



House of Representatives

General Assembly

File No. 207

February Session, 2008

Substitute House Bill No. 5709

House of Representatives, March 26, 2008

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING ACCESS TO QUALITY AND AFFORDABLE HEALTH CARE.

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

1 Section 1. (NEW) (*Effective January 1, 2009*) (a) Notwithstanding the
2 provisions of title 38a of the general statutes, any insurer, health care
3 center, hospital service corporation, medical service corporation or
4 other entity delivering, issuing for delivery, renewing, continuing or
5 amending any individual health insurance policy or certificate in this
6 state on or after January 1, 2009, may establish not more than five
7 health insurance plans that shall be exempt from the health insurance
8 mandates required by title 38a of the general statutes.

9 (b) Such plans shall be approved by the Insurance Commissioner
10 and shall contain the following minimum coverages or benefits:

11 (1) The coverages or benefits set forth in section 38a-503c of the
12 general statutes, subsection (c) of section 38a-504 of the general statutes

13 and subsection (c) of section 38a-505 of the general statutes; or

14 (2) (A) The coverages or benefits set forth in subdivision (2) of
15 subsection (b) of section 38a-476 of the general statutes, sections 38a-
16 476b, 38a-483c, 38a-489, 38a-496, 38a-498a, 38a-502, 38a-503b and 38a-
17 503c of the general statutes, subsection (c) of section 38a-504 of the
18 general statutes and subsection (c) of section 38a-505 of the general
19 statutes; and

20 (B) Offers the following coverages or benefits set forth in sections
21 38a-488a, 38a-490 to 38a-490c, inclusive, 38a-491a, 38a-492 to 38a-493,
22 inclusive, 38a-498, 38a-503, 38a-503d, 38a-503e of the general statutes
23 or the 2008 supplement to the general statutes, subsections (a) and (b)
24 of section 38a-504 of the general statutes, sections 38a-504a to 38a-504g,
25 inclusive, and sections 38a-507 to 38a-509, inclusive, of the general
26 statutes or the 2008 supplement to the general statutes as options,
27 provided the insurer, at the time of initial issuance and upon renewal,
28 shall offer the options specified in this subparagraph, including a
29 description of the coverages of benefits and the cost associated with
30 each such coverage or benefit. The insurer shall receive the acceptance
31 or declination of the options by the insured in writing.

32 (c) Notwithstanding the provisions of title 38a of the general
33 statutes, the commissioner may approve any group health insurance
34 policy or certificate that does not contain all the minimum mandated
35 coverages or benefits set forth in title 38a of the general statutes,
36 provided such policy or certificate is approved only for issue to the
37 ineligible population in the state. For the purpose of this subsection,
38 "ineligible population" means (1) part-time employees, seasonal
39 employees and independent contractors who are not eligible to
40 participate in a group health insurance policy offered by an employer
41 or in any other group health insurance policy, as determined by the
42 commissioner, and (2) retired employees under the age of sixty-five
43 who are not eligible to participate in a group health insurance policy
44 offered by a former employer or in any other group health insurance
45 policy, as determined by the commissioner.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2009</i>	New section

Statement of Legislative Commissioners:

In subsection (b)(1)(B) the references to the 2008 supplement to the general statutes following the string citations were added for clarity.

INS *Joint Favorable Subst.-LCO*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill will result in no fiscal impact to the Department of Insurance (DOI). It allows insurers to establish up to five plans that are exempt from Connecticut's health insurance mandates, follow one of two allowable formats, and procure approval for these plans from the DOI commissioner. The DOI commissioner's responsibility is anticipated to be handled within existing resources.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis**sHB 5709*****AN ACT CONCERNING ACCESS TO QUALITY AND AFFORDABLE HEALTH CARE.*****SUMMARY:**

The bill permits an insurer or other entity (e.g., HMO), if delivering, issuing, renewing, continuing, or amending individual health insurance policies or certificates on or after January 1, 2009, to establish up to five plans that (1) are exempt from Connecticut's health insurance mandates and (2) follow one of two formats (see below). It requires the insurance commissioner to approve the plans.

It also authorizes the commissioner to approve group health insurance policies and certificates that do not include all of Connecticut's mandated benefits if they are available only to Connecticut's "ineligible population." The bill defines this population as independent contractors and part-time, seasonal, and retired employees who are not otherwise eligible for group health insurance.

EFFECTIVE DATE: January 1, 2009

FIRST INDIVIDUAL PLAN FORMAT

The bill permits an individual health insurer to create a plan that is exempt from state health insurance mandates, if it contains at least the following coverage or benefits:

1. minimum benefits set out in regulation for hospital, medical-surgical, major medical, disability income, accident, and specified accident coverage (CGS § 38a-505(c));
2. minimum hospital stay and related maternity and newborn benefits if the plan includes maternity benefits (CGS § 38a-503c);

and

3. post-mastectomy reconstructive breast surgery benefits (CGS § 38a-504(c)).

(Breast reconstruction and maternity hospital stay benefits are based on federal requirements.)

