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SpecialReport

2023 Acts Affecting Insurance

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Notice to Readers

This report provides summaries of new laws (public acts) significantly affecting insurance enacted during the 2023 legislative session. OLR's other Acts Affecting reports, including Acts Affecting Housing and Real Estate and Acts Affecting Health Professionals, are, or will soon be, available on OLR's website: https://www.cga.ct.gov/olr/actsaffecting.asp.

Each summary indicates the public act (PA) number. Not all provisions of the acts are included. The report does not include vetoed acts unless the veto was overridden. Complete summaries of public acts are, or will soon be, available on OLR's website: https://www.cga.ct.gov/olr/olrpasums.asp.

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Captive and Surplus Lines Insurers

Captive Insurers

A new law changes how captive insurers conduct business. Specifically, it allows (1) captive insurers to accept or transfer risk through parametric contracts (i.e., any agreement to make a payment based on a specified triggering event rather than the value of the loss) and (2) with the insurance commissioner's approval, protected cells of sponsored captive insurers to establish separate accounts with allocated assets.

The act also exempts dormant captive insurers from the captive insurance premiums tax (PA 23-15, effective October 1, 2023).

Surplus Lines Renewals

A new law makes it easier for insureds and brokers to procure or renew a surplus lines insurance policy. Under existing law, the insurance commissioner publishes a list of insurance lines that are generally unavailable from licensed insurers. Whenever an insured seeks to procure or renew an insurance line that does not appear on the list, both the insured and the broker must make diligent efforts to get insurance from a licensed insurer and document specified information about the insurance policy.

Prior law required the broker and insured to demonstrate their efforts and provide the information in a signed statement and periodically file it with the Insurance Department; the new law eliminates this requirement and instead requires that insureds and brokers keep documentation on their efforts and insurance policy information. It also requires the brokers to keep all policy information and make it available to the commissioner upon request, rather than file it quarterly (PA 23-65, effective October 1, 2023).

Insurance Industry

Development and Growth of the State's Insurance Industry

The legislature enacted a law requiring the insurance commissioner to promote the development and growth of, and employment opportunities within, the state's insurance industry (PA 23-70, § 3, effective July 1, 2023).

Insurance Department Fees

Under a new law, the insurance commissioner may require people and entities to pay Insurance Department fees electronically. However, the commissioner must waive this requirement for any

person or entity that requests it if he determines that (1) compliance is impractical or causes undue hardship or (2) good cause otherwise exists.

The new law also requires certified reinsurers and reciprocal jurisdiction reinsurers to pay the Insurance Department $2,000 for each certificate issued and renewed. State law and regulations require these reinsurers to apply to the department for certification (PA 23-127, § 1, effective October 1, 2023).

Insurance Licensure

A new law specifies requirements for people or entities who are eligible to get certain non-resident licenses from the Insurance Department. It allows non-resident people or entities to apply for and get a nonresident state license here and designate Connecticut as their home state if their resident state does not offer the same or equivalent resident license and they maintain a principal place of business in Connecticut. This applies to the following licenses: public adjuster, casualty adjuster, motor vehicle physical damage appraiser, certified insurance consultant, surplus lines broker, or any insurance-related occupation for which a license is deemed necessary by the commissioner, other than an insurance producer.

The new law also explicitly applies certain provisions of the general insurance licensing statute to any licensee or license applicant, including an insurance producer licensee or applicant. By law, this includes the requirement that the applicant prove to the commissioner that he or she is financially responsible and of sound moral character (PA 23-127, § 2, effective October 1, 2023).

Health Insurance Contracts and Practices

Terminating Health Care Contracts

Under a new law, a health carrier (e.g., insurer or HMO) and each provider participating in its network generally must give each other at least 90 days' written notice of an intent to terminate the contract before the proposed termination date or, if a nonrenewal, the end of the contract period. The carrier must make a good faith effort to notify all insureds who are regular patients of the participating provider at least 30 days before the proposed termination date or the end of the contract period. The new law also eliminates a requirement that a provider that leaves or is removed from a network give the carrier a list of its covered patients.

