



Senate

General Assembly

File No. 390

February Session, 2016

Senate Bill No. 370

Senate, April 1, 2016

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 Committee makes no recommendation and the bill is considered to be unfavorable in accordance with Joint Rule 19.

AN ACT CONCERNING HEALTH CARE PROVIDER LISTS AND AUTHORIZING PREGNANCY AS A QUALIFYING EVENT FOR SPECIAL ENROLLMENT PERIODS.

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

1 Section 1. Section 38a-472f of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2016*):

3 Each insurer, health care center, managed care organization or other
4 entity that delivers, issues for delivery, renews, amends or continues
5 an individual or a group health insurance policy or medical benefits
6 plan, and each preferred provider network, as defined in section 38a-
7 479aa, that contracts with a health care provider, as defined in section
8 38a-478, for the purposes of providing covered health care services to
9 its enrollees, shall maintain (1) a network of such providers that is
10 consistent with the National Committee for Quality Assurance's
11 network adequacy requirements or URAC's provider network access

12 and availability standards, and (2) an accurate and current list of in-
13 network health care providers and facilities for each such policy, plan
14 or network. Such list shall (A) include (i) the name of each health care
15 provider and the address and phone number of each office or practice
16 where such provider provides health care services to patients, (ii) the
17 name or names of any hospital at which each such provider enjoys
18 privileges, (iii) any specialty and board certification of each such
19 provider, (iv) any language besides English that each such provider
20 speaks, and (v) the name, address and phone number of each facility,
21 and (B) be in a machine readable format as described by the United
22 States Department of Health and Human Services.

23 Sec. 2. Section 38a-567 of the 2016 supplement to the general statutes
24 is repealed and the following is substituted in lieu thereof (*Effective*
25 *January 1, 2017*):

26 Health insurance plans, associations of small employers and other
27 insurance arrangements covering small employers and insurers and
28 producers marketing such plans and arrangements shall be subject to
29 the following provisions:

30 (1) (A) Any such plan or arrangement shall be offered on a
31 guaranteed issue basis with respect to all eligible employees or
32 dependents of such employees, at the option of the small employer,
33 policyholder or contractholder, as the case may be.

34 (B) Any such plan or arrangement shall be renewable with respect
35 to all eligible employees or dependents at the option of the small
36 employer, policyholder or contractholder, as the case may be, except:
37 (i) For nonpayment of the required premiums by the small employer,
38 policyholder or contractholder; (ii) for fraud or misrepresentation of
39 the small employer, policyholder or contractholder or, with respect to
40 coverage of individual insured, the insureds or their representatives;
41 (iii) for noncompliance with plan or arrangement provisions; (iv) when
42 the number of insureds covered under the plan or arrangement is less
43 than the number of insureds or percentage of insureds required by
44 participation requirements under the plan or arrangement; or (v) when

45 the small employer, policyholder or contractholder is no longer
46 actively engaged in the business in which it was engaged on the
47 effective date of the plan or arrangement.

48 (C) Renewability of coverage may be effected by either continuing
49 in effect a plan or arrangement covering a small employer or by
50 substituting upon renewal for the prior plan or arrangement the plan
51 or arrangement then offered by the carrier that most closely
52 corresponds to the prior plan or arrangement and is available to other
53 small employers. Such substitution shall only be made under
54 conditions approved by the commissioner. A carrier may substitute a
55 plan or arrangement as set forth in this subparagraph only if the
56 carrier effects the same substitution upon renewal for all small
57 employers previously covered under the particular plan or
58 arrangement, unless otherwise approved by the commissioner. The
59 substitute plan or arrangement shall be subject to the rating restrictions
60 specified in this section on the same basis as if no substitution had
61 occurred, except for an adjustment based on coverage differences.

62 (D) Any such plan or arrangement shall provide special enrollment
63 periods (i) to all eligible employees or dependents as set forth in 45
64 CFR 147.104, as amended from time to time, [and] (ii) for coverage
65 under such plan or arrangement ordered by a court for a spouse or
66 minor child of an eligible employee where request for enrollment is
67 made not later than thirty days after the issuance of such court order,
68 and (iii) to all eligible pregnant employees at any time after the
69 commencement of the pregnancy, as certified by a physician licensed
70 under chapter 370 or an advanced practice registered nurse licensed
71 under chapter 378, acting within the scope of such physician's or
72 nurse's scope of practice. Coverage under subparagraph (D)(iii) of this
73 subdivision shall be effective as of the first of the month in which the
74 employee receives such certification.

