



General Assembly

Substitute Bill No. 7263

January Session, 2007

* _____ HB07263JUD__042407_____ *

AN ACT CONCERNING HEALTH CARE CENTERS AND INSOLVENCY PROTECTION.

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

1 Section 1. Section 38a-193 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2007*):

3 (a) (1) Before issuing any certificate of authority to any health care
4 center on or after July 1, 1990, the commissioner shall require that a
5 health care center have: (A) An initial net worth of one million five
6 hundred thousand dollars, and (B) agree to thereafter maintain the
7 minimum net worth required under subdivision (4) of this subsection.

8 (2) No health care center shall be licensed to transact business in this
9 state or remain so licensed unless, (A) its net worth bears a reasonable
10 relationship to its liabilities based upon the type, volume and nature of
11 business transacted, and (B) its risk-based capital related to its total
12 adjusted capital is adequate for the type of business transacted. As
13 used in this subsection, "total adjusted capital" means the sum of a
14 health care center's net worth and any other item in the nature of
15 capital as deemed appropriate by the commissioner; and "risk-based
16 capital" means the net worth of the health care center adjusted to
17 recognize the level of risk inherent in its business, including (i) risk
18 with respect to the health care center's assets, (ii) the risk of adverse
19 underwriting experience with respect to the health care center's

20 liabilities and obligations, (iii) the credit risk with respect to the health
21 care center's business, and (iv) all other business risks and such other
22 relevant risks as the commissioner may determine.

23 (3) (A) In determining net worth, no debt shall be considered fully
24 subordinated unless the subordination clause is in a form acceptable to
25 the commissioner. Any interest obligation relating to the repayment of
26 any subordinated debt must be similarly subordinated. (B) The interest
27 expenses relating to the repayment of any fully subordinated debt
28 shall not be considered uncovered expenditures. (C) Any debt incurred
29 by a note meeting the requirements of this section, and otherwise
30 acceptable to the commissioner, shall not be considered a liability and
31 shall be recorded as equity.

32 (4) Except as provided in subdivision (3) and subdivisions (5) to (7),
33 inclusive, of this subsection, each health care center shall maintain a
34 minimum net worth equal to the greater of: (A) One million dollars; or
35 (B) two per cent of its annual premium revenues as reported on the
36 most recent annual financial statement filed with the commissioner on
37 the first one hundred fifty million dollars of premium revenues plus
38 one per cent of annual premium revenues in excess of one hundred
39 fifty million dollars. No health care center authorized by the
40 commissioner to do business in this state, on July 1, 1990, shall be
41 required to comply with the provisions of subparagraph (B) of this
42 subdivision until January 1, 1995.

43 (5) Each health care center that offers or proposes to offer out-of-
44 network benefits shall either:

45 (A) Enter into an agreement with a duly licensed insurance
46 company to provide coverage to subscribers and enrollees outside of
47 the health care center's established network, subject to approval by the
48 commissioner; or

49 (B) Implement an out-of-network benefit system to be operated by
50 the health care center, subject to approval by the commissioner,
51 provided the health care center establishes and maintains its net worth

52 at an amount equal to the greater of (i) three million dollars, (ii) two
53 per cent of its annual premium revenues as reported on the most
54 recent annual financial statement filed with the commissioner on the
55 first one hundred fifty million dollars of premium revenues plus one
56 per cent of annual premium revenues in excess of one hundred fifty
57 million dollars, or (iii) two months of its cost of uncovered
58 expenditures. For purposes of this subsection, "annual premium
59 revenues" does not include revenue earned as a result of an
60 arrangement between a health care center and the federal Centers for
61 Medicare and Medicaid Services, on a cost or risk basis, for services to
62 a Medicare beneficiary, or revenue earned as a result of an
63 arrangement between a health care center and a Medicaid state agency,
64 for services to a Medicaid beneficiary. For the purposes of this
65 subsection, the uncovered expenditures of the health care center for
66 the requisite two-month period shall be calculated as follows:

T1
T2
T3

$$UE = \frac{(X + Y - Z)}{6}$$

67 Where:

68 UE = Uncovered expenditures of the health care center for the
69 requisite two-month period.

70 X = Total year-to-date uncovered expenditures reported in the
71 health care center's most recent statutory quarterly or annual
72 statement.