By law, when a contract between a health carrier and a participating hospital or its parent corporation is terminated or not renewed, the carrier and hospital must continue to abide by the contract for an additional 60 days. For contracts entered into, renewed, amended, or continued on

or after July 1, 2023, the new law (1) also applies this requirement to hospital intermediaries and (2) specifically requires that the contract terms the parties must continue abiding by for 60 days include the reimbursement terms for all health care services (PA 23-171, § 22, effective upon passage).

Electronic Notification to Insureds

A new law requires health carriers (e.g., insurers and HMOs) that deliver, issue, renew, amend, or continue health insurance policies to allow insured individuals who are legally capable of consenting to a policy's covered benefits to elect, in writing, to receive insurance coverage documents electronically. When providing documents electronically, the carriers must comply with all applicable federal and state data security laws (PA 23-171, § 21, effective October 1, 2023).

Facility Fees

Existing law limits when hospitals, health systems, and hospital-based facilities may charge facility fees for outpatient services provided off-site from a hospital campus. Starting July 1, 2024, a new law also prohibits hospitals or health systems from charging facility fees for certain on-campus outpatient procedures that are not provided in the emergency department.

The act allows hospitals or health systems to continue to collect insurance reimbursement for the newly prohibited fees if an insurance contract in effect on July 1, 2024, reimburses these fees. They may continue to do so until the earlier of the contract's expiration, renewal, or amendment (PA 23-171, § 9, effective July 1, 2023).

Health Care Network Tiering Practices

The legislature enacted new transparency rules around health care tiering practices. The new law broadly requires health carriers to disclose how they (1) select providers for different tiers and (2) evaluate providers within each tier. Among other things, the law requires health carriers to give health care providers their score and data used for selecting tiers and a summary of any grievance process (PA 23-171, § 20, effective July 1, 2024.)

Probate Court Judges' and Employees' Insurance Coverage

By law, the Probate Court Administration Fund pays (1) up to 100% of the portion of the premium charged for probate judges' and employees' individual coverage under the group hospitalization and medical and surgical insurance plan and (2) a portion of the additional costs for the judge's or employee's form of coverage. This session, the legislature increased the maximum contribution

from the fund from up to 50% to up to 70% of the additional costs (PA 23-204 as amended, § 57, effective July 1, 2023).

Prohibited Health Care Contracting Practices

A new law prohibits certain anticompetitive health care practices. It prohibits health care providers, health carriers (e.g., insurers and HMOs), and health plan administrators from entering into a health care contract on or after July 1, 2024, that includes an all-or-nothing clause, anti-steering clause, anti-tiering clause, or gag clause. The law makes null and void any of these clauses in a health care contract (i.e., an oral or written agreement to provide services under a health benefit plan), written policy or procedure, or agreement. However, it specifies that (1) all remaining clauses remain in effect for the contract's duration and (2) it does not modify, reduce, or eliminate any existing privacy protections and standards under the federal Health Insurance Portability and Accountability, Genetic Information Nondiscrimination, or federal Americans with Disabilities acts (PA 23-171, § 19, effective July 1, 2024.)

Public School Operator and Health Care Benefit Agreements

The legislature expanded the types of "public school operators" that can join in health care benefit agreements with other school operators or municipalities. Under existing law, a school board or a municipality may join with other school boards or municipalities through a written agreement to form a single entity to provide medical or health care benefits for their employees. The new law additionally allows regional educational service centers, the governing councils of state or local charter schools, and operators of magnet school programs to participate in these agreements as described in law (PA 23-160, § 42, effective July 1, 2023).

Tax Return Information for Access Health CT Outreach

A new law requires Access Health CT to do targeted outreach to people who authorize it on their state income tax return. Under the act, Access Health CT (i.e., the Connecticut Health Insurance Exchange) and the Department of Revenue Services (DRS) must enter into a memorandum of understanding to share tax return information so that Access Health CT may do targeted outreach to state residents, starting January 1, 2024. Correspondingly, the DRS commissioner must revise the state's income tax return form to include a space for residents to authorize Access Health CT to contact them about health insurance enrollment through the exchange (PA 23-204, §§ 299-301, effective January 1, 2024, except the provision directing Access Health CT to conduct targeted outreach is effective upon passage).

