



General Assembly

February Session, 2016

Raised Bill No. 375

LCO No. 2011



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT AUTHORIZING MULTISTATE HEALTH CARE CENTERS IN CONNECTICUT AND ELIMINATING A HEALTH CARRIER UTILIZATION REVIEW REPORT FILING REQUIREMENT.

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

1 Section 1. Section 38a-175 of the 2016 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2016*):

4 As used in this section and sections [38a-175] 38a-176 to 38a-194,
5 inclusive:

6 (1) "Healing arts" means the professions and occupations licensed
7 under the provisions of chapters 370, 372, 373, 375, 378, 379, 380, 381,
8 383 and 400j.

9 (2) "Carrier" means a health care center, insurer, hospital service
10 corporation, medical service corporation or other entity responsible for
11 the payment of benefits or provision of services under a group
12 contract.

13 (3) "Commissioner" means the Insurance Commissioner, except
14 when explicitly stated otherwise.

15 (4) "Evidence of coverage" means a statement of essential features
16 and services of the health care center coverage [which] that is given to
17 the subscriber by the health care center or by the group contract
18 holder.

19 (5) "Federal Health Maintenance Organization Act" means Title XIII
20 of the Public Health Service Act, 42 USC Subchapter XI, as [from time
21 to time] amended from time to time, or any successor thereto relating
22 to qualified health maintenance organizations.

23 (6) "Group contract" means a contract for health care services
24 [which] that by its terms limits eligibility to members of a specified
25 group. The group contract may include coverage for dependents.

26 (7) "Group contract holder" means the person to which a group
27 contract has been issued.

28 (8) "Health care" includes, but shall not be limited to, the following:
29 (A) Medical, surgical and dental care provided through licensed
30 practitioners, including any supporting and ancillary personnel,
31 services and supplies; (B) physical therapy service provided through
32 licensed physical therapists upon the prescription of a physician; (C)
33 psychological examinations provided by registered psychologists; (D)
34 optometric service provided by licensed optometrists; (E) hospital
35 service, both inpatient and outpatient; (F) convalescent institution care
36 and nursing home care; (G) nursing service provided by a registered
37 nurse or by a licensed practical nurse; (H) home care service of all
38 types required for the health of a person; (I) rehabilitation service
39 required or desirable for the health of a person; (J) preventive medical
40 services of all and any types; (K) furnishing necessary appliances,
41 drugs, medicines and supplies; (L) educational services for the health
42 and well-being of a person; (M) ambulance service; and (N) any other
43 care, service or treatment related to the prevention or treatment of

44 disease, the correction of defects and the maintenance of the physical
45 and mental well-being of human beings. Any diagnosis and treatment
46 of diseases of human beings required for health care as defined in this
47 section, if rendered, shall be under the supervision and control of the
48 providers.

49 (9) "Health care center" means: [either: (A) A person, including a
50 profit or a nonprofit corporation organized under the laws of this
51 state] (A) any organization governed by sections 38a-175 to 38a-192,
52 inclusive, and licensed or authorized by the commissioner pursuant to
53 section 38a-41 or 38a-41a, for the purpose of carrying out the activities
54 and purposes set forth in subsection (b) of section 38a-176, at the
55 expense of the health care center, including the providing of health
56 care [, as herein defined,] to members of the community, including
57 subscribers to one or more plans under an agreement entitling such
58 subscribers to health care in consideration of a basic advance or
59 periodic charge and shall include a health maintenance organization,
60 or (B) a line of business conducted by an organization that is formed [,]
61 pursuant to the laws of this state for the purposes of, but not limited to,
62 carrying out the activities and purposes set forth in subsection (b) of
63 section 38a-176.

64 (10) "Individual contract" means a contract for health care services
65 issued to and covering an individual. The individual contract may
66 include dependents of the subscriber.

67 (11) "Individual practice association" means a partnership,
68 corporation, association [,] or other legal entity [which] that has
69 entered into a services arrangement with health care professionals
70 licensed in this state to provide services to enrollees of a health care
71 center.

72 (12) "Insolvent" or "insolvency" means [that] the organization has
73 been declared insolvent and placed under an order of liquidation by a
74 court of competent jurisdiction.

75 (13) "Net worth" means the excess of total admitted assets over total
76 liabilities, but the liabilities shall not include fully subordinated debt,
77 as defined in section 38a-193.

78 (14) "Member" or "enrollee" means an individual who is enrolled in
79 a health care center.

80 (15) "Person" means an individual, corporation, limited liability
81 company, partnership, association, trust or any other legal entity.

82 (16) "Uncovered expenditures" means the cost of health care services
83 that are covered by a health care center, for which an enrollee would
84 also be liable in the event of the center's insolvency, and for which no
85 alternative arrangements have been made that are acceptable to the
86 commissioner. Uncovered expenditures shall not include expenditures
87 for services when a provider has agreed not to bill the enrollee even
88 though the provider is not paid by the health care center or for services
89 that are guaranteed, insured or assumed by a person other than the
90 health care center.

91 (17) "Enrolled population" means a group of persons, defined as to
92 probable age, sex and family composition, [which] that receives health
93 care from a health care center in consideration of a basic advance or
94 periodic charge.

