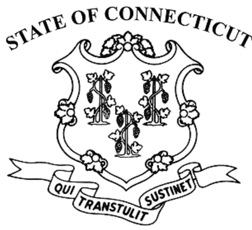

Senate

General Assembly

File No. 39

February Session, 2022

Substitute Senate Bill No. 15

Senate, March 21, 2022

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ENCOURAGING PRIMARY AND PREVENTIVE CARE.

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

1 Section 1. Section 38a-477kk of the 2022 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective January 1, 2024*):

4 (a) For the purposes of this section:

5 (1) "Health carrier" has the same meaning as provided in section 38a-
6 1080; and

7 (2) "Third-party administrator" has the same meaning as provided in
8 section 38a-720.

9 (b) Each health carrier or third-party administrator that issues a card
10 to an individual in this state for the purpose of enabling such individual
11 to prove that such individual has health coverage shall include in such
12 card a statement disclosing whether such coverage is fully insured or
13 self-insured. Such statement shall be prominently displayed on such

14 card in a readily understandable, standardized form prescribed by the
15 Insurance Commissioner.

16 (c) The Insurance Commissioner may adopt regulations, in
17 accordance with the provisions of chapter 54, to implement the
18 provisions of this section.

19 (d) Each health carrier or third-party administrator that issues a card
20 to an individual in this state for the purpose of enabling such individual
21 to prove that such individual has health coverage shall prominently
22 display the following information on such card in a readily
23 understandable manner, in addition to the information provided in
24 subsection (b) of this section:

25 (1) The name of, and contact information for, an in-network primary
26 care provider whom the individual has designated to serve as such
27 individual's preferred primary care provider; or

28 (2) If the individual has not designated a preferred primary care
29 provider under subdivision (1) of this subsection, a telephone number
30 maintained by such health carrier or third-party administrator for the
31 purpose of assisting such individual with accessing telehealth or a list
32 of local in-network primary care providers accepting new patients, or
33 the address of an Internet web site maintained by such health carrier or
34 third-party administrator for the purpose of enabling such individual to
35 contact, and schedule appointments with, local in-network primary care
36 providers, unless such health carrier or third-party administrator issues
37 a separate card to an individual for purposes of such services.

38 (e) The information required to be included on each card under
39 subsection (d) of this section may alternatively be made available in
40 electronic card format by the health carrier or third-party administrator,
41 if requested by the insured member. Any member who requests an
42 electronic card may also receive such card in hard copy via mail.

43 Sec. 2. (NEW) (*Effective January 1, 2023*) (a) (1) For the purposes of this
44 section, "chronic disease" means coronary artery disease, diabetes,

45 hyperlipidemia or hypertension.

46 (2) "Health enhancement program" means a health benefit program
47 that ensures access and removes barriers to essential, high-value clinical
48 services.

49 (b) (1) Not later than January 1, 2024, each insurer, health care center,
50 hospital service corporation, medical service corporation, fraternal
51 benefit society or other entity that delivers, issues for delivery, renews,
52 amends or continues in this state an individual or group health
53 insurance policy providing coverage of the type specified in
54 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
55 statutes shall develop not less than two health enhancement programs
56 under such policy.

57 (2) Each health enhancement program developed pursuant to
58 subdivision (1) of this subsection shall:

59 (A) Be available to each insured under the individual or group health
60 insurance policy; and

61 (B) Provide to each insured under the individual or group health
62 insurance policy incentives that are directly related to the provision of
63 health insurance coverage, provided such insured chooses to complete
64 certain preventive examinations and screenings recommended by the
65 United States Preventive Services Task Force with a rating of "A" or "B".

66 (3) No health enhancement program developed pursuant to
67 subdivision (1) of this subsection shall impose any penalty or other
68 negative incentive on an insured under the individual or group health
69 insurance policy nor shall any insured be required to participate in a
70 health enhancement program.

71 (c) Each individual health insurance policy providing coverage of the
72 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
73 of the general statutes delivered, issued for delivery, renewed, amended
74 or continued in this state shall include coverage for the health
75 enhancement programs that the insurer, health care center, hospital

76 service corporation, medical service corporation, fraternal benefit
77 society or other entity that delivered, issued, renewed, amended or
78 continued such policy developed pursuant to this section.

79 (d) Each group health insurance policy providing coverage of the
80 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
81 of the general statutes delivered, issued for delivery, renewed, amended
82 or continued in this state shall include coverage for the health
83 enhancement programs that the insurer, health care center, hospital
84 service corporation, medical service corporation, fraternal benefit
85 society or other entity that delivered, issued, renewed, amended or
86 continued such policy developed pursuant to this section.

87 (e) The Insurance Commissioner may adopt regulations, in
88 accordance with the provisions of chapter 54 of the general statutes, to
89 implement the provisions of this section.

90 Sec. 3. (NEW) (*Effective January 1, 2024*) (a) For the purposes of this
91 section:

92 (1) "Department" means the Department of Social Services; and

93 (2) "Connecticut medical assistance program" means the state's
94 Medicaid program and the Children's Health Insurance program
95 administered by the Department of Social Services.

