

OFFICE OF LEGISLATIVE RESEARCH  
PUBLIC ACT SUMMARY



**PA 12-44—sSB 205**

*Insurance and Real Estate Committee*

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

**SUMMARY:** This act changes requirements for individual and group health insurance policies that provide coverage for medically necessary early intervention (birth-to-three) services as part of an individualized family service plan.

Existing law prohibits payments for birth-to-three services from applying against any maximum lifetime or annual limit in the policy. The act 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 act specifies that payments for birth-to-three services must be treated the same as other claim experience for premium rating purposes.

The act 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 act 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.,

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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.

OLR Tracking: JLK:RP:JL:ro