75 (2) (A) As used in this subdivision, "grandfathered plan" has the
76 same meaning as "grandfathered health plan" as provided in the
77 Patient Protection and Affordable Care Act, P.L. 111-148, as amended

78 from time to time.

79 (B) With respect to grandfathered plans issued to small employers,
80 the premium rates charged or offered shall be established on the basis
81 of a single pool of all grandfathered plans, adjusted to reflect one or
82 more of the following classifications:

83 (i) Age, provided age brackets of less than five years shall not be
84 utilized;

85 (ii) Gender;

86 (iii) Geographic area, provided an area smaller than a county shall
87 not be utilized;

88 (iv) Industry, provided the rate factor associated with any industry
89 classification shall not vary from the arithmetic average of the highest
90 and lowest rate factors associated with all industry classifications by
91 greater than fifteen per cent of such average, and provided further, the
92 rate factors associated with any industry shall not be increased by
93 more than five per cent per year;

94 (v) Group size, provided the highest rate factor associated with
95 group size shall not vary from the lowest rate factor associated with
96 group size by a ratio of greater than 1.25 to 1.0;

97 (vi) Administrative cost savings resulting from the administration of
98 an association group plan or a plan written pursuant to section 5-259,
99 provided the savings reflect a reduction to the small employer carrier's
100 overall retention that is measurable and specifically realized on items
101 such as marketing, billing or claims paying functions taken on directly
102 by the plan administrator or association, except that such savings may
103 not reflect a reduction realized on commissions;

104 (vii) Savings resulting from a reduction in the profit of a carrier that
105 writes small business plans or arrangements for an association group
106 plan or a plan written pursuant to section 5-259, provided any loss in
107 overall revenue due to a reduction in profit is not shifted to other small

108 employers; and

109 (viii) Family composition, provided the small employer carrier shall
110 utilize only one or more of the following billing classifications: (I)
111 Employee; (II) employee plus family; (III) employee and spouse; (IV)
112 employee and child; (V) employee plus one dependent; and (VI)
113 employee plus two or more dependents.

114 (C) (i) With respect to nongrandfathered plans issued to small
115 employers, the premium rates charged or offered shall be established
116 on the basis of a single pool of all nongrandfathered plans, adjusted to
117 reflect one or more of the following classifications:

118 (I) Age, in accordance with a uniform age rating curve established
119 by the commissioner;

120 (II) Geographic area, as defined by the commissioner.

121 (ii) Total premium rates for family coverage for nongrandfathered
122 plans shall be determined by adding the premiums for each individual
123 family member, except that with respect to family members under
124 twenty-one years of age, the premiums for only the three oldest
125 covered children shall be taken into account in determining the total
126 premium rate for such family.

127 (iii) Premium rates for employees and dependents for
128 nongrandfathered plans shall be calculated for each covered individual
129 and premium rates for the small employer group shall be calculated by
130 totaling the premiums attributable to each covered individual.

131 (iv) Premium rates for any given plan may vary by (I) actuarially
132 justified differences in plan design, and (II) actuarially justified
133 amounts to reflect the policy's provider network and administrative
134 expense differences that can be reasonably allocated to such policy.

135 (3) No small employer carrier or producer shall, directly or
136 indirectly, engage in the following activities:

137 (A) Encouraging or directing small employers to refrain from filing
138 an application for coverage with the small employer carrier because of
139 the health status, claims experience, industry, occupation or
140 geographic location of the small employer, except the provisions of
141 this subparagraph shall not apply to information provided by a small
142 employer carrier or producer to a small employer regarding the
143 carrier's established geographic service area or a restricted network
144 provision of a small employer carrier; or

145 (B) Encouraging or directing small employers to seek coverage from
146 another carrier because of the health status, claims experience,
147 industry, occupation or geographic location of the small employer.

148 (4) No small employer carrier shall, directly or indirectly, enter into
149 any contract, agreement or arrangement with a producer that provides
150 for or results in the compensation paid to a producer for the sale of a
151 health benefit plan to be varied because of the health status, claims
152 experience, industry, occupation or geographic area of the small
153 employer. A small employer carrier shall provide reasonable
154 compensation, as provided under the plan of operation of the
155 program, to a producer, if any, for the sale of a health care plan. No
156 small employer carrier shall terminate, fail to renew or limit its
157 contract or agreement of representation with a producer for any reason
158 related to the health status, claims experience, occupation, or
159 geographic location of the small employers placed by the producer
160 with the small employer carrier.

161 (5) No small employer carrier or producer shall induce or otherwise
162 encourage a small employer to separate or otherwise exclude an
163 employee from health coverage or benefits provided in connection
164 with the employee's employment.