73 Y = Total year-to-date uncovered expenditures reported in the
74 health care center's annual statement for the prior calendar year.

75 Z = Total year-to-date uncovered expenditures reported in the
76 health care center's statutory quarterly or annual statement for the
77 current calendar quarter of the prior calendar year.

78 (6) The total cost of the out-of-network benefits of a health care
79 center shall not exceed ten per cent of the total cost of the health care
80 center's claims and expenses on a quarterly basis without the prior
81 approval of the commissioner and the effectuation of an uncovered
82 expenditures insolvency deposit established with the commissioner
83 pursuant to section 2 of this act.

84 (7) Any health care center that provides out-of-network benefits
85 pursuant to this subsection shall provide a quarterly report concurrent
86 with filing of the required quarterly and annual financial statements
87 which shall demonstrate compliance with the provisions of this
88 subsection.

89 (8) The commissioner may adopt regulations, in accordance with
90 chapter 54, to implement the purposes of this subsection, including,
91 but not limited to, provisions concerning: (A) The preparation and
92 filing of reports by health care centers relating to risk-based capital
93 levels and the calculation thereof; (B) the preparation and filing of
94 comprehensive financial plans when such capital levels are reduced
95 below minimum threshold levels; (C) the confidentiality of such
96 reports and plans; and (D) the regulatory corrective actions the
97 commissioner may take in the event minimum risk-based capital levels
98 are not maintained, or the health care center's financial plans filed with
99 the commissioner are deficient, or the health care center fails to
100 otherwise comply with the provisions of the regulations.

101 (b) Every health care center shall, when determining liabilities,
102 include an amount estimated in the aggregate to provide for any
103 unearned premium and for the payment of all claims for health care
104 expenditures which have been incurred, whether reported or
105 unreported, which are unpaid and for which such organization is or
106 may be liable, and to provide for the expense of adjustment or
107 settlement of such claims. Such liabilities shall be calculated in
108 accordance with those accounting procedures and practices prescribed
109 by the National Association of Insurance Commissioners Accounting
110 Practices and Procedures Manual, version effective January 1, 2001,

111 and subsequent revisions and the National Association of Insurance
112 Commissioners Annual Statement Instructions, subject to any
113 deviations prescribed by the commissioner.

114 (c) (1) Every contract between a health care center and a
115 participating provider of health care services shall be in writing and
116 shall [set forth that in the event the health care center fails to pay for
117 health care services as set forth in the contract, the subscriber or
118 enrollee shall not be liable to the provider for any sums owed by the
119 health care center.] contain the following provisions or variations
120 approved by the Commissioner:

121 "(A) (Name of provider or facility) hereby agrees that in no
122 event, including, but not limited to, nonpayment by (name of health
123 care center), (name of health care center's) insolvency, or breach
124 of this contract shall (name of provider or facility) bill, charge,
125 collect a deposit from, seek compensation, remuneration, or
126 reimbursement from, or have any recourse against a covered person or
127 person acting on their behalf, other than (name of health care center)
128, for services provided pursuant to this contract. This provision shall
129 not prohibit collection of cost-sharing amounts, or costs for
130 noncovered services, which have not otherwise been paid by a primary
131 or secondary carrier in accordance with regulatory standards for
132 coordination of benefits, from covered persons in accordance with the
133 terms of the covered person's health plan.

134 (B) (Name of provider or facility) agrees, in the event of (name of
135 health care center's) insolvency, to continue to provide the services
136 promised in this contract to covered persons of (name of health care
137 center) for the duration of the period for which premiums on behalf
138 of the covered person were paid to (name of health care center) or
139 until the covered person's discharge from inpatient facilities,
140 whichever time is greater.

