



General Assembly

February Session, 2014

**Raised Bill No. 479**

LCO No. 2573



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

**AN ACT CONCERNING THE AUTHORITY AND DUTIES OF THE  
CONNECTICUT HEALTH INSURANCE EXCHANGE AND  
ESTABLISHING CERTAIN STANDARDS FOR CERTAIN STOP LOSS  
INSURANCE POLICIES.**

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

1 Section 1. Subsection (b) of section 38a-1091 of the 2014 supplement  
2 to the general statutes is repealed and the following is substituted in  
3 lieu thereof (*Effective October 1, 2014*):

4 (b) (1) There is established an all-payer claims database program.  
5 The exchange shall: (A) Oversee the planning, implementation and  
6 administration of the all-payer claims database program for the  
7 purpose of collecting, assessing and reporting health care information  
8 relating to safety, quality, cost-effectiveness, access and efficiency for  
9 all levels of health care; (B) ensure that data received from reporting  
10 entities is securely collected, compiled and stored in accordance with  
11 state and federal law; and (C) conduct audits of data submitted by  
12 reporting entities in order to verify its accuracy.

13 (2) The exchange shall seek funding from the federal government,

14 other public sources and other private sources to cover costs associated  
15 with the planning, implementation and administration of the all-payer  
16 claims database program.

17 (3) (A) Upon the adoption of reporting requirements as set forth in  
18 section 38a-1082, a reporting entity shall report health care information  
19 for inclusion in the all-payer claims database in a form and manner  
20 prescribed by the exchange. The exchange may, after notice and  
21 hearing, impose a civil penalty on any reporting entity that fails to  
22 report health care information as prescribed. Such civil penalty shall  
23 not exceed one thousand dollars per day for each day of violation and  
24 shall not be imposed as a cost for the purpose of rate determination or  
25 reimbursement by a third-party payer.

26 (B) The chief executive officer may provide the name of any  
27 reporting entity on which such penalty has been imposed to the  
28 commissioner. After consultation with said officer, the commissioner  
29 may request the Attorney General to bring an action in the superior  
30 court for the judicial district of Hartford to recover any penalty  
31 imposed pursuant to subparagraph (A) of this subdivision.

32 (4) The exchange; [shall: (A) Utilize] (A) Shall utilize data in the all-  
33 payer claims database to provide health care consumers in the state  
34 with information concerning the cost and quality of health care  
35 services that allows such consumers to make economically sound and  
36 medically appropriate health care decisions; and (B) may make data in  
37 the all-payer claims database available in such form as the chief  
38 executive officer of the exchange deems appropriate to [any state  
39 agency, insurer, employer, health care provider, consumer of health  
40 care services or researcher for the purpose of allowing such person or  
41 entity to review such data as it relates to] health care consumers and to  
42 any public and private entity engaged in the review of health care  
43 utilization, health care costs or quality of health care services,  
44 including community and public health assessments. Such disclosure  
45 shall be made in accordance with subdivision (2) of subsection (b) of

46 section 38a-1090. The exchange may set a fee to be charged to each  
47 person or entity [requesting] for access to data stored in the all-payer  
48 claims database.

49 (5) The exchange may (A) in consultation with the All-Payer Claims  
50 Database Advisory Group set forth in subsection (c) of this section,  
51 enter into a contract with a person or entity to plan, implement or  
52 administer the all-payer claims database program, (B) enter into a  
53 contract or take any action that is necessary to obtain fee-for-service  
54 health claims data under the state medical assistance program or  
55 Medicare Part A or Part B, and (C) enter into a contract for the  
56 collection, management or analysis of data received from reporting  
57 entities. Any such contract for the collection, management or analysis  
58 of such data shall expressly prohibit the disclosure of such data for  
59 purposes other than the purposes described in this subdivision.

60 Sec. 2. (NEW) (*Effective October 1, 2014*) (a) Unless expressly  
61 specified, nothing in this section or sections 38a-1080 to 38a-1091,  
62 inclusive, of the general statutes, as amended by this act, and no action  
63 taken by the exchange pursuant to said sections shall be construed to  
64 preempt, supersede or affect the authority of the commissioner to  
65 regulate the business of insurance in the state.