95 (18) "Participating provider" means a provider who, under an
96 express or implied contract with the health care center or with its
97 contractor or subcontractor, has agreed to provide health care services
98 to enrollees with an expectation of receiving payment, other than
99 copayment or deductible, directly or indirectly from the health care
100 center.

101 (19) "Provider" means any licensed health care professional or
102 facility, including individual practice associations.

103 (20) "Subscriber" means an individual whose employment or other

104 status, except family dependency, is the basis for eligibility for
105 enrollment in the health care center, or in the case of an individual
106 contract, the person in whose name the contract is issued.

107 Sec. 2. Section 38a-178 of the general statutes is repealed and the
108 following is substituted in lieu thereof (*Effective July 1, 2016*):

109 Persons desiring to form a health care center may organize under
110 the general law of the state governing corporations, partnerships,
111 associations or trusts, [but] subject to the following provisions: (1) The
112 certificate of incorporation or other organizational document of each
113 such organization shall have endorsed thereon or attached thereto the
114 consent of the commissioner if [he] the commissioner finds the same to
115 be in accordance with the provisions of sections 38a-175 to 38a-192,
116 inclusive, as amended by this act; and (2) the certificate or other
117 document shall include a statement of the area in which the health care
118 center will operate and the services to be rendered by such
119 organization within this state and in other jurisdictions in which the
120 health care center may be authorized to do business.

121 Sec. 3. Section 38a-179 of the general statutes is repealed and the
122 following is substituted in lieu thereof (*Effective July 1, 2016*):

123 (a) If [the] a domestic health care center is organized as a nonprofit,
124 nonstock corporation, the care, control and disposition of the property
125 and funds of each such corporation and the general management of its
126 affairs shall be vested in a board of directors. Each such corporation
127 shall have the power to adopt bylaws for the governing of its affairs,
128 which bylaws shall prescribe the number of directors, their term of
129 office and the manner of their election, subject to the provisions of
130 sections 38a-175 to 38a-192, inclusive, as amended by this act. The
131 bylaws may be adopted and repealed or amended by the affirmative
132 vote of two-thirds of all the directors at any meeting of the board of
133 directors duly held upon at least ten days' notice, provided notice of
134 such meeting shall specify the proposed action concerning the bylaws

135 to be taken at such meeting. The bylaws of the corporation shall
136 provide that the board of directors shall include representation from
137 persons engaged in the healing arts and from persons who are eligible
138 to receive health care from the corporation, subject to the following
139 provisions: (1) One-quarter of the board of directors shall be persons
140 engaged in the different fields in the healing arts at least two of whom
141 shall be a physician and a dentist; (2) one-quarter of the board of
142 directors shall be subscribers who are eligible to receive health care
143 from the health care center, but no such representative need be seated
144 until the first annual meeting following the approval by the
145 commissioner of the initial agreement or agreements to be offered by
146 the corporation, and there shall be only one representative from any
147 group covered by a group service agreement.

148 (b) If [the] a domestic health care center is not organized as a
149 nonprofit, nonstock corporation, management of its affairs shall be in
150 accordance with other applicable laws of the state, provided [that the]
151 such health care center shall establish and maintain a mechanism to
152 afford its members an opportunity to participate in matters of policy
153 and operation such as an advisory panel, advisory referenda on major
154 policy decisions or other similar mechanisms.

155 Sec. 4. Section 38a-186 of the general statutes is repealed and the
156 following is substituted in lieu thereof (*Effective July 1, 2016*):

157 (a) In the event of the dissolution, liquidation or termination of the
158 corporate existence of a domestic health care center [which] that is
159 organized as a nonprofit, nonstock corporation, no part of the property
160 or assets of the health care center shall inure to the benefit of any
161 director, officer, subscriber or employee of the corporation, each of
162 whom by holding such position shall be deemed to have waived and
163 relinquished all rights conferred by statute or otherwise upon
164 subscribers of a corporation without capital stock to share in such
165 assets upon dissolution, liquidation or termination. After the payment
166 of all lawful claims against the corporation, all its remaining assets

167 shall be devoted permanently and exclusively to the purposes for
168 which the corporation is formed, or paid over to an organization
169 organized and operated exclusively for charitable, educational and
170 scientific purposes, and in such amount and proportions, as the board
171 of directors in its discretion shall determine.

172 (b) No person may, with respect to a domestic health care center, (1)
173 make a tender for or a request or invitation for tenders of, or enter into
174 an agreement to exchange securities for or acquire in the open market
175 or otherwise, any voting security of [a] such health care center, (2)
176 enter into any other agreement if, after the consummation [thereof,
177 that] of such agreement, such person would, directly or indirectly, or
178 by conversion or by exercise of any right to acquire, be in control of
179 such health care center, or (3) enter into an agreement to merge or
180 consolidate with or otherwise to acquire control of [a] such health care
181 center, unless, at the time any offer, request or invitation is made or
182 any agreement is entered into, or prior to the acquisition of the
183 securities if no offer or agreement is involved, the person has [filed
184 with the Insurance Commissioner and has mailed or delivered to the
185 health care center, such information as is required by the commissioner
186 and the offer, request, invitation, agreement or acquisition has been
187 approved by the commissioner] complied with the provisions of
188 section 38a-130.

