



Senate

General Assembly

File No. 444

February Session, 2016

Substitute Senate Bill No. 375

Senate, April 4, 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 substitute bill ought to pass.

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2 statutes is repealed and the following is substituted in lieu thereof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, with respect to an
73 organization, that the organization has been declared insolvent and
74 placed under an order of liquidation by a court of competent
75 jurisdiction.

76 (13) "Net worth" means the excess of total admitted assets over total

77 liabilities, but the liabilities shall not include fully subordinated debt,
78 as [defined] that term is used in section 38a-193.

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

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

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

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

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

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

104 (20) "Subscriber" means an individual whose employment or other
105 status, except family dependency, is the basis for eligibility for
106 enrollment in the health care center, or in the case of an individual
107 contract, the person in whose name the contract is issued.

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

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

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

124 (a) If [the] a domestic health care center is organized as a nonprofit,
125 nonstock corporation, the care, control and disposition of the property
126 and funds of each such corporation and the general management of its
127 affairs shall be vested in a board of directors. Each such corporation
128 shall have the power to adopt bylaws for the governing of its affairs,
129 which bylaws shall prescribe the number of directors, their term of
130 office and the manner of their election, subject to the provisions of
131 sections 38a-175 to 38a-192, inclusive, as amended by this act. The
132 bylaws may be adopted and repealed or amended by the affirmative
133 vote of two-thirds of all the directors at any meeting of the board of
134 directors duly held upon at least ten days' notice, provided notice of
135 such meeting shall specify the proposed action concerning the bylaws
136 to be taken at such meeting. The bylaws of the corporation shall
137 provide that the board of directors shall include representation from
138 persons engaged in the healing arts and from persons who are eligible
139 to receive health care from the corporation, subject to the following
140 provisions: (1) One-quarter of the board of directors shall be persons

141 engaged in the different fields in the healing arts at least two of whom
142 shall be a physician and a dentist; (2) one-quarter of the board of
143 directors shall be subscribers who are eligible to receive health care
144 from the health care center, but no such representative need be seated
145 until the first annual meeting following the approval by the
146 commissioner of the initial agreement or agreements to be offered by
147 the corporation, and there shall be only one representative from any
148 group covered by a group service agreement.

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

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

158 (a) In the event of the dissolution, liquidation or termination of the
159 corporate existence of a domestic health care center [which] that is
160 organized as a nonprofit, nonstock corporation, no part of the property
161 or assets of the health care center shall inure to the benefit of any
162 director, officer, subscriber or employee of the corporation, each of
163 whom by holding such position shall be deemed to have waived and
164 relinquished all rights conferred by statute or otherwise upon
165 subscribers of a corporation without capital stock to share in such
166 assets upon dissolution, liquidation or termination. After the payment
167 of all lawful claims against the corporation, all its remaining assets
168 shall be devoted permanently and exclusively to the purposes for
169 which the corporation is formed, or paid over to an organization
170 organized and operated exclusively for charitable, educational and
171 scientific purposes, and in such amount and proportions, as the board
172 of directors in its discretion shall determine.

173 (b) No person may, with respect to a domestic health care center, (1)

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

190 Sec. 5. Section 38a-188 of the 2016 supplement to the general statutes
191 is repealed and the following is substituted in lieu thereof (*Effective July*
192 *1, 2016*):

193 (a) Each health care center governed by sections 38a-175 to 38a-192,
194 inclusive, as amended by this act, shall be exempt from the provisions
195 of the general statutes relating to insurance in the conduct of its
196 operations under said sections and in such other activities as do
197 constitute the business of insurance, unless expressly included therein,
198 and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51,
199 38a-52, as amended by this act, 38a-56, 38a-57, 38a-58a, 38a-129 to 38a-
200 140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a
201 health care center shall not be deemed in violation of sections 38a-815
202 to 38a-819, inclusive, solely by virtue of such health care center
203 selectively contracting with certain providers in one or more
204 specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j,
205 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to
206 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-
207 786, 38a-790, 38a-792 and 38a-794, provided a health care center

208 organized as a nonprofit, nonstock corporation shall be exempt from
209 sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-
210 735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772
211 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health
212 care center is operated as a line of business, the foregoing provisions
213 shall, where possible, be applied only to that line of business and not
214 to the organization as a whole.