Health Insurance Coverage

Coverage for Infertility Diagnosis and Treatment

A new law prohibits certain health insurance policies, beginning January 1, 2024, from discriminating on the basis of gender identity or expression, sexual orientation, or age with respect to coverage for medically necessary infertility diagnosis and treatment. It also revises the allowed parameters for coverage of infertility-related expenses to conform to the federal Affordable Care Act. Specifically, it eliminates the ability of a policy to (1) limit infertility coverage to those (a) under age 40 and (b) who had coverage under the policy for at least 12 months and (2) require an insured to disclose any previous infertility treatment covered under a different policy (PA 23-127, §§ 11 & 12, effective October 1, 2023).

Coverage for In-Home Hospice Services

A new law requires certain individual and group health insurance policies to cover in-home hospice services provided by a licensed hospice home care agency to the same extent they cover hospital in-patient hospice services and subject to the same terms and conditions that apply to all other benefits under the policy. It also prohibits policies from excluding coverage for a hospice service solely because it is provided in the home and not at a hospital, as long as the home service is appropriate for the insured.

Under the act, health insurers, HMOs, and other entities may still conduct utilization review for in-home hospice services, as long as it is done in the same manner, and uses the same clinical criteria, as for the same hospice services provided in a hospital (PA 23-174, §§ 3 & 4, effective January 1, 2024).

Coverage for Mental Health Wellness Examinations

A new law eliminates the requirement that certain commercial health insurance policies cover mental health wellness examinations when performed by a primary care provider but maintains the existing requirement that the policies cover the examinations when performed by a licensed mental health professional (PA 23-148, effective upon passage).

Coverage for Newborns

By law, certain health insurance policies that cover family members must cover newborns from birth. The coverage must include injury and sickness benefits, including the care and treatment of congenital defects and birth abnormalities. A new law extends, from 61 days after birth to 91 days after the birth, the time period within which the insured person must (1) notify the health carrier about the birth and (2) pay any required premium or subscription fee to continue the newborn's

coverage beyond that period. As under existing law, if notification and payment is not provided within the specified period, claims originating during that period are not prejudiced (PA 23-204, §§ 223 & 224, effective January 1, 2024).

Health Insurance Programs for Paraeducators

The legislature required the comptroller to establish two programs providing subsidies and stipends to paraeducators for certain health insurance and health care-related costs. The first program provides a subsidy reimbursement for paraeducators' initial costs to fund a health savings account (HSA), which is a tax advantaged account available to people with high deductible health plans. The second provides a stipend for purchasing qualified health insurance to paraeducators who work for a board of education that generally does not provide a health insurance plan with an actuarial value of at least 60%. The law also establishes a paraeducator health care working group (PA 23-204, §§ 203-206 & 421, effective July 1, 2023).

Step Therapy

A new law lowers, from 60 to 30 days, the maximum amount of time an insurer can require an insured to use step therapy. For the three-year period beginning January 1, 2024, it also prohibits step therapy for drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder. Additionally, a health care provider treating an insured with these conditions may deem step therapy clinically ineffective, generally requiring insurers to authorize dispensation of and coverage for the drug prescribed by the provider, if it is covered under the insurance policy or contract. The law also creates a step-therapy task force (PA 23-204, §§ 225-227, effective January 1, 2024, except the task force is effective upon passage).

Health Insurance Utilization Reviews

Electronic Processing

Under a new law, health care providers participating in a health carrier's network must use a carrier's secure electronic system to process utilization reviews. However, a participating provider's failure to use the program must not contribute to an adverse determination (e.g., a benefit denial) (PA 23-204, § 230, effective January 1, 2024).

Procedural Changes

The legislature enacted a law changing how a health carrier must process utilization review requests that fail to meet the carrier's filing procedures. Broadly, the law (1) requires health carriers to acknowledge receipt of a review request as soon as practicable but within 24 hours after receiving it, unless federal law requires a faster response; (2) requires health carriers to provide

certain written notices within three, instead of five days, of providing them orally; and (3) prohibits health carriers from requiring that health care professionals or hospitals submit additional information with a prospective or concurrent review that is not reasonably available to the provider or hospital at the time the request is submitted (PA 23-204, § 222, effective January 1, 2024).