141 (C) Notwithstanding any other provision in this contract, nothing in
142 this contract shall be construed to modify the rights and benefits

143 contained in the covered person's health plan.

144 (D) (Name of provider or facility) may not bill the covered
145 person for covered services, except for cost-sharing amounts, where
146 (name of health care center) denies payment because the provider
147 or facility has failed to comply with the terms or conditions of this
148 contract.

149 (E) (Name of provider or facility) further agrees (i) that the
150 provisions of subparagraphs (A), (B), (C) and (D) of this subdivision
151 (or citations appropriate to the contract form) shall survive
152 termination of this contract regardless of the cause giving rise to
153 termination and shall be construed to be for the benefit of (name of
154 health care center's) covered persons, and (ii) that this provision
155 supersedes any oral or written contrary agreement now existing or
156 hereafter entered into between (name of provider or facility) and
157 covered persons or persons acting on their behalf.

158 (F) If (name of provider or facility) contracts with other
159 providers or facilities who agree to provide covered services to
160 covered persons of (name of health care center) with the
161 expectation of receiving payment directly or indirectly from (name of
162 health care center) , such providers or facilities shall agree to abide
163 by the provisions of subparagraphs (A), (B), (C), (D) and (E) of this
164 subsection (or citations appropriate to the contract form)"

165 (2) In the event that the participating provider contract has not been
166 reduced to writing as required by this subsection or that the contract
167 fails to contain the [required prohibition] provisions required by
168 subdivision (1) of this subsection, the participating provider shall not
169 collect or attempt to collect from the subscriber or enrollee sums owed
170 by the health care center.

171 (3) No participating provider, or agent, trustee or assignee thereof,
172 may: (A) Maintain any action at law against a subscriber or enrollee to
173 collect sums owed by the health care center; or (B) request payment
174 from a subscriber or enrollee for such sums. For purposes of this

175 subdivision "request payment" includes, but is not limited to,
176 submitting a bill for services not actually owed or submitting for such
177 services an invoice or other communication detailing the cost of the
178 services that is not clearly marked with the phrase "THIS IS NOT A
179 BILL". The contract between a health care center and a participating
180 provider shall inform the participating provider that pursuant to
181 section 20-7f, it is an unfair trade practice in violation of chapter 735a
182 for any health care provider to request payment from an enrollee,
183 other than a copayment or deductible, for covered medical services, or
184 to report to a credit reporting agency an enrollee's failure to pay a bill
185 for medical services when a health care center has primary
186 responsibility for payment of such services.

187 (d) The commissioner shall require that each health care center have
188 a plan for handling insolvency which allows for continuation of
189 benefits for the duration of the contract period for which premiums
190 have been paid and continuation of benefits to members who are
191 confined to inpatient facilities on the date of insolvency until their
192 discharge or expiration of benefits. In considering such a plan, the
193 commissioner may approve one or more of the following: (1) Insurance
194 to cover the expenses to be paid for continued benefits after an
195 insolvency; (2) provisions in provider contracts that obligate the
196 provider to provide services after the health care center's insolvency
197 for the duration of the period for which premium payment has been
198 made and until the enrollees' discharge from inpatient facilities; (3)
199 insolvency reserves; (4) acceptable letters of credit; or (5) any other
200 arrangements to assure that benefits are continued as specified above.

201 (e) Every agreement to provide health care services between a
202 provider and a health care center shall require the provider to provide
203 at least sixty days' advance notice to the health care center to terminate
204 the agreement.

205 (f) (1) Unless otherwise provided in this subsection, each health care
206 center shall deposit with the commissioner or, at the discretion of the
207 commissioner, with any organization or trustee acceptable to the

208 commissioner through which a custodian or controlled account is
209 utilized, cash, securities or any combination of cash or securities or
210 other measures that are acceptable to the commissioner, which at all
211 times shall have a value of not less than five hundred thousand
212 dollars.