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

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

240 Sec. 6. Subdivision (9) of section 12-201 of the 2016 supplement to

241 the general statutes is repealed and the following is substituted in lieu
242 thereof (*Effective July 1, 2016*):

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

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

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

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

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

273 tax year against the taxes imposed by chapter 207, 208, 208a, 209, 210,
274 211 or 212 or against the tax imposed on domestic health care centers,
275 under the provisions of section 12-202a, as amended by this act, shall
276 be allowable only after all other credits allowable against such taxes for
277 such tax year have been applied.

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

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

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

303 (2) (A) Each domestic insurer or domestic health care center doing
304 health insurance business in this state shall annually pay to the
305 Insurance Commissioner, for deposit in the Insurance Fund

306 established under section 38a-52a, a health and welfare fee assessed by
307 the Insurance Commissioner pursuant to this section.

308 Sec. 10. Subdivision (2) of subsection (b) of section 19a-7p of the
309 2016 supplement to the general statutes is repealed and the following
310 is substituted in lieu thereof (*Effective July 1, 2016*):

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

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

319 (h) The commissioner shall, at least once in every five years, visit
320 and examine the affairs of each domestic insurance company, domestic
321 health care center, domestic fraternal benefit society, and foreign and
322 alien insurance company doing business in this state. Notwithstanding
323 subdivision (1) of subsection (c) of this section, no domestic insurance
324 company or other domestic entity subject to examination under this
325 section shall pay as costs associated with the examination the salaries,
326 fringe benefits, traveling and maintenance expenses of examining
327 personnel of the Insurance Department engaged in such examination if
328 such domestic company or domestic entity is otherwise liable to
329 assessment levied under section 38a-47, except that a domestic
330 insurance company or other domestic entity shall pay the traveling
331 and maintenance expenses of examining personnel of the Insurance
332 Department when such company or entity is examined outside the
333 state.

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

336 Whenever it appears to the commissioner that permission to

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

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

354 Any (1) domestic insurance company or other domestic entity
355 aggrieved because of any assessment levied under section 38a-48, (2)
356 fraternal benefit society or foreign or alien insurance company or other
357 entity aggrieved because of any assessment levied under the
358 provisions of sections 38a-49 to 38a-51, inclusive, or (3) domestic
359 insurer, domestic health care center, third-party administrator licensed
360 pursuant to section 38a-720a or exempt insurer, as defined in
361 subdivision (1) of subsection (b) of section 19a-7j, aggrieved because of
362 any assessment levied under said section 19a-7j, may, within one
363 month from the time provided for the payment of such assessment,
364 appeal therefrom to the superior court for the judicial district of New
365 Britain, which appeal shall be accompanied by a citation to the
366 commissioner to appear before said court. Such citation shall be signed
367 by the same authority, and such appeal shall be returnable at the same
368 time and served and returned in the same manner, as is required in
369 case of a summons in a civil action. The authority issuing the citation
370 shall take from the appellant a bond or recognizance to the state, with

371 surety to prosecute the appeal to effect and to comply with the orders
372 and decrees of the court in the premises. Such appeals shall be
373 preferred cases, to be heard, unless cause appears to the contrary, at
374 the first session, by the court or by a committee appointed by the court.
375 Said court may grant such relief as may be equitable, and, if such
376 assessment has been paid prior to the granting of such relief, may
377 order the Treasurer to pay the amount of such relief, with interest at
378 the rate of six per cent per annum, to the aggrieved company. If the
379 appeal has been taken without probable cause, the court may tax
380 double or triple costs, as the case demands; and, upon all such appeals
381 which may be denied, costs may be taxed against the appellant at the
382 discretion of the court, but no costs shall be taxed against the state.