189 Sec. 5. Section 38a-188 of the 2016 supplement to the general statutes
190 is repealed and the following is substituted in lieu thereof (*Effective July*
191 *1, 2016*):

192 (a) Each health care center governed by sections 38a-175 to 38a-192,
193 inclusive, as amended by this act, shall be exempt from the provisions
194 of the general statutes relating to insurance in the conduct of its
195 operations under said sections and in such other activities as do
196 constitute the business of insurance, unless expressly included therein,
197 and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51,
198 38a-52, as amended by this act, 38a-56, 38a-57, 38a-58a, 38a-129 to 38a-

199 140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a
200 health care center shall not be deemed in violation of sections 38a-815
201 to 38a-819, inclusive, solely by virtue of such health care center
202 selectively contracting with certain providers in one or more
203 specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j,
204 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to
205 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-
206 786, 38a-790, 38a-792 and 38a-794, provided a health care center
207 organized as a nonprofit, nonstock corporation shall be exempt from
208 sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-
209 735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772
210 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health
211 care center is operated as a line of business, the foregoing provisions
212 shall, where possible, be applied only to that line of business and not
213 to the organization as a whole.

214 (b) The commissioner may adopt regulations, in accordance with
215 chapter 54, stating the circumstances under which the resources of a
216 person [which] that controls a health care center, or operates a health
217 care center as a line of business will be considered in evaluating the
218 financial condition of a health care center. Such regulations, if adopted,
219 shall require as a condition to the consideration of the resources of
220 such person that controls a health care center, or operates a health care
221 center as a line of business to provide satisfactory assurances to the
222 commissioner that such person will assume the financial obligations of
223 the health care center. During the period prior to the effective date of
224 regulations issued under this section, the commissioner shall, upon
225 request, consider the resources of a person that controls a health care
226 center, or operates a health care center as a line of business, if the
227 commissioner receives satisfactory assurances from such person that it
228 will assume the financial obligations of the health care center and
229 determines that such person meets such other requirements as the
230 commissioner determines are necessary.

231 (c) A health care center organized as a nonprofit, nonstock

232 corporation shall be exempt from the sales and use tax and all property
233 of each such corporation shall be exempt from state, district and
234 municipal taxes. Each corporation governed by sections 38a-175 to 38a-
235 192, inclusive, as amended by this act, shall be subject to the provisions
236 of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall
237 be construed to override contractual and delivery system
238 arrangements governing a health care center's provider relationships.

239 Sec. 6. Subdivision (9) of section 12-201 of the 2016 supplement to
240 the general statutes is repealed and the following is substituted in lieu
241 thereof (*Effective July 1, 2016*):

242 (9) "Direct subscriber charges" means all charges made by a
243 domestic health care center [, as defined in section 38a-175,] to
244 subscribers, [as defined in section 38a-175,] by whomever paid. As
245 used in this subdivision, "health care center" and "subscriber" have the
246 same meanings as provided in section 38a-175, as amended by this act;

247 Sec. 7. Subsection (a) of section 12-202a of the 2016 supplement to
248 the general statutes is repealed and the following is substituted in lieu
249 thereof (*Effective July 1, 2016*):

250 (a) Each domestic health care center [, as defined in section 38a-175,]
251 that is governed by sections 38a-175 to 38a-192, inclusive, as amended
252 by this act, shall pay a tax to the Commissioner of Revenue Services for
253 the calendar year commencing on January 1, 1995, and annually
254 thereafter, at the rate of one and three-quarters per cent of the total net
255 direct subscriber charges received by such health care center during
256 each such calendar year on any new or renewal contract or policy
257 approved by the Insurance Commissioner under section 38a-183. Such
258 payment shall be in addition to any other payment required under
259 section 38a-48.

260 Sec. 8. Subsections (c) to (e), inclusive, of section 12-217t of the 2016
261 supplement to the general statutes are repealed and the following is
262 substituted in lieu thereof (*Effective July 1, 2016*):

263 (c) The credit provided for by this section shall be allowed for any
264 taxes owed on the grand list of October 1, 1994, and each grand list
265 annually thereafter or included in the list prescribed under section 12-
266 80a for such grand list. Such credits shall first be used by the taxpayer
267 against the corporation business tax under this chapter, if any, and
268 then may be used against any tax paid by the taxpayer under the
269 provisions of chapter 207, 208a, 209, 210, 211 or 212 or the tax imposed
270 upon a domestic health care center under section 12-202a. The amount
271 of credits allowable under this section in any tax year against the taxes
272 imposed by chapter 207, 208, 208a, 209, 210, 211 or 212 or against the
273 tax imposed on domestic health care centers, under the provisions of
274 section 12-202a, shall be allowable only after all other credits allowable
275 against such taxes for such tax year have been applied.

276 (d) In the case of leased electronic data processing equipment, the
277 lessee, not the lessor, shall be entitled to claim the credit allowed
278 pursuant to this section if the lease by its terms or operation imposes
279 on the lessee the cost of the personal property taxes on such
280 equipment, provided the lessor and lessee may elect, in writing, that
281 the lessor may claim the credit provided by this section. The lessor
282 shall provide a copy of such election to the Commissioner of Revenue
283 Services, upon the request of said commissioner.

