



General Assembly

Amendment

February Session, 2014

LCO No. 5663

SB0047805663SR0

Offered by:
SEN. KELLY, 21st Dist.

To: Subst. Senate Bill No. 478 File No. 364 Cal. No. 269

(As Amended by Senate Amendment Schedule "(A)")

"AN ACT CONCERNING THE DUTIES OF THE HEALTH REINSURANCE ASSOCIATION AND REQUIREMENTS OF THE CONNECTICUT SMALL EMPLOYER REINSURANCE POOL, UPDATING THE PREEXISTING CONDITIONS STATUTE, AND CONCERNING CERTAIN GROUP HEALTH INSURANCE POLICIES."

1 After the last section, add the following and renumber sections and
2 internal references accordingly:

3 "Sec. 501. Section 38a-1092 of the 2014 supplement to the general
4 statutes is repealed and the following is substituted in lieu thereof
5 (*Effective July 1, 2014*):

6 (a) (1) Not later than March 31, 2014, and quarterly thereafter, the
7 [Connecticut Health Insurance Exchange board of directors,
8 established pursuant to section 38a-1081,] board shall report to the
9 joint standing committees of the General Assembly having cognizance
10 of matters relating to public health, human services and insurance

11 concerning health care services provided through the exchange. Such
12 reports shall include: [(1)] (A) The number of persons in households
13 with incomes from one hundred thirty-three per cent up to one
14 hundred fifty per cent of the federal poverty level who were enrolled
15 in a qualified health plan at any time on or after January 1, 2014; [(2)]
16 (B) the number of persons in households with incomes from one
17 hundred fifty per cent up to and including two hundred per cent of the
18 federal poverty level who were enrolled in a qualified health plan at
19 any time on and after January 1, 2014; [(3)] (C) the number of persons
20 in households with incomes from one hundred thirty-three per cent up
21 to and including two hundred per cent of the federal poverty level
22 who have been continuously enrolled in a qualified health plan during
23 the current calendar year; [(4)] (D) the number of persons in
24 households with incomes from one hundred thirty-three per cent up to
25 and including two hundred per cent of the federal poverty level who
26 were enrolled in a qualified health plan and who subsequently became
27 eligible to receive benefits under the Medicaid program or whose
28 household income increased to more than two hundred per cent of the
29 federal poverty level; [(5)] (E) the number of persons in households
30 with incomes from one hundred thirty-three per cent up to and
31 including two hundred per cent of the federal poverty level who
32 experienced a gap in health care coverage; [(6)] (F) the cost to the state
33 of providing health care services to persons identified in subparagraph
34 (E) of this subdivision [(5) of this subsection] and the cost to such
35 persons to access health care coverage through the exchange; [(7)] (G)
36 the cost of the second-lowest-priced silver premium plan in the
37 exchange; and [(8)] (H) any other information that said board believes
38 would be necessary to allow said committees to evaluate the cost and
39 benefits of a basic health plan.

40 [(b)] (2) The [Connecticut Health Insurance Exchange board of
41 directors] board shall include in the first quarterly report submitted
42 each year to said committees in accordance with [subsection (a) of this
43 section] subdivision (1) of this subsection, the number of persons in
44 households with incomes from one hundred thirty-three up to and

45 including two hundred per cent of the federal poverty level who were
46 enrolled in a qualified health plan at the end of the previous calendar
47 year.

48 (b) Not later than July 31, 2014, and monthly thereafter, the board
49 shall report to the joint standing committees of the General Assembly
50 having cognizance of matters relating to public health, human services
51 and insurance concerning health care services provided through the
52 exchange. Such reports shall include: (1) The number of individuals
53 who enrolled in Medicaid in the prior month through the exchange; (2)
54 the number of individuals who enrolled in a qualified health plan in
55 the prior month through the exchange and which plans such
56 individuals selected; (3) whether each individual reported enrolled
57 under subdivision (1) or (2) of this subsection was insured
58 immediately prior to such enrollment and if so, the source of such
59 insurance; and (4) the number of individuals enrolled in the prior
60 month through the exchange who were eligible for a federal subsidy.

61 Sec. 502. Section 38a-1080 of the 2014 supplement to the general
62 statutes is repealed and the following is substituted in lieu thereof
63 (*Effective July 1, 2014*):

64 For purposes of sections 38a-1080 to [38a-1091] 38a-1092, inclusive,
65 as amended by this act:

66 (1) "Board" means the board of directors of the Connecticut Health
67 Insurance Exchange;

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

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

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

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

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

80 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),
81 (14), (15) and (16) of section 38a-469 or any combination thereof;

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

83 (iii) Liability insurance, including general liability insurance and
84 automobile liability insurance;

85 (iv) Workers' compensation insurance;

86 (v) Automobile medical payment insurance;

87 (vi) Credit insurance;

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

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

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

97 (i) Limited scope dental or vision benefits;

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

100 (iii) Other similar, limited benefits specified in regulations issued

101 pursuant to the Health Insurance Portability and Accountability Act of
102 1996, P.L. 104-191, as amended from time to time;

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

106 (D) "Health benefit plan" does not include coverage of the type
107 specified in subdivisions (3) and (13) of section 38a-469 or other fixed
108 indemnity insurance if (i) such coverage is provided under a separate
109 insurance policy, certificate or contract, (ii) there is no coordination
110 between the provision of the benefits and any exclusion of benefits
111 under any group health plan maintained by the same plan sponsor,
112 and (iii) the benefits are paid with respect to an event without regard
113 to whether benefits were also provided under any group health plan
114 maintained by the same plan sponsor;

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

117 (7) "Health carrier" means an insurance company, fraternal benefit
118 society, hospital service corporation, medical service corporation
119 health care center or other entity subject to the insurance laws and
120 regulations of the state or the jurisdiction of the commissioner that
121 contracts or offers to contract to provide, deliver, pay for or reimburse
122 any of the costs of health care services;

123 (8) "Internal Revenue Code" means the Internal Revenue Code of
124 1986, or any subsequent corresponding internal revenue code of the
125 United States, as amended from time to time;

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

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

129 (11) "Qualified employer" has the same meaning as provided in

130 Section 1312 of the Affordable Care Act;

131 (12) "Qualified health plan" means a health benefit plan that has in
 132 effect a certification that the plan meets the criteria for certification
 133 described in Section 1311(c) of the Affordable Care Act and section
 134 38a-1086;

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

137 (14) "Secretary" means the Secretary of the United States
 138 Department of Health and Human Services;

139 (15) "Small employer" has the same meaning as provided in section
 140 38a-564."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	<i>July 1, 2014</i>	38a-1092
Sec. 502	<i>July 1, 2014</i>	38a-1080