Prohibition on Reviews of Recurring Prescription Drugs to Treat Autoimmune Disorders, Multiple Sclerosis, or Cancer

Under a new law, certain health carriers (e.g., insurers and HMOs) are generally prohibited from requiring a prospective or concurrent review of a recurring prescription drug used to directly treat an autoimmune disorder, multiple sclerosis, or cancer that they already approved through utilization review (PA 23-204, §§ 220 & 221, generally effective January 1, 2025).

Reporting from Managed Care Organizations

A new law requires managed care organizations (MCOs) to annually report certain prior authorization and utilization review data, actuarial analyses, and estimated premium savings to the insurance commissioner. It correspondingly requires the commissioner to include some of this information in his annual consumer report card (PA 23-204, §§ 228 & 229, effective October 1, 2023).

Request Time Frames

The legislature shortened the timeframes within which health carriers must notify an insured or his or her authorized representative of the decisions about the following utilization reviews:

1. a non-urgent prospective or concurrent review request, from 15 to seven calendar days after the date the health carrier receives the request (but the health carrier may extend this once for up to 15 days as long as the insured's provider notifies the carrier that the service will not be performed for at least three months from the date the request was received);

2. a one-time extension of a non-urgent prospective or concurrent review request due to circumstances beyond the carrier's control, from 15 to five calendar days (for retrospective reviews, the new law maintains current law's one-time extension of 15 calendar days); and

3. urgent care requests, from 48 hours (or 72 hours if the request or response time falls on a weekend) to 24 hours after the health carrier receives the request (PA 23-204, § 222, effective January 1, 2024).

Medicaid, Medicare, and Other Related Programs

HUSKY Expansion for Immigrant Children

Beginning July 1, 2024, new legislation extends HUSKY health benefits to children ages 15 and under, rather than ages 12 and under, who meet program income limits but are ineligible due to immigration status. Further, the law requires the Department of Social Services (DSS) to study extending coverage to anyone ages 25 and younger under similar conditions (PA 23-204, §§ 283-285, effective upon passage).

HUSKY Health Child Enrollment

A new law requires DSS, for FY 24, to hire temporary and part-time employees who will be responsible for collaborating with nonprofit organizations to identify and enroll eligible children in the Husky Health Program (PA 23-101, § 16, effective July 1, 2023).

Medicaid 340B Drug Pricing Program

The federal 340B Drug Pricing Program requires drug manufacturers participating in Medicaid to sell certain outpatient prescription drugs at discounted prices to health care organizations that care for uninsured and low-income patients.

Starting January 1, 2024, a new law prohibits certain provisions in contracts between 340B covered entities (including pharmacies under contract with them) and pharmacy benefit managers (PBMs) (including PBM subsidiaries). For example, it prohibits these contracts from providing lower reimbursement rates for prescription drugs than the rate paid to pharmacies that are not 340B covered entities. The act also prohibits PBMs from (1) considering whether an entity is a 340B covered entity when determining reimbursement rates, except to the extent allowed by law; and (2) retaliating against a 340B covered entity because it exercises a right or remedy under these provisions.

Additionally, the act requires the DSS commissioner to convene a working group to evaluate various issues related to the 340B program. By January 1, 2024, the commissioner must report on the group's findings and recommendations (PA 23-171, §§ 15 & 16, effective October 1, 2023, except upon passage for the working group provisions).

Medicaid Payments and Third-Party Liability

Under federal law, Medicaid is generally the "payer of last resort," which means that health insurers and other third parties legally liable for health care services received by Medicaid beneficiaries must pay for them. A new law codifies two federal requirements for these third parties. First, it

requires third parties to accept DSS's prior authorization as their own for claims for recovery or indemnification for a service provided under the state's Medicaid plan or a Medicaid waiver. Secondly, it shortens the required response time from liable third parties, including health insurers (PA 23-204, §§ 292 & 293, effective October 1, 2023).

Medicaid Reimbursement for School-Based Mental Health Assessments

This session, the legislature passed a law requiring the DSS commissioner to provide Medicaid reimbursement for suicide risk assessments and other mental health evaluations and services provided at a school-based health center or public school, to the extent doing so is allowed under federal law.

The law also requires the commissioner to (1) amend the Medicaid state plan, if necessary, to provide the reimbursement and (2) set the reimbursement at a level that ensures an adequate pool of providers to provide the assessments, evaluations, and services (PA 23-101, § 9, effective July 1, 2023).