383 Sec. 14. Section 38a-53 of the 2016 supplement to the general statutes
384 is repealed and the following is substituted in lieu thereof (*Effective July*
385 *1, 2016*):

386 (a) (1) Each domestic insurance company or domestic health care
387 center shall, annually, on or before the first day of March, submit to the
388 commissioner, and electronically to the National Association of
389 Insurance Commissioners, a true and complete report, signed and
390 sworn to by its president or a vice president, and secretary or an
391 assistant secretary, of its financial condition on the thirty-first day of
392 December next preceding, prepared in accordance with the National
393 Association of Insurance Commissioners annual statement instructions
394 handbook and following those accounting procedures and practices
395 prescribed by the National Association of Insurance Commissioners
396 accounting practices and procedures manual, subject to any deviations
397 in form and detail as may be prescribed by the commissioner. An
398 electronically filed report in accordance with section 38a-53a that is
399 timely submitted to the National Association of Insurance
400 Commissioners shall not exempt a domestic insurance company or
401 domestic health care center from timely filing a true and complete
402 paper copy with the commissioner.

403 (2) Each accredited reinsurer, as defined in subdivision (1) of

404 subsection (c) of section 38a-85, and assuming insurance company, as
405 provided in section 38a-85, shall file an annual report in accordance
406 with the provisions of section 38a-85.

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

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

431 (d) In addition to such annual report and the quarterly report
432 required under subsection (c) of this section, the commissioner,
433 whenever the commissioner determines that more frequent reports are
434 required because of certain factors or trends affecting companies
435 writing a particular class or classes of business or because of changes
436 in the company's management or financial or operating condition, may

437 require any insurance company or health care center doing business in
438 this state to file financial statements on other than an annual or
439 quarterly basis.

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

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

470 Sec. 15. Subsection (a) of section 38a-54 of the general statutes is
471 repealed and the following is substituted in lieu thereof (*Effective July*
472 *1, 2016*):

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

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

486 (a) No domestic insurer, domestic health care center or domestic
487 fraternal benefit society may pledge, hypothecate or otherwise
488 encumber its assets to secure the debt, guaranty or obligations of any
489 other person without the prior written consent of the Insurance
490 Commissioner. This prohibition shall not apply to obligations of the
491 insurer under surety bonds or insurance contracts issued in the regular
492 course of business.

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

503 with the commissioner pursuant to section 38a-53, as amended by this
504 act, or 38a-614.

505 (2) Nothing in this subsection shall be construed as prohibiting a
506 domestic insurer, domestic health care center or domestic fraternal
507 benefit society from pledging, hypothecating or encumbering any
508 assets in connection with: (A) Transactions in the ordinary course of
509 business, including, but not limited to: (i) Complying with any
510 statutory requirement, (ii) reinsurance transactions otherwise in
511 compliance with applicable statutory requirements, or (iii) investments
512 or investment practices otherwise in compliance with applicable
513 statutory requirements, including, but not limited to, securities
514 lending, repurchase transactions, reverse repurchase transactions,
515 swap, futures and options transactions, and any other transactions
516 which are not prohibited by the investment law and regulations of this
517 state; (B) transactions subject to the provisions of sections 38a-129 to
518 38a-140, inclusive; or (C) any other transaction deemed excluded by
519 the Insurance Commissioner. Assets pledged, hypothecated or
520 encumbered pursuant to subparagraph (A), (B) or (C) of this
521 subdivision shall not be charged against the limits set forth in
522 subdivision (1) of this subsection.

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

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

531 An amendment to the certificate of incorporation of a domestic
532 insurance company or a domestic health care center with capital stock
533 that changes the name of the company or health care center shall not
534 become effective until approved by the Insurance Commissioner after
535 reasonable notice and a public hearing, if such notice and hearing are

536 deemed by the commissioner to be in the public interest. A certificate
537 of amendment conforming to the requirements of section 33-800 shall
538 be filed in the office of the Insurance Commissioner before any
539 amendment to the certificate of incorporation of a domestic insurance
540 company or a domestic health care center with capital stock becomes
541 effective.

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

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

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

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

569 sections 38a-591e, as amended by this act, and 38a-591f.