165 (6) No small employer carrier or producer shall disclose (A) to a
166 small employer the fact that any or all of the eligible employees of such
167 small employer have been or will be reinsured with the pool, or (B) to
168 any eligible employee or dependent the fact that he has been or will be
169 reinsured with the pool.

170 (7) If a small employer carrier enters into a contract, agreement or
171 other arrangement with another party to provide administrative,
172 marketing or other services related to the offering of health benefit
173 plans to small employers in this state, the other party shall be subject
174 to the provisions of this section.

175 (8) The commissioner may adopt regulations, in accordance with the
176 provisions of chapter 54, setting forth additional standards to provide
177 for the fair marketing and broad availability of health benefit plans to
178 small employers.

179 (9) Any violation of subdivisions (3) to (7), inclusive, of this section
180 and of any regulations established under subdivision (8) of this section
181 shall be an unfair and prohibited practice under sections 38a-815 to
182 38a-830, inclusive.

183 Sec. 3. Subsection (g) of section 38a-481 of the 2016 supplement to
184 the general statutes is repealed and the following is substituted in lieu
185 thereof (*Effective January 1, 2017*):

186 (g) (1) As used in this subsection, "Affordable Care Act" means the
187 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
188 from time to time, and regulations adopted thereunder, and
189 "grandfathered plan" has the same meaning as "grandfathered health
190 plan" as provided in the Affordable Care Act.

191 (2) Each individual health insurance policy subject to the Affordable
192 Care Act shall (A) be offered on a guaranteed issue basis with respect
193 to all eligible individuals or dependents, and (B) provide special
194 enrollment periods (i) to all eligible individuals or dependents as set
195 forth in 45 CFR 147.104, as amended from time to time, and (ii) to all
196 eligible pregnant individuals at any time after the commencement of
197 the pregnancy, as certified by a physician licensed under chapter 370
198 or an advanced practice registered nurse licensed under chapter 378,
199 acting within the scope of such physician's or nurse's scope of practice.
200 Coverage under subparagraph (B)(ii) of this subdivision shall be
201 effective as of the first of the month in which the employee receives

202 such certification.

203 (3) With respect to grandfathered plans of a policy under
204 subdivision (2) of this subsection, the premium rates charged or
205 offered shall be established on the basis of a single pool of all
206 grandfathered plans.

207 (4) With respect to nongrandfathered plans of a policy under
208 subdivision (2) of this subsection:

209 (A) The premium rates charged or offered shall be established on
210 the basis of a single pool of all nongrandfathered plans, adjusted to
211 reflect one or more of the following classifications:

212 (i) Age, in accordance with a uniform age rating curve established
213 by the commissioner;

214 (ii) Geographic area, as defined by the commissioner;

215 (iii) Tobacco use, except that such rate may not vary by a ratio of
216 greater than 1.5 to 1.0 and may only be applied with respect to
217 individuals who may legally use tobacco under state and federal law.
218 For purposes of this subparagraph, "tobacco use" means the use of
219 tobacco products four or more times per week on average within a
220 period not longer than the six months immediately preceding.
221 "Tobacco use" does not include the religious or ceremonial use of
222 tobacco;

223 (B) Total premium rates for family coverage shall be determined by
224 adding the premiums for each individual family member, except that
225 with respect to family members under twenty-one years of age, the
226 premiums for only the three oldest covered children shall be taken into
227 account in determining the total premium rate for such family.

228 (5) Premium rates for a grandfathered or nongrandfathered policy
229 under subdivision (2) of this subsection may vary by (A) actuarially
230 justified differences in plan design, and (B) actuarially justified
231 amounts to reflect the policy's provider network and administrative

232 expense differences that can be reasonably allocated to such policy.

233 Sec. 4. Subsection (a) of section 38a-183 of the 2016 supplement to
234 the general statutes is repealed and the following is substituted in lieu
235 thereof (*Effective January 1, 2017*):

236 (a) (1) A health care center governed by sections 38a-175 to 38a-192,
237 inclusive, shall not enter into any agreement with subscribers unless
238 and until it has filed with the commissioner a full schedule of the
239 amounts to be paid by the subscribers and has obtained the
240 commissioner's approval thereof. Such filing shall include an actuarial
241 memorandum that includes, but is not limited to, pricing assumptions
242 and claims experience, and premium rates and loss ratios from the
243 inception of the contract or policy. The commissioner may refuse such
244 approval if the commissioner finds such amounts to be excessive,
245 inadequate or discriminatory. As used in this subsection, "loss ratio"
246 means the ratio of incurred claims to earned premiums by the number
247 of years of policy duration for all combined durations.