66 (b) All health carriers in the state shall comply with all applicable  
67 health insurance laws of the state and regulations adopted and orders  
68 issued by the commissioner, and all applicable provisions of sections  
69 38a-1083 and 38a-1091 of the general statutes, as amended by this act,  
70 and procedures adopted by the board pursuant to section 38a-1082 of  
71 the general statutes.

72 Sec. 3. Section 38a-1090 of the 2014 supplement to the general  
73 statutes is repealed and the following is substituted in lieu thereof  
74 (*Effective October 1, 2014*):

75 (a) The exchange shall continue as long as it shall have legal  
76 authority to exist pursuant to the general statutes and until its

77 existence is terminated by law. Upon the termination of the existence  
78 of the exchange, all its rights and properties shall pass to and be vested  
79 in the state of Connecticut.

80 (b) The exchange shall be subject to the Freedom of Information Act,  
81 as defined in section 1-200, except that:

82 (1) The following information under sections 38a-1081 to 38a-1089,  
83 inclusive, as amended by this act, shall not be subject to disclosure  
84 under section 1-210: (A) The names and applications of individuals  
85 and employers seeking coverage through the exchange; (B)  
86 individuals' health information; and (C) information exchanged  
87 between the exchange and the (i) Departments of Social Services,  
88 Public Health and Revenue Services, (ii) Insurance Department, (iii)  
89 office of the Comptroller, or (iv) any other state agency that is subject  
90 to confidentiality agreements under contracts entered into with the  
91 exchange; and

92 (2) (A) Any disclosures made pursuant to subdivision (4) of  
93 subsection (b) of section 38a-1091, as amended by this act, of health  
94 information, as defined in 45 CFR 160.103, as amended from time to  
95 time, provided such health information is permitted to be disclosed  
96 under the Health Insurance Portability and Accountability Act of 1996,  
97 P.L. 104-191, as amended from time to time, or regulations adopted  
98 thereunder, shall have identifiers removed, as set forth in 45 CFR  
99 164.514, as amended from time to time; and

100 (B) Any disclosures made pursuant to subdivision (4) of subsection  
101 (b) of section 38a-1091, as amended by this act, of information other  
102 than health information shall be made in a manner to protect the  
103 confidentiality of such other information as required by state and  
104 federal law.

105 [(c) Unless expressly specified, nothing in this section or sections  
106 38a-1080 to 38a-1089, inclusive, and no action taken by the exchange  
107 pursuant to said sections shall be construed to preempt, supersede or

108 affect the authority of the commissioner to regulate the business of  
109 insurance in the state. All health carriers offering qualified health plans  
110 in the state shall comply with all applicable health insurance laws of  
111 the state and regulations adopted and orders issued by the  
112 commissioner.]

113 Sec. 4. Section 38a-1083 of the 2014 supplement to the general  
114 statutes is amended by adding subsection (d) as follows (*Effective*  
115 *October 1, 2014*):

116 (NEW) (d) (1) The chief executive officer of the exchange may  
117 provide to the commissioner the name of any health carrier that fails to  
118 pay any assessment or user fee to the exchange under subdivision (7)  
119 of subsection (c) of this section. The commissioner may, after notice  
120 and hearing, suspend, revoke or refuse to renew a health carrier's  
121 license if the commissioner finds the health carrier failed to pay such  
122 assessment or user fee.

123 (2) Any health carrier aggrieved by the action of the commissioner  
124 in suspending, revoking or refusing to renew a license may appeal  
125 therefrom, in accordance with the provisions of section 4-183 of the  
126 general statutes, except venue for such appeal shall be in the judicial  
127 district of New Britain.

