STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-70-11
SEPTEMBER 1, 2011

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: NOTICE PURSUANT TO CONNECTICUT GENERAL STATUTE 38a-477a OF NEW OR MODIFIED BENEFITS REQUIRED TO BE PROVIDED

The legislature enacted several new laws that impact individual and group health insurance policies delivered or issued for delivery in Connecticut. All entities are reminded that all policy forms are subject to prior approval. Policies are reviewed in the order of date received by the Insurance Department. For policy forms that are already approved, you are asked to file an endorsement or amendatory rider to be attached to the approved policy in order to expedite the review process. For new benefits on policies that require rates be filed, a rate filing should be made at the same time as the form filing even if there is no adjustment to the rates.

PUBLIC ACT 11-44 AN ACT CONCERNING THE BUREAU OF REHABILITATIVE SERVICES AND IMPLEMENTATION OF PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH

Sections 147 and 148 of this public act prohibit all individual and group policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state from imposing a coinsurance, copayment, deductible or other out-of-pocket expense for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e for children from birth until age three. The deductible limits do not apply to high deductible plans as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said Internal Revenue Code.

In addition, such group policies must provide a maximum benefit of fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child for a child with autism spectrum disorders as defined in section 38a-514b of the Connecticut General Statutes, who is receiving early intervention services as defined in section 17a-248 of the Connecticut General Statutes. Any coverage provided for autism spectrum disorders through an individualized family service plan pursuant to section 17a-248e shall be credited toward the

coverage amounts required under section 38a-514b. No payment made under this section shall be applied against any maximum lifetime or annual limits.

These provisions are effective January 1, 2012.

PUBLIC ACT 11-58 AN ACT CONCERNING HEALTH CARE REFORM

This public act modifies some existing state requirements pursuant to the Patient Protection and Affordability Act, P.L. 111-148, as amended ("PPACA"). All individual and group health insurance policies of the type specified in subdivisions (1), (2), (4), (6), (10), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever occurs first, the date on which the child: becomes covered under a group health plan through the dependent's own employment or attains the age of twenty-six. Each such policy shall cover a stepchild on the same basis as a biological child.

The public act also prohibits any individual or group health insurance plan or insurance arrangement from imposing a preexisting condition provision that excludes coverage for individuals eighteen years of age and younger.

Individual and group policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state are prohibited from imposing a lifetime dollar limit for essential health benefits as defined in PPACA. Lifetime limits for non-essential benefits shall not be less than one million dollars per covered individual.

These provisions are effective from passage.

Individual and group policies delivered, issued for delivery, amended, renewed or continued in this state covering dental services with providers that participate in the insurer's network shall include the following statement in the certificate and policy:

"IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document. "

This provision is effective January 1, 2012.

PUBLIC ACT 11-67 AN ACT CONCERNING INSURANCE COVERAGE FOR BREAST MAGNETIC RESONANCE IMNAGING AND PERMITTING DISTRICTS TO JOIN MUNICIPALITIES AND BOARDS OF EDUCATION TO PROCURE HEALTH CARE BENEFITS

This public act requires all individual health insurance policies of the type specified in subdivisions (1), (2), (4), (10), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state to provide coverage for magnetic resonance imaging of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advance practice registered nurse. This public act eliminates the requirement to provide coverage for mammograms or additional benefits for ultrasound screening in accordance with section 38a-503 of the Connecticut General Statutes for individual policies of type (6) of section 38a-469 of the Connecticut General Statutes.

This public act requires all group health insurance policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state to provide coverage for magnetic resonance imaging of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advance practice registered nurse.

These provisions are effective January 1, 2012.

PUBLIC ACT 11-83 AN ACT CONCERNING THE AMERICAN COLLEGE OF RADIOLOGY AND COLORECTAL CANCER SCREENING RECOMMENDATIONS AND HEALTH INSURANCE COVERAGE FOR COLONOSCOPIES

This public act prohibits all individual and group policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state from imposing a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician. This provision does not apply to high deductible plans as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said

Internal Revenue Code. This public act also adds the American College of Radiology to the list of entities involved with determining screening standards.

