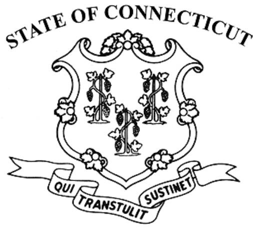

General Assembly

Amendment

February Session, 2016

LCO No. **5295**

Offered by:
SEN. FASANO, 34th Dist.
SEN. KELLY, 21st Dist.

To: House Bill No. **5444** File No. 725 Cal. No. 500

"AN ACT CONCERNING THE EXECUTION OF SURETY BONDS BY THE CONNECTICUT HEALTH INSURANCE EXCHANGE AND THE CONNECTICUT AIRPORT AUTHORITY."

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

3 "Sec. 501. Section 38a-567 of the 2016 supplement to the general
4 statutes is repealed and the following is substituted in lieu thereof
5 (*Effective January 1, 2018*):

6 Health insurance plans, associations of small employers and other
7 insurance arrangements covering small employers and insurers and
8 producers marketing such plans and arrangements shall be subject to
9 the following provisions:

10 (1) (A) Any such plan or arrangement shall be offered on a
11 guaranteed issue basis with respect to all eligible employees or
12 dependents of such employees, at the option of the small employer,

13 policyholder or contractholder, as the case may be.

14 (B) Any such plan or arrangement shall be renewable with respect
15 to all eligible employees or dependents at the option of the small
16 employer, policyholder or contractholder, as the case may be, except:
17 (i) For nonpayment of the required premiums by the small employer,
18 policyholder or contractholder; (ii) for fraud or misrepresentation of
19 the small employer, policyholder or contractholder or, with respect to
20 coverage of individual insured, the insureds or their representatives;
21 (iii) for noncompliance with plan or arrangement provisions; (iv) when
22 the number of insureds covered under the plan or arrangement is less
23 than the number of insureds or percentage of insureds required by
24 participation requirements under the plan or arrangement; or (v) when
25 the small employer, policyholder or contractholder is no longer
26 actively engaged in the business in which it was engaged on the
27 effective date of the plan or arrangement.

28 (C) Renewability of coverage may be effected by either continuing
29 in effect a plan or arrangement covering a small employer or by
30 substituting upon renewal for the prior plan or arrangement the plan
31 or arrangement then offered by the carrier that most closely
32 corresponds to the prior plan or arrangement and is available to other
33 small employers. Such substitution shall only be made under
34 conditions approved by the commissioner. A carrier may substitute a
35 plan or arrangement as set forth in this subparagraph only if the
36 carrier effects the same substitution upon renewal for all small
37 employers previously covered under the particular plan or
38 arrangement, unless otherwise approved by the commissioner. The
39 substitute plan or arrangement shall be subject to the rating restrictions
40 specified in this section on the same basis as if no substitution had
41 occurred, except for an adjustment based on coverage differences.

42 (D) Any such plan or arrangement shall provide special enrollment
43 periods (i) to all eligible employees or dependents as set forth in 45
44 CFR 147.104, as amended from time to time, **[**and**]** (ii) for coverage
45 under such plan or arrangement ordered by a court for a spouse or

46 minor child of an eligible employee where request for enrollment is
47 made not later than thirty days after the issuance of such court order,
48 and (iii) to all eligible pregnant employees at any time after the
49 commencement of the pregnancy, as certified by a physician licensed
50 under chapter 370 or an advanced practice registered nurse licensed
51 under chapter 378, acting within the scope of such physician's or
52 nurse's scope of practice. Coverage under subparagraph (D)(iii) of this
53 subdivision shall be effective as of the first of the month in which the
54 employee receives such certification.

55 (2) (A) As used in this subdivision, "grandfathered plan" has the
56 same meaning as "grandfathered health plan" as provided in the
57 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
58 from time to time.

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

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

65 (ii) Gender;

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

68 (iv) Industry, provided the rate factor associated with any industry
69 classification shall not vary from the arithmetic average of the highest
70 and lowest rate factors associated with all industry classifications by
71 greater than fifteen per cent of such average, and provided further, the
72 rate factors associated with any industry shall not be increased by
73 more than five per cent per year;

74 (v) Group size, provided the highest rate factor associated with
75 group size shall not vary from the lowest rate factor associated with

76 group size by a ratio of greater than 1.25 to 1.0;

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

84 (vii) Savings resulting from a reduction in the profit of a carrier that
85 writes small business plans or arrangements for an association group
86 plan or a plan written pursuant to section 5-259, provided any loss in
87 overall revenue due to a reduction in profit is not shifted to other small
88 employers; and

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

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

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

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

101 (ii) Total premium rates for family coverage for nongrandfathered
102 plans shall be determined by adding the premiums for each individual
103 family member, except that with respect to family members under
104 twenty-one years of age, the premiums for only the three oldest
105 covered children shall be taken into account in determining the total

106 premium rate for such family.

107 (iii) Premium rates for employees and dependents for
108 nongrandfathered plans shall be calculated for each covered individual
109 and premium rates for the small employer group shall be calculated by
110 totaling the premiums attributable to each covered individual.