128 Sec. 5. (NEW) (*Effective October 1, 2014*) (a) (1) On and after January  
129 1, 2015, no insurance company shall deliver, issue for delivery or  
130 renew a stop loss insurance policy in this state for health care or  
131 medical benefits that: (A) Has an annual attachment point for claims  
132 incurred per individual covered that is less than forty-five thousand  
133 dollars; (B) for qualified employers that are small employers, as  
134 defined in Section 1304 of the Patient Protection and Affordable Care  
135 Act, P.L. 111-148, as amended from time to time, has an annual  
136 aggregate attachment point that is less than forty-five thousand dollars  
137 or five thousand dollars multiplied by the number of enrolled  
138 employees, whichever is greater; (C) for qualified employers that are

139 large employers, as defined in Section 1304 of the Patient Protection  
140 and Affordable Care Act, P.L. 111-148, as amended from time to time,  
141 has an annual aggregate attachment point that is less than one  
142 hundred twenty per cent of expected claims; or (D) provides direct  
143 coverage for the health care or medical expenses of an enrollee.

144 (2) As used in this section, (A) "attachment point" means the claims  
145 amount incurred by the insured, above which the insurance company  
146 that issued the stop loss insurance policy will incur liability for  
147 payment, and (B) "expected claims" means the claims amount that, in  
148 the absence of a stop loss insurance policy or other insurance coverage,  
149 is projected to be incurred by the insured under its health insurance  
150 policy or medical benefits plan.

151 (b) If an insurance company delivers, issues for delivery or renews  
152 an employer's stop loss insurance policy in this state for health care or  
153 medical benefits that is not prohibited under subsection (a) of this  
154 section, such insurance company shall determine at least annually the  
155 number of such employer's employees.

156 (c) Not later than March fifteenth annually, each insurance company  
157 that delivers, issues for delivery or renews an employer's stop loss  
158 insurance policy in this state for health care or medical benefits that is  
159 not prohibited under subsection (a) of this section shall submit to the  
160 Insurance Commissioner a written certification by an actuary who is a  
161 member in good standing of the American Academy of Actuaries.  
162 Such certification shall include, but is not limited to, (1) a summary of  
163 the records of and actuarial assumptions and methods used by such  
164 company and reviewed by such actuary to establish attachment points  
165 and other applicable determinations related to the stop loss insurance  
166 policy, (2) a statement that the premiums charged by such company  
167 for each such stop loss insurance policy are reasonable in connection  
168 with the risks borne by such company, and (3) a statement that such  
169 company is in compliance with the provisions of this section. Each  
170 such company shall retain a copy of such certification at its principal

171 place of business.

172 (d) The Insurance Commissioner may adopt regulations in  
173 accordance with the provisions of chapter 54 to implement the  
174 provisions of this section.

175 Sec. 6. Section 38a-1080 of the 2014 supplement to the general  
176 statutes is repealed and the following is substituted in lieu thereof  
177 (*Effective October 1, 2014*):

178 For purposes of sections 38a-1080 to [38a-1091] 38a-1092, inclusive,  
179 as amended by this act, and section 2 of this act:

180 (1) "Board" means the board of directors of the Connecticut Health  
181 Insurance Exchange;

182 (2) "Commissioner" means the Insurance Commissioner;

183 (3) "Exchange" means the Connecticut Health Insurance Exchange  
184 established pursuant to section 38a-1081;

185 (4) "Affordable Care Act" means the Patient Protection and  
186 Affordable Care Act, P.L. 111-148, as amended by the Health Care and  
187 Education Reconciliation Act, P.L. 111-152, as both may be amended  
188 from time to time, and regulations adopted thereunder;

189 (5) (A) "Health benefit plan" means an insurance policy or contract  
190 offered, delivered, issued for delivery, renewed, amended or  
191 continued in the state by a health carrier to provide, deliver, pay for or  
192 reimburse any of the costs of health care services.

193 (B) "Health benefit plan" does not include:

194 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),  
195 (14), (15) and (16) of section 38a-469 or any combination thereof;

196 (ii) Coverage issued as a supplement to liability insurance;

197 (iii) Liability insurance, including general liability insurance and  
198 automobile liability insurance;

199 (iv) Workers' compensation insurance;

200 (v) Automobile medical payment insurance;

201 (vi) Credit insurance;

202 (vii) Coverage for on-site medical clinics; or

203 (viii) Other similar insurance coverage specified in regulations  
204 issued pursuant to the Health Insurance Portability and Accountability  
205 Act of 1996, P.L. 104-191, as amended from time to time, under which  
206 benefits for health care services are secondary or incidental to other  
207 insurance benefits.