284 (e) In the case of taxpayers filing a combined unitary tax return
285 pursuant to section 12-222, the credit provided by this section shall be
286 allowed on a combined basis, such that the amount of personal
287 property taxes paid by such taxpayers with respect to such equipment
288 may be claimed as a tax credit against the combined unitary tax
289 liability of such taxpayers as determined under this chapter. Credits
290 available to taxpayers which are subject to tax under this chapter but
291 not subject to tax under chapter 207, 208a, 209, 210, 211 or 212 or the
292 tax imposed on domestic health care centers under the provisions of
293 section 12-202a, as amended by this act, shall be used prior to credits of
294 companies included in such combined unitary tax return which are
295 also subject to tax under said chapter 207, 208a, 209, 210, 211 or 212 or

296 the tax imposed upon domestic health centers pursuant to the
297 provisions of section 12-202a, as amended by this act.

298 Sec. 9. Subparagraph (A) of subdivision (2) of subsection (b) of
299 section 19a-7j of the general statutes is repealed and the following is
300 substituted in lieu thereof (*Effective July 1, 2016*):

301 (2) (A) Each domestic insurer or domestic health care center doing
302 health insurance business in this state shall annually pay to the
303 Insurance Commissioner, for deposit in the Insurance Fund
304 established under section 38a-52a, a health and welfare fee assessed by
305 the Insurance Commissioner pursuant to this section.

306 Sec. 10. Subdivision (2) of subsection (b) of section 19a-7p of the
307 2016 supplement to the general statutes is repealed and the following
308 is substituted in lieu thereof (*Effective July 1, 2016*):

309 (2) Each domestic insurer or domestic health care center doing
310 health insurance business in this state shall annually pay to the
311 Insurance Commissioner, for deposit in the Insurance Fund
312 established under section 38a-52a, a public health fee assessed by the
313 Insurance Commissioner pursuant to this section.

314 Sec. 11. Subsection (h) of section 38a-14 of the 2016 supplement to
315 the general statutes is repealed and the following is substituted in lieu
316 thereof (*Effective July 1, 2016*):

317 (h) The commissioner shall, at least once in every five years, visit
318 and examine the affairs of each domestic insurance company, domestic
319 health care center, domestic fraternal benefit society, and foreign and
320 alien insurance company doing business in this state. Notwithstanding
321 subdivision (1) of subsection (c) of this section, no domestic insurance
322 company or other domestic entity subject to examination under this
323 section shall pay as costs associated with the examination the salaries,
324 fringe benefits, traveling and maintenance expenses of examining
325 personnel of the Insurance Department engaged in such examination if

326 such domestic company or domestic entity is otherwise liable to
327 assessment levied under section 38a-47, except that a domestic
328 insurance company or other domestic entity shall pay the traveling
329 and maintenance expenses of examining personnel of the Insurance
330 Department when such company or entity is examined outside the
331 state.

332 Sec. 12. Section 38a-43 of the general statutes is repealed and the
333 following is substituted in lieu thereof (*Effective July 1, 2016*):

334 Whenever it appears to the commissioner that permission to
335 transact business within any state of the United States or within any
336 foreign country has been refused to any domestic insurance company
337 or domestic health care center after (1) a certificate of the solvency and
338 good management of such company or health care center has been
339 issued to it by the commissioner, and [after] (2) such company or
340 health care center has complied with any reasonable laws of such state
341 or foreign country requiring deposits of money or securities with the
342 government of such state or country, the commissioner may
343 immediately cancel the authority of each company or health care
344 center organized under the laws of such state or foreign government
345 and licensed to do business in this state and may refuse a certificate of
346 authority to each such company or health care center thereafter
347 applying for authority to do business in this state, until the
348 commissioner's certificate has been recognized by the government of
349 such state or country.

350 Sec. 13. Section 38a-52 of the general statutes is repealed and the
351 following is substituted in lieu thereof (*Effective July 1, 2016*):

352 Any (1) domestic insurance company or other domestic entity
353 aggrieved because of any assessment levied under section 38a-48, (2)
354 fraternal benefit society or foreign or alien insurance company or other
355 entity aggrieved because of any assessment levied under the
356 provisions of sections 38a-49 to 38a-51, inclusive, or (3) domestic

357 insurer, domestic health care center, third-party administrator licensed
358 pursuant to section 38a-720a or exempt insurer, as defined in
359 subdivision (1) of subsection (b) of section 19a-7j, aggrieved because of
360 any assessment levied under said section 19a-7j, may, within one
361 month from the time provided for the payment of such assessment,
362 appeal therefrom to the superior court for the judicial district of New
363 Britain, which appeal shall be accompanied by a citation to the
364 commissioner to appear before said court. Such citation shall be signed
365 by the same authority, and such appeal shall be returnable at the same
366 time and served and returned in the same manner, as is required in
367 case of a summons in a civil action. The authority issuing the citation
368 shall take from the appellant a bond or recognizance to the state, with
369 surety to prosecute the appeal to effect and to comply with the orders
370 and decrees of the court in the premises. Such appeals shall be
371 preferred cases, to be heard, unless cause appears to the contrary, at
372 the first session, by the court or by a committee appointed by the court.
373 Said court may grant such relief as may be equitable, and, if such
374 assessment has been paid prior to the granting of such relief, may
375 order the Treasurer to pay the amount of such relief, with interest at
376 the rate of six per cent per annum, to the aggrieved company. If the
377 appeal has been taken without probable cause, the court may tax
378 double or triple costs, as the case demands; and, upon all such appeals
379 which may be denied, costs may be taxed against the appellant at the
380 discretion of the court, but no costs shall be taxed against the state.

