy and Management and the State Comptroller make a request

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in writing to the Insurance Commissioner that such nonprofit organization be deemed a small employer for the purposes of this chapter, [or (D)] (iv) an association for personal care assistants procuring health insurance pursuant to section 5-259, as amended by this act, or (v) a community action agency procuring health insurance pursuant to section 5-259, as amended by this act.

Sec. 4. Subdivisions (5) and (6) of section 38a-567 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(5) (A) With respect to plans or arrangements issued on or after July 1, 1995, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

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(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, as amended by this act, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions; [and]

(vii) Savings resulting from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259, as amended by this act, provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; and

[(vii)] (viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

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(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

Sec. 5. Section 38a-567 of the general statutes is amended by adding subdivision (22) as follows (*Effective from passage*):

(NEW) (22) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, as amended by this act, or by an association group plan, at the option of the Comptroller or the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (A) the plan or plans offered or issued cover such small employers as a single entity and cover not less than ten thousand eligible individuals on the date issued, (B) each small employer is charged or offered the same premium rate with respect to each eligible individual and dependent, and (C) the plan or plans are written on a guaranteed issue basis.

Sec. 6. Subsection (b) of section 38a-569 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Any member may reinsure with the pool coverage of an eligible

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employee of a small employer, or any dependent of such an employee, except that no member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, whose premium rates are not subject to section 38a-567, as amended by this act, pursuant to subdivision (22) of section 38a-567, as amended by this act. Any reinsurance placed with the pool from the date of the establishment of the pool regarding the coverage of an eligible employee of a small employer, or any dependent of such an employee shall be provided as follows:

(1) (A) With respect to a special health care plan or a small employer health care plan, the pool shall reinsure the level of coverage provided; (B) with respect to other plans, the pool shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer health care plan or the actuarial equivalent thereof as defined and authorized by the board; and (C) in either case, no reinsurance may be provided in any calendar year for a reinsured employee or dependent until five thousand dollars in benefit payments have been made for services provided during that calendar year for that reinsured employee or dependent, which payments would have been reimbursed through said reinsurance in the absence of the annual five-thousand-dollar deductible. The amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board;

(2) With respect to eligible employees, and their dependents, coverage may be reinsured: (A) Within such period of time after the commencement of their coverage under the plan as may be authorized by the board, or (B) commencing January 1, 1992, on the first plan anniversary after the employer's coverage has been in effect with the small employer carrier for a period of three years, and every third plan anniversary thereafter, provided, commencing May 1, 1994, reinsurance pursuant to this subparagraph shall only be permitted

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with respect to eligible employees and their dependents of a small employer which has no more than two eligible employees as of the applicable anniversary;

(3) Reinsurance coverage may be terminated for each reinsured employee or dependent on any plan anniversary; [and]

(4) Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth; [.] and

(5) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection: (A) Coverage for eligible employees and their dependents provided under a group policy covering two or more small employers shall not be eligible for reinsurance when such coverage is discontinued and replaced by a group policy of another carrier covering two or more small employers, unless coverage for such eligible employees or dependents was reinsured by the prior carrier; and (B) at the time coverage is assumed for such group by a succeeding carrier, such carrier shall notify the pool of its intention to provide coverage for such group and shall identify the employees and dependents whose coverage will continue to be reinsured. The time limitations for providing such notice shall be established by the pool.

Sec. 7. (NEW) (*Effective October 1, 2005*) (a) The Insurance Commissioner shall approve any health insurance policy or contract, including, but not limited to, a policy or contract filed by a health care center, that uses variable networks and enrollee cost-sharing as set forth in subsection (b) of this section if (1) the policy or contract meets the requirements of title 38a of the general statutes, (2) the policy or contract form or amendment thereto filed with the commissioner is accompanied by a rate filing for the policy or contract and (3) the commissioner finds that the rate filing reflects a reasonable reduction

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in premiums or fees as compared to policies or contracts that do not use such variable networks and enrollee cost-sharing.

(b) Such policies and contracts shall be limited to policies and contracts that: (1) Offer choices among provider networks of different size; (2) offer different deductibles depending on the type of health care facility used; or (3) offer prescription drug benefits that use any combination of deductibles, coinsurance not to exceed thirty per cent or copayments, including combinations of such deductibles, coinsurance or copayments at different benefit levels.

Approved July 8, 2005