248 (2) Premium rates and special enrollment periods offered to
249 individuals shall be consistent with the requirements set forth in
250 section 38a-481, as amended by this act.

251 (3) Premium rates and special enrollment periods offered to small
252 employers, as defined in section 38a-564, shall be consistent with the
253 requirements set forth in section 38a-567, as amended by this act.

254 (4) No such health care center shall enter into any agreement with
255 subscribers unless and until it has filed with the commissioner a copy
256 of such agreement or agreements, including all riders and
257 endorsements thereon, and until the commissioner's approval thereof
258 has been obtained. The commissioner shall, within a reasonable time
259 after the filing of any request for an approval of the amounts to be
260 paid, any agreement or any form, notify the health care center of the
261 commissioner's approval or disapproval thereof.

262 Sec. 5. Section 38a-208 of the 2016 supplement to the general statutes

263 is repealed and the following is substituted in lieu thereof (*Effective*
264 *January 1, 2017*):

265 (a) No such corporation shall enter into any contract with
266 subscribers unless and until it has filed with the Insurance
267 Commissioner a full schedule of the rates to be paid by the subscribers
268 and has obtained said commissioner's approval thereof. Such filing
269 shall include an actuarial memorandum that includes, but is not
270 limited to, pricing assumptions and claims experience, and premium
271 rates and loss ratios from the inception of the contract. The
272 commissioner may refuse such approval if the commissioner finds
273 such rates to be excessive, inadequate or discriminatory. As used in
274 this subsection, "loss ratio" means the ratio of incurred claims to
275 earned premiums by the number of years of policy duration for all
276 combined durations.

277 (b) Premium rates and special enrollment periods offered to
278 individuals shall be consistent with the requirements set forth in
279 section 38a-481, as amended by this act.

280 (c) Premium rates and special enrollment periods offered to small
281 employers, as defined in section 38a-564, shall be consistent with the
282 requirements set forth in section 38a-567, as amended by this act.

283 (d) No hospital service corporation shall enter into any contract with
284 subscribers unless and until it has filed with the Insurance
285 Commissioner a copy of such contract, including all riders and
286 endorsements thereof, and until said commissioner's approval thereof
287 has been obtained. The Insurance Commissioner shall, within a
288 reasonable time after the filing of any such form, notify such
289 corporation of the commissioner's approval or disapproval thereof.

290 Sec. 6. Section 38a-218 of the 2016 supplement to the general statutes
291 is repealed and the following is substituted in lieu thereof (*Effective*
292 *January 1, 2017*):

293 (a) No such medical service corporation shall enter into any contract

294 with subscribers unless and until it has filed with the Insurance
 295 Commissioner a full schedule of the rates to be paid by the subscriber
 296 and has obtained said commissioner's approval thereof. Such filing
 297 shall include an actuarial memorandum that includes, but is not
 298 limited to, pricing assumptions and claims experience, and premium
 299 rates and loss ratios from the inception of the contract. The
 300 commissioner may refuse such approval if the commissioner finds
 301 such rates are excessive, inadequate or discriminatory. As used in this
 302 subsection, "loss ratio" means the ratio of incurred claims to earned
 303 premiums by the number of years of policy duration for all combined
 304 durations.

305 (b) Premium rates and special enrollment periods offered to
 306 individuals shall be consistent with the requirements set forth in
 307 section 38a-481, as amended by this act.

308 (c) Premium rates and special enrollment periods offered to small
 309 employers, as defined in section 38a-564, shall be consistent with the
 310 requirements set forth in section 38a-567, as amended by this act.

311 (d) No such medical service corporation shall enter into any contract
 312 with subscribers unless and until it has filed with the Insurance
 313 Commissioner a copy of such contract, including all riders and
 314 endorsements thereof, and until said commissioner's approval thereof
 315 has been obtained. The Insurance Commissioner shall, within a
 316 reasonable time after the filing of any such form, notify such
 317 corporation of the commissioner's approval or disapproval thereof.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2016</i>	38a-472f
Sec. 2	<i>January 1, 2017</i>	38a-567
Sec. 3	<i>January 1, 2017</i>	38a-481(g)
Sec. 4	<i>January 1, 2017</i>	38a-183(a)
Sec. 5	<i>January 1, 2017</i>	38a-208
Sec. 6	<i>January 1, 2017</i>	38a-218

INS *Unfavorable Pursuant to Joint Rule 19*

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.