96 (b) On any applicable card that the department issues to an
97 individual eligible for the Connecticut medical assistance program and
98 at the time such card is issued based on current practice, in addition to
99 other information that the department may include, the department
100 shall include on such card, to the extent that the following information
101 is available at the time the card is issued:

102 (1) The name of, and contact information for, a primary care provider
103 enrolled in the Connecticut medical assistance program whom the
104 individual has designated to serve as such individual's preferred
105 primary care provider, or the primary care provider whom the
106 department or its agent has identified as the primary care provider to

107 whom the individual has been attributed based on analysis of available
108 health care claims information for the individual; or

109 (2) If the individual has not designated a preferred primary care
110 provider under subdivision (1) of this subsection and the department is
111 not able to attribute the individual to a primary care provider based on
112 available health care claims information for the individual, the
113 department shall include on such card a notation to contact the
114 department's agent, with available contact information or a reference to
115 such agent, for assistance with finding, contacting and scheduling
116 appointments with primary care providers enrolled in the Connecticut
117 medical assistance program.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2024*	38a-477kk
Sec. 2	*January 1, 2023*	New section
Sec. 3	*January 1, 2024*	New section

INS *Joint Favorable Subst.*

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: None

Municipal Impact: See below

Explanation

The bill, which requires private health carriers in Connecticut to develop at least two health enhancement programs (HEPs) under their policies and to display certain information on health insurance ID cards, does not result in a fiscal impact to the state. It is anticipated that the Insurance Department, which may adopt implementing regulations under the bill, can review compliance within existing resources.

It is unknown if there will be a fiscal impact to fully insured municipalities as a result of HEP provisions of the bill.

The bill also requires the Department of Social Services (DSS) to print certain information on medical assistance program ID cards, which is not anticipated to result in a fiscal impact as it applies to cards issued on and after January 1, 2024.

The Out Years

State Impact: None

Municipal Impact: Unknown

OLR Bill Analysis
sSB 15

AN ACT ENCOURAGING PRIMARY AND PREVENTIVE CARE.

SUMMARY

This bill requires health carriers (e.g., insurers and HMOs) that deliver, issue, renew, amend, or continue certain individual or group health insurance policies in the state to develop at least two health enhancement programs (HEPs) under the policies by January 1, 2024. The bill defines a HEP as a health benefit program that ensures access and removes barriers to essential, high-value clinical services. The bill authorizes the insurance commissioner to adopt implementing regulations.

The bill also requires health carriers and third-party administrators (TPAs) that issue health insurance identification (ID) cards to insureds to prominently display on them, in a readily understandable manner, information to assist the insured with accessing and contacting a primary care provider (PCP).

Lastly, the bill requires the Department of Social Services (DSS), on any ID card it issues to an individual who is eligible for the state's medical assistance program (i.e., Medicaid or HUSKY B), to include information about accessing and contacting a PCP.

EFFECTIVE DATE: January 1, 2023, except the provisions about ID cards are effective January 1, 2024.

HEALTH ENHANCEMENT PROGRAMS

The bill requires health carriers to develop at least two HEPs by January 1, 2024. Each HEP must (1) be available to each insured under the health insurance policy and (2) provide incentives to each insured directly related to providing health insurance coverage for insureds

choosing to complete certain preventive examinations and screenings the U.S. Preventive Services Task Force recommends with an "A" or "B" rating. (Presumably, the bill means to limit this to chronic diseases as defined in the bill (i.e., coronary artery disease, diabetes, hyperlipidemia, or hypertension). However, while the bill defines "chronic disease," it does not otherwise use the term.)

The bill prohibits a HEP from imposing any penalty or negative incentive on an insured. It also specifies that an insured cannot be required to participate in a HEP.

The bill also requires certain individual and group health insurance policies to cover the HEPs. However, it is unclear if this means they must cover HEP administration costs or the examinations and screenings insureds receive through the HEP.

The bill's HEP provisions apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

HEALTH INSURANCE ID CARDS

Under the bill, health carriers and TPAs that issue health insurance ID cards must include on an insured's ID card the name and contact information for an in-network PCP whom the insured designated as his or her preferred PCP.

If the insured did not designate a PCP, the carrier or TPA must instead include on the ID card (1) a telephone number the insured may call to access telehealth or a list of local in-network PCPs accepting new patients or (2) the website address that allows the insured to contact and schedule appointments with local in-network PCPs, unless the carrier or TPA issues a separate card for these purposes.

The bill allows carriers and TPAs to provide the above information in an electronic card to an insured who requests it in that format.

Anyone who receives an electronic card may also receive a hard copy ID card in the mail.

By law, the insurance commissioner may adopt implementing regulations for ID cards.

MEDICAL ASSISTANCE PROGRAM ID CARDS

The bill requires DSS to include on its medical assistance program ID cards, to the extent available when issuing the card, the name and contact information for a PCP enrolled in the program whom (1) the covered individual designated as his or her preferred PCP or (2) DSS has identified based on the individual's health care claims.

If the individual did not designate a PCP, and DSS could not attribute the individual to one based on health care claims data, then DSS must instead include on the ID card a note to contact a DSS agent. The note must contain the agent's contact information for help finding, contacting, and scheduling appointments with PCPs enrolled in the medical assistance program.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 0 (03/10/2022)