208 (C) "Health benefit plan" does not include the following benefits if  
209 they are provided under a separate insurance policy, certificate or  
210 contract or are otherwise not an integral part of the plan:

211 (i) Limited scope dental or vision benefits;

212 (ii) Benefits for long-term care, nursing home care, home health  
213 care, community-based care or any combination thereof; or

214 (iii) Other similar, limited benefits specified in regulations issued  
215 pursuant to the Health Insurance Portability and Accountability Act of  
216 1996, P.L. 104-191, as amended from time to time;

217 (iv) Other supplemental coverage, similar to coverage of the type  
218 specified in subdivisions (9) and (14) of section 38a-469, provided  
219 under a group health plan.

220 (D) "Health benefit plan" does not include coverage of the type  
221 specified in subdivisions (3) and (13) of section 38a-469 or other fixed  
222 indemnity insurance if (i) such coverage is provided under a separate  
223 insurance policy, certificate or contract, (ii) there is no coordination

224 between the provision of the benefits and any exclusion of benefits  
225 under any group health plan maintained by the same plan sponsor,  
226 and (iii) the benefits are paid with respect to an event without regard  
227 to whether benefits were also provided under any group health plan  
228 maintained by the same plan sponsor;

229 (6) "Health care services" has the same meaning as provided in  
230 section 38a-478;

231 (7) "Health carrier" means an insurance company, fraternal benefit  
232 society, hospital service corporation, medical service corporation  
233 health care center or other entity subject to the insurance laws and  
234 regulations of the state or the jurisdiction of the commissioner that  
235 contracts or offers to contract to provide, deliver, pay for or reimburse  
236 any of the costs of health care services;

237 (8) "Internal Revenue Code" means the Internal Revenue Code of  
238 1986, or any subsequent corresponding internal revenue code of the  
239 United States, as amended from time to time;

240 (9) "Person" has the same meaning as provided in section 38a-1;

241 (10) "Qualified dental plan" means a limited scope dental plan that  
242 has been certified in accordance with subsection (e) of section 38a-1086;

243 (11) "Qualified employer" has the same meaning as provided in  
244 Section 1312 of the Affordable Care Act;

245 (12) "Qualified health plan" means a health benefit plan that has in  
246 effect a certification that the plan meets the criteria for certification  
247 described in Section 1311(c) of the Affordable Care Act and section  
248 38a-1086;

249 (13) "Qualified individual" has the same meaning as provided in  
250 Section 1312 of the Affordable Care Act;

251 (14) "Secretary" means the Secretary of the United States

252 Department of Health and Human Services;

253 (15) "Small employer" has the same meaning as provided in section  
254 38a-564.

255 Sec. 7. Section 38a-1092 of the 2014 supplement to the general  
256 statutes is repealed and the following is substituted in lieu thereof  
257 (*Effective October 1, 2014*):

258 (a) Not later than March 31, 2014, and quarterly thereafter, the  
259 [Connecticut Health Insurance Exchange board of directors,  
260 established pursuant to section 38a-1081,] board shall report to the  
261 joint standing committees of the General Assembly having cognizance  
262 of matters relating to public health, human services and insurance  
263 concerning health care services provided through the exchange. Such  
264 reports shall include: (1) The number of persons in households with  
265 incomes from one hundred thirty-three per cent up to one hundred  
266 fifty per cent of the federal poverty level who were enrolled in a  
267 qualified health plan at any time on or after January 1, 2014; (2) the  
268 number of persons in households with incomes from one hundred fifty  
269 per cent up to and including two hundred per cent of the federal  
270 poverty level who were enrolled in a qualified health plan at any time  
271 on and after January 1, 2014; (3) the number of persons in households  
272 with incomes from one hundred thirty-three per cent up to and  
273 including two hundred per cent of the federal poverty level who have  
274 been continuously enrolled in a qualified health plan during the  
275 current calendar year; (4) the number of persons in households with  
276 incomes from one hundred thirty-three per cent up to and including  
277 two hundred per cent of the federal poverty level who were enrolled in  
278 a qualified health plan and who subsequently became eligible to  
279 receive benefits under the Medicaid program or whose household  
280 income increased to more than two hundred per cent of the federal  
281 poverty level; (5) the number of persons in households with incomes  
282 from one hundred thirty-three per cent up to and including two  
283 hundred per cent of the federal poverty level who experienced a gap in