381 Sec. 14. Section 38a-53 of the 2016 supplement to the general statutes
382 is repealed and the following is substituted in lieu thereof (*Effective July*
383 *1, 2016*):

384 (a) (1) Each domestic insurance company or domestic health care
385 center shall, annually, on or before the first day of March, submit to the
386 commissioner, and electronically to the National Association of
387 Insurance Commissioners, a true and complete report, signed and
388 sworn to by its president or a vice president, and secretary or an
389 assistant secretary, of its financial condition on the thirty-first day of

390 December next preceding, prepared in accordance with the National
391 Association of Insurance Commissioners annual statement instructions
392 handbook and following those accounting procedures and practices
393 prescribed by the National Association of Insurance Commissioners
394 accounting practices and procedures manual, subject to any deviations
395 in form and detail as may be prescribed by the commissioner. An
396 electronically filed report in accordance with section 38a-53a that is
397 timely submitted to the National Association of Insurance
398 Commissioners shall not exempt a domestic insurance company or
399 domestic health care center from timely filing a true and complete
400 paper copy with the commissioner.

401 (2) Each accredited reinsurer, as defined in subdivision (1) of
402 subsection (c) of section 38a-85, and assuming insurance company, as
403 provided in section 38a-85, shall file an annual report in accordance
404 with the provisions of section 38a-85.

405 (b) Each foreign insurance company doing business in this state
406 shall, annually, on or before the first day of March, submit to the
407 commissioner, by electronically filing with the National Association of
408 Insurance Commissioners, a true and complete report, signed and
409 sworn to by its president or a vice president, and secretary or an
410 assistant secretary, of its financial condition on the thirty-first day of
411 December next preceding, prepared in accordance with the National
412 Association of Insurance Commissioners annual statement instructions
413 handbook and following those accounting procedures and practices
414 prescribed by the National Association of Insurance Commissioners
415 accounting practices and procedures manual, subject to any deviations
416 in form and detail as may be prescribed by the commissioner. An
417 electronically filed report in accordance with section 38a-53a that is
418 timely submitted to the National Association of Commissioners shall
419 be deemed to have been submitted to the commissioner in accordance
420 with this section.

421 (c) In addition to such annual report, the commissioner, when the

422 commissioner deems it necessary, may require any insurance company
423 or health care center doing business in this state to file financial
424 statements on a quarterly basis. An electronically filed true and
425 complete report filed in accordance with section 38a-53a that is timely
426 filed with the National Association of Insurance Commissioners shall
427 be deemed to have been submitted to the commissioner in accordance
428 with the provisions of this section.

429 (d) In addition to such annual report and the quarterly report
430 required under subsection (c) of this section, the commissioner,
431 whenever the commissioner determines that more frequent reports are
432 required because of certain factors or trends affecting companies
433 writing a particular class or classes of business or because of changes
434 in the company's management or financial or operating condition, may
435 require any insurance company or health care center doing business in
436 this state to file financial statements on other than an annual or
437 quarterly basis.

438 (e) Any insurance company or health care center doing business in
439 this state that fails to file any report or statement required under this
440 section shall pay a late filing fee of one hundred seventy-five dollars
441 per day for each day from the due date of such report or statement to
442 the date of filing. The commissioner may extend the due date of any
443 report or statement required under this section (1) if the insurance
444 company or health care center cannot file such report or statement
445 because the governor of such company's or center's state of domicile
446 has proclaimed a state of emergency in such state and such state of
447 emergency impairs the company's or center's ability to file the report
448 or statement, (2) if the insurance regulatory official of the state of
449 domicile of a foreign insurance company has permitted such company
450 to file such report or statement late, or (3) for a domestic insurance
451 company or a domestic health care center, for good cause shown.

452 (f) Each insurance company or health care center doing business in
453 this state shall include in all reports required to be filed with the

454 commissioner under this section a certification by an actuary or reserve
455 specialist of all reserve liabilities prepared in accordance with
456 regulations that shall be adopted by the commissioner in accordance
457 with chapter 54. The regulations shall: (1) Specify the contents and
458 scope of the certification; (2) provide for the availability to the
459 commissioner of the workpapers of the actuary or loss reserve
460 specialist; and (3) provide for granting companies or centers
461 exemptions from compliance with the requirements of this subsection.
462 The commissioner shall maintain, as confidential, all workpapers of
463 the actuary or loss reserve specialist and the actuarial report and
464 actuarial opinion summary provided in support of the certification.
465 Such workpapers, reports and summaries shall not be subject to
466 subpoena or disclosure under the Freedom of Information Act, as
467 defined in section 1-200.