570 (2) Such document shall describe the following:

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

573 (B) Data sources and clinical review criteria used in making
574 determinations;

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

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

579 (E) Provisions to ensure the confidentiality of clinical, proprietary
580 and protected health information;

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

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

587 (d) Each health carrier shall:

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

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

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

594 (C) A description of the external review procedures set forth in
595 section 38a-591g, in a format prescribed by the commissioner and

596 including a statement that discloses that:

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

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

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

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

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

621 (3) Inform a covered person or the covered person's health care
622 professional, as applicable, at the time the covered person or the
623 covered person's health care professional requests a prospective or
624 concurrent review: (A) The network status under such covered
625 person's health benefit plan of the health care professional who will be
626 providing the health care service or course of treatment; (B) an

627 estimate of the amount the health carrier will reimburse such health
628 care professional for such service or treatment; and (C) how such
629 amount compares to the usual, customary and reasonable charge, as
630 determined by the Centers for Medicare and Medicaid Services, for
631 such service or treatment;

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

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

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

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

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

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

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

656 (A) A summary report of its utilization review program activities in

657 the calendar year immediately preceding; and

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

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

664 (ii) The number of covered lives;

665 (iii) The total number of grievances received;

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

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

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

672 (vii) A synopsis of actions being taken to correct any problems
673 identified.

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

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

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

685 its health benefit plans that are fully compliant with the provisions of
686 sections 38a-591a to 38a-591n, inclusive.

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

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

693 (2) (A) Each health carrier shall maintain such records for not less
694 than six years after the notice of an adverse determination that is the
695 subject of a grievance was provided to a covered person or the covered
696 person's authorized representative, as applicable, under section 38a-
697 591d.

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

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

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

714 [(d)] (c) (1) Each health carrier shall maintain written records of all
715 requests for external reviews, whether such requests are for standard

716 or expedited external reviews, that such health carrier receives notice
 717 of from the commissioner in a calendar year. The health carrier shall
 718 maintain such records in the aggregate by state where the covered
 719 person requesting such review resides and by each type of health
 720 benefit plan offered by the health carrier, and shall submit a report to
 721 the commissioner upon request, in a format prescribed by the
 722 commissioner.

723 (2) Such report shall include, in the aggregate by state where the
 724 covered person requesting such review resides and by each type of
 725 health benefit plan:

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

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

732 (C) Any other information the commissioner may request or
 733 require.

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2016	38a-175
Sec. 2	July 1, 2016	38a-178
Sec. 3	July 1, 2016	38a-179
Sec. 4	July 1, 2016	38a-186
Sec. 5	July 1, 2016	38a-188
Sec. 6	July 1, 2016	12-201(9)
Sec. 7	July 1, 2016	12-202a(a)
Sec. 8	July 1, 2016	12-217t(c) to (e)

Sec. 9	July 1, 2016	19a-7j(b)(2)(A)
Sec. 10	July 1, 2016	19a-7p(b)(2)
Sec. 11	July 1, 2016	38a-14(h)
Sec. 12	July 1, 2016	38a-43
Sec. 13	July 1, 2016	38a-52
Sec. 14	July 1, 2016	38a-53
Sec. 15	July 1, 2016	38a-54(a)
Sec. 16	July 1, 2016	38a-55
Sec. 17	July 1, 2016	38a-59
Sec. 18	July 1, 2016	38a-591b
Sec. 19	July 1, 2016	38a-591e(a)(3)
Sec. 20	July 1, 2016	38a-591h

Statement of Legislative Commissioners:

In Sections 8(c) and 18(c)(1), "as amended by this act" was added and in Section 1(12), (13) and (16), technical changes were added, for consistency with standard drafting conventions.

INS *Joint Favorable Subst. -LCO*

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.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 17 \$	FY 18 \$
Insurance Dept.	GF - Revenue Gain	1,430 - 4,290	380 - 1,140
Department of Revenue Services	GF - Precludes Revenue Gain	Potential	Potential

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill allows the Insurance Department to license health care centers organized outside of Connecticut (called foreign HMOs) to do business in the state. It is anticipated that one to three foreign HMOs will apply for licensure, resulting in a General Fund revenue gain ranging from \$1,430 - \$4,290 in FY 17 and \$380 - \$1,140 in FY 18.¹ To the extent that additional foreign HMOs apply for licensure in FY 18, revenue of \$1,430 per center would result.

