



Senate

General Assembly

File No. 163

February Session, 2012

Substitute Senate Bill No. 205

Senate, March 29, 2012

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING INSURANCE COVERAGE FOR THE BIRTH-TO-THREE PROGRAM.

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

1 Section 1. Section 38a-490a of the 2012 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2012*):

4 (a) Each individual health insurance policy providing coverage of
5 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
6 38a-469 delivered, issued for delivery, [or] renewed, amended or
7 continued in this state [on or after July 1, 1996,] shall provide coverage
8 for medically necessary early intervention services provided as part of
9 an individualized family service plan pursuant to section 17a-248e.
10 Such policy shall provide coverage for such services provided by
11 qualified personnel, as defined in section 17a-248, for a child from birth
12 until the child's third birthday.

13 (b) No such policy shall impose a coinsurance, copayment,

14 deductible or other out-of-pocket expense for such services, except that
15 a high deductible plan, as that term is used in subsection (f) of section
16 38a-493, shall not be subject to the deductible limits set forth in this
17 section.

18 (c) Such policy shall provide a maximum benefit of six thousand
19 four hundred dollars per child per year and an aggregate benefit of
20 nineteen thousand two hundred dollars per child over the total three-
21 year period.

22 (d) No payment made under this section shall (1) be applied by the
23 insurer, health care center or plan administrator against or result in a
24 loss of benefits due to any maximum lifetime or annual limits specified
25 in the policy, [or health benefits plan] (2) adversely affect the
26 availability of health insurance to the child, the child's parent or the
27 child's family members insured under any such policy, or (3) be a
28 reason for the insurer, health care center or plan administrator to
29 rescind or cancel such policy. Payments made under this section shall
30 not be treated differently than other claim experience for purposes of
31 premium rating.

32 Sec. 2. Section 38a-516a of the 2012 supplement to the general
33 statutes is repealed and the following is substituted in lieu thereof
34 (*Effective July 1, 2012*):

35 (a) Each group health insurance policy providing coverage of the
36 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
37 469 delivered, issued for delivery, [or] renewed, amended or continued
38 in this state [on or after July 1, 1996,] shall provide coverage for
39 medically necessary early intervention services provided as part of an
40 individualized family service plan pursuant to section 17a-248e. Such
41 policy shall provide coverage for such services provided by qualified
42 personnel, as defined in section 17a-248, for a child from birth until the
43 child's third birthday.

44 (b) No such policy shall impose a coinsurance, copayment,
45 deductible or other out-of-pocket expense for such services, except that

46 a high deductible plan, as that term is used in subsection (f) of section
 47 38a-493, shall not be subject to the deductible limits set forth in this
 48 section.

49 (c) Such policy shall provide a maximum benefit of six thousand
 50 four hundred dollars per child per year and an aggregate benefit of
 51 nineteen thousand two hundred dollars per child over the total three-
 52 year period, except that for a child with autism spectrum disorder, as
 53 defined in section 38a-514b, who is receiving early intervention
 54 services as defined in section 17a-248, the maximum benefit available
 55 through early intervention providers shall be fifty thousand dollars per
 56 child per year and an aggregate benefit of one hundred fifty thousand
 57 dollars per child over the total three-year period as provided for in
 58 section 38a-514b. Nothing in this section shall be construed to increase
 59 the amount of coverage required for autism spectrum disorder for any
 60 child beyond the amounts set forth in section 38a-514b. Any coverage
 61 provided for autism spectrum disorder through an individualized
 62 family service plan pursuant to section 17a-248e shall be credited
 63 toward the coverage amounts required under section 38a-514b.

64 (d) No payment made under this section shall (1) be applied by the
 65 insurer, health care center or plan administrator against or result in a
 66 loss of benefits due to any maximum lifetime or annual limits specified
 67 in the policy, [or health benefits plan] (2) adversely affect the
 68 availability of health insurance to the child, the child's parent or the
 69 child's family members insured under any such policy, or (3) be a
 70 reason for the insurer, health care center or plan administrator to
 71 rescind or cancel such policy. Payments made under this section shall
 72 not be treated differently than other claim experience for purposes of
 73 premium rating.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2012	38a-490a
Sec. 2	July 1, 2012	38a-516a

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill adds provisions to insurance coverage for medically necessary early intervention (Birth to Three) services. The bill does not result in a fiscal impact to the commercial insurance revenue received by the state's Birth to Three program that is administered by the Department of Developmental Services (DDS). In FY 11 DDS received \$3.9 million in insurance revenue.

The additional insurance provisions in the bill bring the states' Birth to Three insurance statutes into conformance with recently revised federal (IDEA) regulations that become effective on July 1, 2012. The state's Birth to Three program receives approximately \$4 million annually in federal funding under the Individuals with Disabilities Education Act (IDEA) Part C. The IDEA regulations allow health insurance reimbursement to count toward "maintenance of effort" for state and local funds.

The bill does not result in a fiscal impact to the state employee and retiree health plan and is not anticipated to impact fully insured municipal plans. Due to current federal law, municipalities with self-insured plans are exempt from state health insurance mandates.

The Out Years

State Impact: None

Municipal Impact: None

Sources: *CT Birth to Three, Annual Data Report, 2011*
Federal Register - Vol. 76, No. 188, September 28, 2011

OLR Bill Analysis**sSB 205*****AN ACT CONCERNING INSURANCE COVERAGE FOR THE BIRTH-TO-THREE PROGRAM.*****SUMMARY:**

This bill makes changes in the requirements for individual and group health insurance policies that provide coverage for medically necessary early intervention (birth-to-three) services provided as part of an individualized family service plan.

Current law prohibits payments for birth-to-three services from applying against any maximum lifetime or annual limit in the policy. The bill also prohibits payments from causing:

1. a loss of benefits due to a policy limit,
2. an insured child or family member to be denied health insurance coverage, and
3. a policy rescission or cancellation.

The bill specifies that payments for birth-to-three services must be treated the same as other claim experience for premium rating purposes.

The bill also expands the list of policies that must provide birth-to-three coverage to include certain policies amended or continued in Connecticut, rather than only those delivered, issued, or renewed here.

EFFECTIVE DATE: July 1, 2012

APPLICABILITY

The bill applies to individual and group health insurance policies

delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Birth-to-Three Coverage Requirements

Individual and group health insurance policies must cover at least \$6,400 per child annually for medically necessary birth-to-three services, up to \$19,200 per child over three years. For children with autism receiving birth-to-three services, group health insurance policies must cover at least \$50,000 per child annually, up to \$150,000 per child over three years.

Individual and group policies cannot impose out-of-pocket expenses (e.g., coinsurance, copayments, or deductibles) for birth-to-three services, except for a high deductible health plan designed to be compatible with federally qualified health savings accounts.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/15/2012)