468 Sec. 15. Subsection (a) of section 38a-54 of the general statutes is
469 repealed and the following is substituted in lieu thereof (*Effective July*
470 *1, 2016*):

471 (a) Each domestic insurance company, domestic health care center
472 or domestic fraternal benefit society doing business in this state shall
473 have an annual audit conducted by an independent certified public
474 accountant and shall annually file an audited financial report with the
475 commissioner, and electronically to the National Association of
476 Insurance Commissioners on or before the first day of June for the year
477 ending the preceding December thirty-first. An electronically filed true
478 and complete report timely submitted to the National Association of
479 Insurance Commissioners does not exempt a domestic insurance
480 company or a domestic health care center from timely filing a true and
481 complete paper copy to the commissioner.

482 Sec. 16. Section 38a-55 of the general statutes is repealed and the
483 following is substituted in lieu thereof (*Effective July 1, 2016*):

484 (a) No domestic insurer, domestic health care center or domestic

485 fraternal benefit society may pledge, hypothecate or otherwise
486 encumber its assets to secure the debt, guaranty or obligations of any
487 other person without the prior written consent of the Insurance
488 Commissioner. This prohibition shall not apply to obligations of the
489 insurer under surety bonds or insurance contracts issued in the regular
490 course of business.

491 (b) (1) No domestic insurer, domestic health care center or domestic
492 fraternal benefit society may, without the prior written consent of the
493 Insurance Commissioner, pledge, hypothecate or otherwise encumber
494 its assets to secure its own debt, guaranty or obligations if the amount
495 of the assets pledged, hypothecated or otherwise encumbered, when
496 the pledge, hypothecation or encumbrance is made, together with the
497 aggregate amount of assets pledged, hypothecated or encumbered to
498 secure all such debts, guarantees and obligations, exceeds the lesser of
499 five per cent of admitted assets or twenty-five per cent of surplus as
500 regards policyholders as reported in its last financial statement filed
501 with the commissioner pursuant to section 38a-53, as amended by this
502 act, or 38a-614.

503 (2) Nothing in this subsection shall be construed as prohibiting a
504 domestic insurer, domestic health care center or domestic fraternal
505 benefit society from pledging, hypothecating or encumbering any
506 assets in connection with: (A) Transactions in the ordinary course of
507 business, including, but not limited to: (i) Complying with any
508 statutory requirement, (ii) reinsurance transactions otherwise in
509 compliance with applicable statutory requirements, or (iii) investments
510 or investment practices otherwise in compliance with applicable
511 statutory requirements, including, but not limited to, securities
512 lending, repurchase transactions, reverse repurchase transactions,
513 swap, futures and options transactions, and any other transactions
514 which are not prohibited by the investment law and regulations of this
515 state; (B) transactions subject to the provisions of sections 38a-129 to
516 38a-140, inclusive; or (C) any other transaction deemed excluded by
517 the Insurance Commissioner. Assets pledged, hypothecated or

518 encumbered pursuant to subparagraph (A), (B) or (C) of this
519 subdivision shall not be charged against the limits set forth in
520 subdivision (1) of this subsection.

521 (3) In the case of a domestic life insurance company, the provisions
522 of this subsection shall apply to a separate account only to the extent
523 that reserves for guarantees with respect to (A) benefits guaranteed as
524 to dollar amount and duration or (B) funds guaranteed as to principal
525 amount or stated rate of interest are held in a separate account in
526 accordance with subdivision (3) of subsection (a) of section 38a-433.

527 Sec. 17. Section 38a-59 of the general statutes is repealed and the
528 following is substituted in lieu thereof (*Effective July 1, 2016*):

529 An amendment to the certificate of incorporation of a domestic
530 insurance company or a domestic health care center with capital stock
531 that changes the name of the company or health care center shall not
532 become effective until approved by the Insurance Commissioner after
533 reasonable notice and a public hearing, if such notice and hearing are
534 deemed by the commissioner to be in the public interest. A certificate
535 of amendment conforming to the requirements of section 33-800 shall
536 be filed in the office of the Insurance Commissioner before any
537 amendment to the certificate of incorporation of a domestic insurance
538 company or a domestic health care center with capital stock becomes
539 effective.

540 Sec. 18. Section 38a-591b of the 2016 supplement to the general
541 statutes, as amended by section 10 of public act 15-146, is repealed and
542 the following is substituted in lieu thereof (*Effective July 1, 2016*):

543 (a) Sections 38a-591a to 38a-591n, inclusive, shall apply to (1) any
544 health carrier offering a health benefit plan and that provides or
545 performs utilization review including prospective, concurrent or
546 retrospective review benefit determinations, and (2) any utilization
547 review company or designee of a health carrier that performs
548 utilization review on the health carrier's behalf, including prospective,

549 concurrent or retrospective review benefit determinations.

550 (b) Each health carrier shall be responsible for monitoring all
551 utilization review program activities carried out by or on behalf of
552 such health carrier. Such health carrier shall comply with the
553 provisions of sections 38a-591a to 38a-591n, inclusive, and any
554 regulations adopted thereunder, and shall be responsible for ensuring
555 that any utilization review company or other entity such health carrier
556 contracts with to perform utilization review complies with said
557 sections and regulations. Each health carrier shall ensure that
558 appropriate personnel have operational responsibility for the activities
559 of the health carrier's utilization review program.

