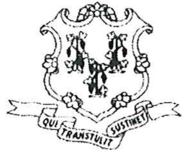


STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony
Insurance and Real Estate Committee
February 21, 2017

Senate Bill No. 807 An Act Increasing License Fees Charged to, The Minimum Net Worth of and Security Maintained by Preferred Provider Networks, and Making Minor and Technical Changes to Certain Insurance-Related Statutes.

Committee Chairs, Co-Chairs, Ranking Member, and Members of the Insurance and Real Estate Committee, the Insurance Department appreciates the opportunity to submit written testimony on **Senate Bill No. 807 An Act Increasing License Fees Charged to, The Minimum Net Worth of and Security Maintained by Preferred Provider Networks, and Making Minor and Technical Changes to Certain Insurance-Related Statutes.** The Department thanks the Committee for raising this bill and hearing it on the Department's behalf.

This bill includes technical changes that the Department is seeking in Title 38a.

Sections 1 and 3: Preferred Provider Networks:

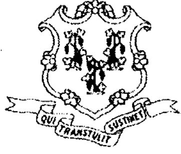
Sections 1 and 3 of the bill make changes to CGS 38a-11(a) and 38a-479aa with regard to licensure of Preferred Provider Networks (PPNs). A PPN is a network (a physician hospital group, a physician organization, or an accountable care organization) that may contract with an insurance company. These updated standards are to ensure greater coverage for consumers of PPNs. This legislation increases the licensing fee (from $2,750 to $5,000) and requires PPNs to keep a higher minimum net worth (changes the requirement from $250,000 to $500,000) and maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security for the exclusive use of paying any outstanding amounts owed to participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations worth an amount equivalent to four (4) months of payments. The previous standard was two (2) months. This will guarantee better financial solvency and allow PPNs to better serve their consumers.

Section 2: Medical Malpractice Closed Claim Report:

Section 2 of the bill amends CGS 38a-395(d) to change the due date of the Department's annual Medical Malpractice Report. The current due date of the report is March 15th annually, however, the Department is unable to submit the report in time based off of when the data is received from the industry. The Department's intention is simply to push back the due date to June 30th annually to ensure that the deadline is met.

The Department compiles and includes in the Report medical malpractice rate filing information for doctors, hospitals and other medical professionals. This information is also made available to the public. The Department has found that it is becoming increasingly difficult to compile and produce the Report

About the Connecticut Insurance Department: The mission of the Connecticut Insurance Department is to protect consumers through regulation of the industry, outreach, education and advocacy. The Department recovers an average of more than $4 million yearly on behalf of consumers and regulates the industry by ensuring carriers adhere to state insurance laws and regulations and are financially solvent to pay claims. The Department's annual budget is funded through assessments from the insurance industry. For every dollar of direct expense, the Department brings in about $7.45 to the state in revenues. Each year, the Department returns more than $215 million in assessments, fees and penalties to the state's General Fund.



by March 15 since all data and other information is not sufficiently available. As a result, the Department believes that by extending the annual due date of the report to **June 30**, it will be in a better position to have the data compiled, analyzed and published by that date.

Sections 4 through 23: Multistate Dental Health Care Centers and Other Related Changes:

Sections 4 through 23 make amendments in multiple areas of Title 38a by changing references from *"38a-175 to 38a-192"* to *38a-175 to 38a-194."* Sections 20-24 of PA 16-213 authorized Single Purpose Dental Health Care Centers (HMOs) to operate in Connecticut. However, these sections had inconsistent references to the aforementioned sections of state statutes. The Department specifically requested the changes reflected in sections 8, 9, 11, and 12 of this bill. As for the remaining sections, the Department agreed with LCO to make the conforming changes throughout.

Section 24: Network Adequacy:

Section 24 of the bill amends CGS 38a-472f(a)(6). With regard to network adequacy, it was the intent of PA 16-205 to include dental and vision carriers in the network adequacy requirements. The legislation in its final form exempted dental and vision carriers from following the standards laid out for other types of carriers, so the Department has proposed this technical correction to resolve the discrepancy. These technical corrections provide more consumer protection and gives the Department greater oversight of dental and vision plans.

The Department thanks the members of the Insurance and Real Estate Committee for the opportunity to submit testimony on S.B. 807.

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