SECOND INDIVIDUAL PLAN FORMAT

The bill permits an insurer to create a plan that is exempt from Connecticut's health insurance mandates, if it includes, (1) certain identified mandated benefits and (2) other benefits the insured individual elects from a list that the bill requires the insurer to offer. It requires the insurer, when first issuing this plan and at each renewal, to offer the optional benefits (which under current law are mandatory benefits) and obtain, for each benefit, the insured's acceptance or refusal in writing. The offer must describe each benefit and its associated cost.

Mandatory Benefits

The bill requires the plan to contain at least the following coverage or benefits:

1. minimum benefits set out in regulation for hospital, medical-surgical, major medical, disability income, accident, and specified accident coverage (CGS § 38a-505(c));
2. minimum hospital stay and related maternity and newborn benefits if the plan includes maternity benefits (CGS § 38a-503c);
3. post-mastectomy reconstructive breast surgery (CGS § 38a-504(c));
4. a preexisting benefit exclusion that cannot last more than 12 months (CGS § 38a-476(b)(2));
5. mental health benefits that cannot limit the availability of the most effective psychotropic drugs (CGS § 38a-476b);

6. experimental treatments that have completed a Phase III FDA clinical trial (CGS § 38a-483c);
7. handicapped dependent children's coverage (CGS § 38a-489);
8. occupational therapy (CGS § 38a-496);
9. no preauthorization for 9-1-1 emergency calls (CGS § 38a-498a);
10. Veteran's Home and Hospital services (CGS § 38a-502); and
11. direct access to an obstetrician-gynecologist (CGS § 38a-503b).

Optional Benefits

The bill requires the insurer to offer the individual the benefits specified in the following statutes:

1. mental health services (CGS § 38a-488a);
2. newborn and adopted children's coverage (CGS §§ 38a-490 and 38a-508);
3. early childhood intervention services ("birth-to-three") (CGS § 38a-490a);
4. hearing aids for children under age 13 (CGS § 38a-490b);
5. orthodontic processes and appliances to treat craniofacial disorders in children under age 19 (CGS § 38a-490c);
6. anesthesia and related hospital care for dental services (CGS § 38a-491a);
7. emergency medical care for accidental ingestion or consumption of controlled drugs (CGS § 38a-492);
8. prescribed hypodermic needles and syringes (CGS § 38a-492a);
9. off-label cancer drugs (a drug recognized for treating a specific type of cancer but prescribed for another) (CGS § 38a-492b);

10. modified food products, including specialized formula for children up to age 12, to treat inherited metabolic diseases, including cystic fibrosis (CGS § 38a-492c);
11. diabetes lab and diagnostic testing, self-management training, equipment, drugs, and supplies (CGS §§ 38a-492d and 38a-492e);
12. prescription drugs removed from a formulary but used for a patient's chronic disease treatment (CGS § 38a-492f);
13. prostate cancer screening for men over age 50 or with symptoms or family history (CGS § 38a-492g);
14. Lyme disease treatment (CGS § 38a-492h);
15. pain treatment that a pain management specialist orders (CGS § 38a-492i);
16. ostomy-related appliances and supplies if the plan covers ostomy surgery (CGS § 38a-492j);
17. colorectal cancer screening (CGS § 38a-492k);
18. child cancer patient's neuropsychological testing (CGS § 38a-492l);
19. home health care (CGS § 38a-493);
20. ambulance service (CGS § 38a-498);
21. mammograms for women over age 34 and ultrasounds for women with dense breasts or an increased breast cancer risk (CGS § 38a-503);
22. minimum hospital stay after mastectomy (CGS § 38a-503d);
23. contraceptives if the plan covers prescriptions (CGS § 38a-503e);
24. treatment of leukemia and tumors, outpatient chemotherapy,

reconstructive surgery, non-dental prosthesis, and wigs for chemotherapy patients (CGS §§ 38a-504(a) and 38a-504(b));

- 25. cancer clinical trials (CGS §§ 38a-504a to 38a-504g);
- 26. chiropractic services (CGS § 38a-507); and
- 27. infertility testing and treatment (CGS § 38a-508).

GROUP POLICY FOR INELIGIBLE POPULATION

The bill permits the insurance commissioner to approve group health insurance policies or certificates that do not comply with state benefit mandates for Connecticut’s ineligible population.

“Ineligible population” means (1) part-time employees, seasonal employees, and independent contractors who are not eligible for an employer-sponsored or other group health insurance policy and (2) retired employees under age 65 who are not eligible for a former employer’s or other group health insurance policy. The bill permits the insurance commissioner to determine what constitutes “other group health insurance.”

BACKGROUND

Related Bills

The Insurance and Real Estate Committee reported:

- 1. sHB 5696, requiring insurance coverage for autism;
- 2. sSB 478, requiring full insurance coverage for preventive care;
- 3. sSB 280, requiring (a) insurance coverage for bone marrow testing and prosthetics, and (b) a cost-benefit study of Connecticut health insurance mandates; and
- 4. sHB 5721, establishing “affordable health care plans.”

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 14 Nay 5 (03/11/2008)