560 (c) (1) A health carrier that requires utilization review of a benefit
561 request under a health benefit plan shall implement a utilization
562 review program and develop a written document that describes all
563 utilization review activities and procedures, whether or not delegated,
564 for (A) the filing of benefit requests, (B) the notification to covered
565 persons of utilization review and benefit determinations, and (C) the
566 review of adverse determinations and grievances in accordance with
567 sections 38a-591e and 38a-591f.

568 (2) Such document shall describe the following:

569 (A) Procedures to evaluate the medical necessity, appropriateness,
570 health care setting, level of care or effectiveness of health care services;

571 (B) Data sources and clinical review criteria used in making
572 determinations;

573 (C) Procedures to ensure consistent application of clinical review
574 criteria and compatible determinations;

575 (D) Data collection processes and analytical methods used to assess
576 utilization of health care services;

577 (E) Provisions to ensure the confidentiality of clinical, proprietary

578 and protected health information;

579 (F) The health carrier's organizational mechanism, such as a
580 utilization review committee or quality assurance or other committee,
581 that periodically assesses the health carrier's utilization review
582 program and reports to the health carrier's governing body; and

583 (G) The health carrier's staff position that is responsible for the day-
584 to-day management of the utilization review program.

585 (d) Each health carrier shall:

586 (1) Include in the insurance policy, certificate of coverage or
587 handbook provided to covered persons a clear and comprehensive
588 description of:

589 (A) Its utilization review and benefit determination procedures;

590 (B) Its grievance procedures, including the grievance procedures for
591 requesting a review of an adverse determination;

592 (C) A description of the external review procedures set forth in
593 section 38a-591g, in a format prescribed by the commissioner and
594 including a statement that discloses that:

595 (i) A covered person may file a request for an external review of an
596 adverse determination or a final adverse determination with the
597 commissioner and that such review is available when the adverse
598 determination or the final adverse determination involves an issue of
599 medical necessity, appropriateness, health care setting, level of care or
600 effectiveness. Such disclosure shall include the contact information of
601 the commissioner; and

602 (ii) When filing a request for an external review of an adverse
603 determination or a final adverse determination, the covered person
604 shall be required to authorize the release of any medical records that
605 may be required to be reviewed for the purpose of making a decision

606 on such request;

607 (D) A statement of the rights and responsibilities of covered persons
608 with respect to each of the procedures under subparagraphs (A) to (C),
609 inclusive, of this subdivision. Such statement shall include a disclosure
610 that a covered person has the right to contact the commissioner's office
611 or the Office of Healthcare Advocate at any time for assistance and
612 shall include the contact information for said offices;

613 (E) A description of what constitutes a surprise bill, as defined in
614 subsection (a) of section 38a-477aa;

615 (2) Inform its covered persons, at the time of initial enrollment and
616 at least annually thereafter, of its grievance procedures. This
617 requirement may be fulfilled by including such procedures in an
618 enrollment agreement or update to such agreement;

619 (3) Inform a covered person or the covered person's health care
620 professional, as applicable, at the time the covered person or the
621 covered person's health care professional requests a prospective or
622 concurrent review: (A) The network status under such covered
623 person's health benefit plan of the health care professional who will be
624 providing the health care service or course of treatment; (B) an
625 estimate of the amount the health carrier will reimburse such health
626 care professional for such service or treatment; and (C) how such
627 amount compares to the usual, customary and reasonable charge, as
628 determined by the Centers for Medicare and Medicaid Services, for
629 such service or treatment;

630 (4) Inform a covered person and the covered person's health care
631 professional of the health carrier's grievance procedures whenever the
632 health carrier denies certification of a benefit requested by a covered
633 person's health care professional;

634 (5) Prominently post on its Internet web site the description
635 required under subparagraph (E) of subdivision (1) of this subsection;

636 (6) Include in materials intended for prospective covered persons a
637 summary of its utilization review and benefit determination
638 procedures;

639 (7) Print on its membership or identification cards a toll-free
640 telephone number for utilization review and benefit determinations;

641 (8) Maintain records of all benefit requests, claims and notices
642 associated with utilization review and benefit determinations made in
643 accordance with section 38a-591d for not less than six years after such
644 requests, claims and notices were made. Each health carrier shall make
645 such records available for examination by the commissioner and
646 appropriate federal oversight agencies upon request; and

647 (9) Maintain records in accordance with section 38a-591h of all
648 grievances received. Each health carrier shall make such records
649 available for examination by covered persons, to the extent such
650 records are permitted to be disclosed by law, the commissioner and
651 appropriate federal oversight agencies upon request.

652 [(e) (1) On or before March first annually, each health carrier shall
653 file with the commissioner:

654 (A) A summary report of its utilization review program activities in
655 the calendar year immediately preceding; and

656 (B) A report that includes for each type of health benefit plan
657 offered by the health carrier:

658 (i) A certificate of compliance certifying that the utilization review
659 program of the health carrier or its designee complies with all
660 applicable state and federal laws concerning confidentiality and
661 reporting requirements;

662 (ii) The number of covered lives;

663 (iii) The total number of grievances received;

664 (iv) The number of grievances resolved at each level, if applicable,
665 and their resolution;

666 (v) The number of grievances appealed to the commissioner of
667 which the health carrier has been informed;

668 (vi) The number of grievances referred to alternative dispute
669 resolution procedures or resulting in litigation; and

670 (vii) A synopsis of actions being taken to correct any problems
671 identified.