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

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

117 (A) Encouraging or directing small employers to refrain from filing
118 an application for coverage with the small employer carrier because of
119 the health status, claims experience, industry, occupation or
120 geographic location of the small employer, except the provisions of
121 this subparagraph shall not apply to information provided by a small
122 employer carrier or producer to a small employer regarding the
123 carrier's established geographic service area or a restricted network
124 provision of a small employer carrier; or

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

128 (4) No small employer carrier shall, directly or indirectly, enter into
129 any contract, agreement or arrangement with a producer that provides
130 for or results in the compensation paid to a producer for the sale of a
131 health benefit plan to be varied because of the health status, claims
132 experience, industry, occupation or geographic area of the small
133 employer. A small employer carrier shall provide reasonable
134 compensation, as provided under the plan of operation of the
135 program, to a producer, if any, for the sale of a health care plan. No
136 small employer carrier shall terminate, fail to renew or limit its

137 contract or agreement of representation with a producer for any reason
138 related to the health status, claims experience, occupation, or
139 geographic location of the small employers placed by the producer
140 with the small employer carrier.

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

145 (6) No small employer carrier or producer shall disclose (A) to a
146 small employer the fact that any or all of the eligible employees of such
147 small employer have been or will be reinsured with the pool, or (B) to
148 any eligible employee or dependent the fact that he has been or will be
149 reinsured with the pool.

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

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

159 (9) Any violation of subdivisions (3) to (7), inclusive, of this section
160 and of any regulations established under subdivision (8) of this section
161 shall be an unfair and prohibited practice under sections 38a-815 to
162 38a-830, inclusive.

163 Sec. 502. Subsection (g) of section 38a-481 of the 2016 supplement to
164 the general statutes is repealed and the following is substituted in lieu
165 thereof (*Effective January 1, 2018*):

166 (g) (1) As used in this subsection, "Affordable Care Act" means the

167 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
168 from time to time, and regulations adopted thereunder, and
169 "grandfathered plan" has the same meaning as "grandfathered health
170 plan" as provided in the Affordable Care Act.

171 (2) Each individual health insurance policy subject to the Affordable
172 Care Act shall (A) be offered on a guaranteed issue basis with respect
173 to all eligible individuals or dependents, and (B) provide special
174 enrollment periods (i) to all eligible individuals or dependents as set
175 forth in 45 CFR 147.104, as amended from time to time, and (ii) to all
176 eligible pregnant individuals at any time after the commencement of
177 the pregnancy, as certified by a physician licensed under chapter 370
178 or an advanced practice registered nurse licensed under chapter 378,
179 acting within the scope of such physician's or nurse's scope of practice.
180 Coverage under subparagraph (B)(ii) of this subdivision shall be
181 effective as of the first of the month in which the employee receives
182 such certification.

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

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

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

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

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

195 (iii) Tobacco use, except that such rate may not vary by a ratio of
196 greater than 1.5 to 1.0 and may only be applied with respect to

197 individuals who may legally use tobacco under state and federal law.
198 For purposes of this subparagraph, "tobacco use" means the use of
199 tobacco products four or more times per week on average within a
200 period not longer than the six months immediately preceding.
201 "Tobacco use" does not include the religious or ceremonial use of
202 tobacco;

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

208 (5) Premium rates for a grandfathered or nongrandfathered policy
209 under subdivision (2) of this subsection may vary by (A) actuarially
210 justified differences in plan design, and (B) actuarially justified
211 amounts to reflect the policy's provider network and administrative
212 expense differences that can be reasonably allocated to such policy.

213 Sec. 503. Subsection (a) of section 38a-183 of the 2016 supplement to
214 the general statutes is repealed and the following is substituted in lieu
215 thereof (*Effective January 1, 2018*):

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

228 (2) Premium rates <u>and special enrollment periods</u> offered to

229 individuals shall be consistent with the requirements set forth in
230 section 38a-481, as amended by this act.

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

234 (4) No such health care center shall enter into any agreement with
235 subscribers unless and until it has filed with the commissioner a copy
236 of such agreement or agreements, including all riders and
237 endorsements thereon, and until the commissioner's approval thereof
238 has been obtained. The commissioner shall, within a reasonable time
239 after the filing of any request for an approval of the amounts to be
240 paid, any agreement or any form, notify the health care center of the
241 commissioner's approval or disapproval thereof.

242 Sec. 504. Section 38a-208 of the 2016 supplement to the general
243 statutes is repealed and the following is substituted in lieu thereof
244 (*Effective January 1, 2018*):

245 (a) No such corporation shall enter into any contract with
246 subscribers unless and until it has filed with the Insurance
247 Commissioner a full schedule of the rates to be paid by the subscribers
248 and has obtained said commissioner's approval thereof. Such filing
249 shall include an actuarial memorandum that includes, but is not
250 limited to, pricing assumptions and claims experience, and premium
251 rates and loss ratios from the inception of the contract. The
252 commissioner may refuse such approval if the commissioner finds
253 such rates to be excessive, inadequate or discriminatory. As used in
254 this subsection, "loss ratio" means the ratio of incurred claims to
255 earned premiums by the number of years of policy duration for all
256 combined durations.

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

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

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

Sec. 505. Section 38a-218 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

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

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

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

291 (d) No such medical service corporation shall enter into any contract
292 with subscribers unless and until it has filed with the Insurance
293 Commissioner a copy of such contract, including all riders and
294 endorsements thereof, and until said commissioner's approval thereof
295 has been obtained. The Insurance Commissioner shall, within a
296 reasonable time after the filing of any such form, notify such
297 corporation of the commissioner's approval or disapproval thereof."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	*January 1, 2018*	38a-567
Sec. 502	*January 1, 2018*	38a-481(g)
Sec. 503	*January 1, 2018*	38a-183(a)
Sec. 504	*January 1, 2018*	38a-208
Sec. 505	*January 1, 2018*	38a-218