284 health care coverage; (6) the cost to the state of providing health care  
285 services to persons identified in subdivision (5) of this subsection and  
286 the cost to such persons to access health care coverage through the  
287 exchange; (7) the cost of the second-lowest-priced silver premium plan  
288 in the exchange; and (8) any other information that said board believes  
289 would be necessary to allow said committees to evaluate the cost and  
290 benefits of a basic health plan.

291 (b) The [Connecticut Health Insurance Exchange board of directors]  
292 board shall include in the first quarterly report submitted each year to  
293 said committees in accordance with subsection (a) of this section, the  
294 number of persons in households with incomes from one hundred  
295 thirty-three up to and including two hundred per cent of the federal  
296 poverty level who were enrolled in a qualified health plan at the end of  
297 the previous calendar year.

298 Sec. 8. Subdivisions (3) and (4) of subsection (c) of section 38a-1081  
299 of the 2014 supplement to the general statutes are repealed and the  
300 following is substituted in lieu thereof (*Effective October 1, 2014*):

301 (3) Appointed board members may not designate a representative to  
302 perform in their absence their respective duties under sections 38a-  
303 1080 to [38a-1091] 38a-1092, inclusive, as amended by this act. The  
304 Governor shall select a chairperson from among the board members  
305 and the board members shall annually elect a vice-chairperson.  
306 Meetings of the board of directors shall be held at such times as shall  
307 be specified in the bylaws adopted by the board and at such other time  
308 or times as the chairperson deems necessary. Any board member who  
309 fails to attend more than fifty per cent of all meetings held during any  
310 calendar year shall be deemed to have resigned from the board.

311 (4) Six board members shall constitute a quorum for the transaction  
312 of any business or the exercise of any power of the exchange. For the  
313 transaction of any business or the exercise of any power of the  
314 exchange, the exchange may act by a majority of the board members

315 present at any meeting at which a quorum is in attendance. No  
 316 vacancy in the membership of the board of directors shall impair the  
 317 right of such board members to exercise all the rights and perform all  
 318 the duties of the board. Except as otherwise provided, any action taken  
 319 by the board under the provisions of sections 38a-1080 to [38a-1091]  
 320 38a-1092, inclusive, as amended by this act, may be authorized by  
 321 resolution approved by a majority of the board members present at  
 322 any regular or special meeting, which resolution shall take effect  
 323 immediately unless otherwise provided in the resolution.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2014</i>	38a-1091(b)
Sec. 2	<i>October 1, 2014</i>	New section
Sec. 3	<i>October 1, 2014</i>	38a-1090
Sec. 4	<i>October 1, 2014</i>	38a-1083
Sec. 5	<i>October 1, 2014</i>	New section
Sec. 6	<i>October 1, 2014</i>	38a-1080
Sec. 7	<i>October 1, 2014</i>	38a-1092
Sec. 8	<i>October 1, 2014</i>	38a-1081(c)(3) and (4)

**Statement of Purpose:**

To (1) allow the Connecticut Health Insurance Exchange to make data in the all-payer claims database available to certain public or private entities, (2) specify that health carriers shall comply with applicable provisions of sections 38a-1083 and 38a-1091 and procedures adopted by the exchange board, (3) authorize the Insurance Commissioner to suspend, revoke or refuse to renew the license of a health carrier that fails to pay an assessment or user fee to the exchange, and (4) establish certain standards for stop loss insurance policies in this state for health care or medical benefits.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*