672 (2) The commissioner shall adopt regulations, in accordance with
673 chapter 54, to establish the form and content of the reports specified in
674 subdivision (1) of this subsection.]

675 Sec. 19. Subdivision (3) of subsection (a) of section 38a-591e of the
676 general statutes is repealed and the following is substituted in lieu
677 thereof (*Effective July 1, 2016*):

678 (3) In addition to a copy of such procedures, each health carrier shall
679 file annually with the commissioner, [as part of its annual report
680 required under subsection (e) of section 38a-591b] in a form prescribed
681 by the commissioner, a certificate of compliance stating that the health
682 carrier has established and maintains grievance procedures for each of
683 its health benefit plans that are fully compliant with the provisions of
684 sections 38a-591a to 38a-591n, inclusive.

685 Sec. 20. Section 38a-591h of the general statutes is repealed and the
686 following is substituted in lieu thereof (*Effective July 1, 2016*):

687 (a) (1) Each health carrier shall maintain written records to
688 document all grievances of adverse determinations it receives,
689 including the notices and claims associated with such grievances,
690 during a calendar year.

691 (2) (A) Each health carrier shall maintain such records for not less

692 than six years after the notice of an adverse determination that is the
693 subject of a grievance was provided to a covered person or the covered
694 person's authorized representative, as applicable, under section 38a-
695 591d.

696 (B) The health carrier shall make such records available for
697 examination by covered persons, to the extent such records are
698 permitted to be disclosed by law, the commissioner and appropriate
699 federal oversight agencies upon request. Such records shall be
700 maintained in a manner that is reasonably clear and accessible to the
701 commissioner.

702 (b) For each grievance the record shall contain, at a minimum, the
703 following information: (1) A general description of the reason for the
704 grievance; (2) the date the health carrier received the grievance; (3) the
705 date of each review or, if applicable, review meeting of the grievance;
706 (4) the resolution at each level of the grievance, if applicable; (5) the
707 date of resolution at each such level, if applicable; and (6) the name of
708 the covered person for whom the grievance was filed.

709 [(c) Each health carrier shall submit a report annually to the
710 commissioner, in accordance with section 38a-591b, of the grievances it
711 received.]

712 [(d)] (c) (1) Each health carrier shall maintain written records of all
713 requests for external reviews, whether such requests are for standard
714 or expedited external reviews, that such health carrier receives notice
715 of from the commissioner in a calendar year. The health carrier shall
716 maintain such records in the aggregate by state where the covered
717 person requesting such review resides and by each type of health
718 benefit plan offered by the health carrier, and shall submit a report to
719 the commissioner upon request, in a format prescribed by the
720 commissioner.

721 (2) Such report shall include, in the aggregate by state where the
722 covered person requesting such review resides and by each type of

723 health benefit plan:

724 (A) The total number of requests for an external review, whether
 725 such requests were for a standard or expedited external review;

726 (B) From the total number of such requests reported under
 727 subparagraph (A) of this subdivision, the number of requests
 728 determined eligible for a full external review, whether such requests
 729 were for a standard or expedited external review; and

730 (C) Any other information the commissioner may request or
 731 require.

732 (3) The health carrier shall retain the written records required
 733 pursuant to subdivision (1) of this subsection for not less than six years
 734 after the request for an external review or an expedited external review
 735 was received.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2016</i>	38a-175
Sec. 2	<i>July 1, 2016</i>	38a-178
Sec. 3	<i>July 1, 2016</i>	38a-179
Sec. 4	<i>July 1, 2016</i>	38a-186
Sec. 5	<i>July 1, 2016</i>	38a-188
Sec. 6	<i>July 1, 2016</i>	12-201(9)
Sec. 7	<i>July 1, 2016</i>	12-202a(a)
Sec. 8	<i>July 1, 2016</i>	12-217t(c) to (e)
Sec. 9	<i>July 1, 2016</i>	19a-7j(b)(2)(A)
Sec. 10	<i>July 1, 2016</i>	19a-7p(b)(2)
Sec. 11	<i>July 1, 2016</i>	38a-14(h)
Sec. 12	<i>July 1, 2016</i>	38a-43
Sec. 13	<i>July 1, 2016</i>	38a-52
Sec. 14	<i>July 1, 2016</i>	38a-53
Sec. 15	<i>July 1, 2016</i>	38a-54(a)
Sec. 16	<i>July 1, 2016</i>	38a-55
Sec. 17	<i>July 1, 2016</i>	38a-59

Sec. 18	<i>July 1, 2016</i>	38a-591b
Sec. 19	<i>July 1, 2016</i>	38a-591e(a)(3)
Sec. 20	<i>July 1, 2016</i>	38a-591h

Statement of Purpose:

To authorize multistate health care centers in Connecticut and eliminate a utilization review report filing requirement for health carriers.

[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.]