The bill specifies that the Insurance Premiums Tax applies to domestic health care centers only. To the extent foreign health care centers are established in the state under the bill's provisions, this precludes a revenue gain associated with the potential taxation of such health care centers.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Connecticut Licensing Info Center <http://ct-clic.com>

¹ The fees for an initial health care center license total \$1,430 and the cost of subsequent year fees total \$380.

OLR Bill Analysis**sSB 375*****AN ACT AUTHORIZING MULTISTATE HEALTH CARE CENTERS IN CONNECTICUT AND ELIMINATING A HEALTH CARRIER UTILIZATION REVIEW REPORT FILING REQUIREMENT.*****SUMMARY:**

This bill allows the Insurance Department to authorize health care centers (commonly called HMOs) organized outside of Connecticut to do business in Connecticut. It does this by removing from the definition of “health care center” a requirement that an HMO that does business here be organized under Connecticut laws (§ 1). The bill generally subjects foreign HMOs (e.g., those organized under the laws of another state) to the same laws that currently apply to domestic HMOs, with certain exceptions.

Under the bill, foreign HMOs are not required to pay annual taxes on direct subscriber charges and are therefore not eligible for a tax credit allowed for personal property taxes paid on electronic data processing equipment (§§ 6 to 8). Domestic HMOs must pay an annual tax of 1.75% of total net direct subscriber charges collected in a calendar year.

Additionally, the bill does not require foreign HMOs to pay a health and welfare fee or public health fee, which domestic HMOs must pay (§§ 9 & 10). These fees are used to pay for certain Department of Public Health programs, including a vaccination program, needle and syringe exchange program, and breast and cervical cancer detection and treatment program.

Lastly, the bill eliminates a duplicate report requirement and makes conforming changes (§§ 18 to 20). It eliminates the requirement that health carriers (e.g., insurers, HMOs, and other entities issuing health

benefit plans) annually, by March 1, file a utilization review report with the insurance commissioner. Health carriers must already report utilization review information in their annual managed care reports due May 1 to the commissioner under CGS § 38a-478c.

EFFECTIVE DATE: July 1, 2016

DOMESTIC VERSUS FOREIGN HMO REQUIREMENTS

In addition to the tax laws and fees discussed above, the bill also applies certain existing HMO and insurance laws to domestic HMOs only, as shown in Table 1.

Table 1: Additional Laws Applying to Domestic HMOs Only Under the Bill

CGS §	Bill §	Description
38a-179	3	A nonprofit, nonstock, domestic HMO must vest management of its affairs in a board of directors
38a-186	4	Addresses how a nonprofit, nonstock, domestic HMO must dispose of its property if the HMO terminates Prohibits certain stock transactions and mergers unless the parties comply with existing laws governing a change of control
38a-14(h)	11	The insurance commissioner must examine domestic HMOs at least once every five years
38a-53	14	A domestic HMO must annually, by March 1, submit a financial statement to the insurance commissioner and the National Association of Insurance Commissioners (NAIC) for the prior calendar year
38a-54	15	A domestic HMO must annually, by June 1, file an audited financial report conducted by a certified public accountant with the insurance commissioner and NAIC
38a-55	16	A domestic HMO cannot encumber its assets to secure debt without the commissioner's written consent
38a-59	17	Addresses how a domestic HMO with capital stock may amend its certificate of incorporation for a name change

The bill requires an HMO, foreign or domestic, to include on its certificate of incorporation or other organizational document a list of other jurisdictions in which it is authorized to do business (§ 2). By law, the certificate or document must also include the area within Connecticut in which the HMO will operate and the services it will render.

The bill specifies that all HMOs, foreign or domestic, are subject to CGS § 38a-58a, the law governing how a company can transfer its state of domicile to or from Connecticut (§ 5). Also, the bill allows the insurance commissioner to prohibit a foreign HMO from doing business in Connecticut if permission to transact business in its state or country of domicile has been refused to a domestic HMO (i.e., licensure reciprocity) (§ 12).

BACKGROUND

Related Bill

sSB 368, reported favorably by the Insurance and Real Estate Committee, authorizes dental-only HMOs to operate in Connecticut.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 0 (03/17/2016)