213 (2) A health care center that is in operation on October 1, 2007, shall
214 make a deposit equal to two hundred fifty thousand dollars. In the
215 second year, the amount of the additional deposit for a health care
216 center that is in operation on October 1, 2007, shall be equal to two
217 hundred fifty thousand dollars, for a total of five hundred thousand
218 dollars.

219 (3) The deposit shall be an admitted asset of the health care center in
220 the determination of net worth.

221 (4) All income from deposits shall be an asset of the organization. A
222 health care center that has made a securities deposit may withdraw
223 such deposit or any part thereof after making a substitute deposit of
224 cash, securities or any combination of cash or securities or other
225 measures of equal amount and value. Any securities shall be approved
226 by the commissioner before being deposited.

227 (5) The deposit shall be used to protect the interests of the health
228 care center's enrollees and to assure continuation of health care
229 services to enrollees of a health care center that is in rehabilitation or
230 conservation. The commissioner may use the deposit for
231 administrative costs directly attributable to a receivership or
232 liquidation. If the health care center is placed in rehabilitation or
233 liquidation, the deposit shall be an asset subject to the provisions of the
234 Insurers Rehabilitation and Liquidation Act.

235 Sec. 2. (NEW) (Effective October 1, 2007) (a) If at any time uncovered
236 expenditures exceed ten per cent of total health care expenditures, a
237 health care center shall place an uncovered expenditures insolvency
238 deposit with the Insurance Commissioner or with an organization or
239 trustee acceptable to the commissioner through which a custodial or

240 controlled account is maintained, cash or securities that are acceptable
241 to the commissioner. The deposit shall at all times have a fair market
242 value in an amount of one hundred twenty per cent of the health care
243 center's outstanding liability for uncovered expenditures for enrollees
244 in this state, including incurred but not reported claims, and shall be
245 calculated as of the first day of the month and maintained for the
246 remainder of the month. If a health care center is not otherwise
247 required to file a quarterly report, it shall file a report not later than
248 forty-five days after the end of the calendar quarter with information
249 sufficient to demonstrate compliance with this section.

250 (b) The deposit required under this section is in addition to the
251 deposit required under subsection (f) of section 38a-193 of the general
252 statutes, as amended by this act, and is an admitted asset of the health
253 care center in the determination of net worth. All income from deposits
254 or trust accounts shall be assets of the health care center and may be
255 withdrawn from the deposit or account quarterly with the approval of
256 the commissioner.

257 (c) A health care center that has made a deposit, may withdraw such
258 deposit or any part of such deposit, if (1) a substitute deposit of cash or
259 securities of equal amount and value is made, (2) the fair market value
260 exceeds the amount of the required deposit, or (3) the required deposit
261 under subsection (a) of this section is reduced or eliminated. Deposits,
262 substitutions or withdrawals may be made only with the prior written
263 approval of the commissioner.

264 (d) The deposit required under this section shall be held in trust
265 separate and apart from all other moneys, funds and accounts and
266 may be used only as provided under this section. The commissioner
267 may use the deposit of an insolvent health care center for
268 administrative costs associated with administering the deposit and
269 payment of claims of enrollees of this state for uncovered expenditures
270 in this state. Claims for uncovered expenditures shall be paid on a pro
271 rata basis based on assets available to pay the ultimate liability for
272 incurred expenditures. Partial distribution may be made pending final

273 distribution. Any amount of the deposit remaining shall be paid into
274 the liquidation or receivership of the health care center.

275 (e) The commissioner may, by regulation adopted in accordance
276 with chapter 54 of the general statutes, prescribe the time, manner and
277 form for filing claims under subsection (d) of this section.

278 (f) The commissioner may, by regulation adopted in accordance
279 with chapter 54 of the general statutes, or by order, require a health
280 care center to file annual, quarterly or more frequent reports deemed
281 necessary to demonstrate compliance with this section. The
282 commissioner may require that the reports include liability for
283 uncovered expenditures as well as an audit opinion.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2007</i>	38a-193
Sec. 2	<i>October 1, 2007</i>	New section

INS *Joint Favorable Subst.-LCO*

JUD *Joint Favorable*