Medicare Advantage Plans Report

A new law requires the Insurance Department, by January 1, 2025, and in consultation with the Office of Health Strategy, to report to the Insurance and Real Estate Committee on (1) an analysis of Medicare Advantage plans' utilization management and provider payment practices and (2) related recommendations. (Medicare Advantage Plans are managed care plans administered by federally approved private insurers. These plans must cover all services covered by traditional Medicare and some offer additional benefits.) The Insurance Department may engage the services of third-party professionals and specialists to help meet these requirements, with any costs paid from the General Fund within available appropriations (PA 23-171, § 18 effective upon passage).

Non-Health Insurance Prescription Drug Programs

Drug Discount Card Program and Centralized Drug Purchase Feasibility Study

A new law requires the state comptroller to establish a Drug Discount Card Program for state residents. As part of the program, he may join with other states or a regional consortium to pool prescription drug purchasing power to lower prescription drug costs, among other things.

The new law also requires the comptroller to study the feasibility of centralizing statewide contracts to consolidate drug purchasing by state agencies, state hospitals, state-operated local mental

health authorities, and other public entities, as necessary. By November 1, 2023, these entities that procure these drugs must provide the comptroller with information on the drug types, amount, and cost. By February 1, 2024, the comptroller must submit the study's findings to the governor and legislature (PA 23-171, § 1, effective October 1, 2023).

Generic Drug Outreach Program Report

Under a new law, the Department of Consumer Protection (DCP) commissioner must report to the Public Health Committee on recommendations for a framework to establish an outreach and education program to inform physicians when (1) drug patents will expire and (2) generic alternatives exist for drugs with recently expired patents. The commissioner must report by January 1, 2025, and in consultation with UConn's School of Pharmacy (PA 23-171, § 2, effective upon passage).

Pharmacy Benefit Managers Study

A new law requires the Office of Health Strategy (OHS), in consultation with the Insurance Department, to report on PBMs' prescription drug distribution practices in Connecticut and other states. The report must make recommendations to reduce consumers' prescription drug costs and regulate in-state PBMs. OHS must report to the Insurance and Real Estate Committee by January 1, 2025 (PA 23-171, § 7, effective upon passage).

Property and Casualty and Other Lines of Insurance

Aircraft Liability Insurance Requirement

Beginning October 1, 2023, a new law prohibits people from operating or allowing someone to operate aircraft based or hangered in the state without liability insurance coverage meeting the law's requirements. Specifically, the policy must cover the owner and pilot for claims by passengers or other people for bodily injuries, death, or property damage that may arise from the aircraft's operation in the amount of at least (1) $500,000 per accident and (2) $100,000 per passenger seat. Aircraft owners must provide proof of this insurance when requested by airport officials or law enforcement, and in-state air navigation facility owners and operators must keep a list of aircraft based or hangered at their facilities that includes liability insurance information. The new law's requirements do not apply to aircraft subject to federal liability insurance requirements (PA 23-135, § 30, effective October 1, 2023).

Prohibition on Adverse Actions Related to Reproductive Health Care Services

A new law prohibits professional liability insurers from taking adverse action against a health care provider (such as denying coverage or increasing rates) if it was based solely on (1) the provider's alleged participation in reproductive health care services or (2) another U.S. jurisdiction's disciplinary actions solely based on this alleged participation (PA 23-128, § 4, effective upon passage).

Waiver of Insurance Requirements for Non-Residential Buildings in Common Interest Communities

Under the Common Interest Ownership Act, residential common interest communities generally must maintain various types of insurance. But a new law allows residential common interest communities to vary or waive the law's insurance requirements for a building's units if all units within the building are restricted to nonresidential use (PA 23-18, § 4, effective October 1, 2023).

Worker's Compensation Medical Plans

A new law requires the Workers' Compensation Commission chairperson, in setting standards for approving employer or insurer medical plans, to include whether the plan has an administrative process allowing employees to seek certain information about the medical and health care services recommended by the plan's providers (e.g., their appropriateness and payment).

The act also requires the Judiciary Committee chairpersons or their designees to convene a working group to review the level of partial permanent disability payments available to injured employees under the workers' compensation laws (PA 23-32, §§ 1 & 3, effective October 1, 2023 for the standards provisions and upon passage for the working group).

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