This provision is effective January 1, 2012.

PUBLIC ACT 11-88 AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR BONE MARROW TESTING

This public act requires all individual and group policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state to provide coverage for expenses arising from human leukocyte antigen testing for A, B and DR antigens for utilization in bone marrow transplantation. No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such testing in excess of twenty percent of the cost for such testing per year. This provision does not apply to high deductible plans as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said Internal Revenue Code. Such policy shall require that testing be performed in a facility accredited by the American Society for Histocompatibility and Immunogenetics or its successor and certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a as amended from time to time. Such policy shall limit coverage to individuals who at the time of such testing complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program. Such policy may limit such coverage to a lifetime maximum benefit of one testing.

These provisions are effective January 1, 2012.

PUBLIC ACT 11-169 AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT

This public act prohibits requires all individual and group health insurance policies of the type specified in subdivisions (1), (2), (4), (10), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state, that provides coverage for prescription drugs from requiring an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs. Such policy may require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug.

These provisions are effective January 1, 2012.

PUBLIC ACT 11-171 AN ACT CONCERNING INSURANCE COVERAGE FOR BREAST MAGNETIC RESONANCE IMAGING AND EXTENDING THE NOTIFICATION PERIOD TO INSURERS FOLLOWING THE BIRTH OF A CHILD

This public act requires all individual health insurance policies of the type specified in subdivisions (1), (2), (4), (10), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state to provide coverage for breast magnetic resonance imaging in accordance with guidelines established by the American Cancer Society or the American College of Radiology. This public act eliminates the requirement to provide coverage for mammograms or additional benefits for ultrasound screening in accordance with section 38a-503 of the Connecticut General Statutes for individual policies of type (6) of section 38a-469 of the Connecticut General Statutes.

This public act requires all group health insurance policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state to provide coverage for breast magnetic resonance imaging in accordance with guidelines established by the American Cancer Society or the American College of Radiology.

This act also extends the notification period to insurers following the birth of a child from thirty-one to sixty-one days for individual policies of the type specified in subdivisions (1), (2), (4), (6), (10), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state.

This act also extends the notification period to insurers following the birth of a child from thirty-one to sixty-one days for group policies of the type specified in subdivisions (1), (2), (4), (6), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state.

These provisions are effective January 1, 2012.

PUBLIC ACT 11-172 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CERTAIN CLINICAL TRIAL PATIENTS

This public act expands existing coverage for the routine patient care costs for clinical trials for cancer to include such coverage for clinical trials for disabling or life-threatening chronic diseases in human beings under all individual and group policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state. The act also expands the eligibility for such coverage to include a clinical trial qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19, 2000 Medicare National Coverage Determination, as amended from time to time.

This act also prohibits all individual or group health insurance policies delivered, issued for delivery, renewed, amended or continued in this state that provide coverage for prescribed drugs approved by the federal Food and Drug Administration ("FDA") for treatment of certain types of disabling or life-threatening chronic diseases from excluding coverage for any such drug on the basis that such drug has been prescribed for the treatment of a disabling or life-threatening chronic disease for which the drug has not been approved by the FDA provided the drug is recognized for treatment of a disabling or life-threatening chronic disease for which the drug has been prescribed in one of the following established reference compendia: (1) The U. S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI). Such policies are not required to cover any experimental or investigational drugs or any drug that the FDA has determined to be contraindicated for treatment of the specific type of disabling or life-threatening chronic disease for which the drug has been prescribed.

These provisions are effective January 1, 2012.

PUBLIC ACT 11-225 AN ACT CONCERNING INSURANCE COVERAGE FOR THE SCREENING AND TREATMENT OF PROSTATE CANCER AND PROHIBITING DIFFERENTIAL PAYMENT RATES TO HEALTH CARE PROVIDERS FOR COLONOSCOPY OR ENDOSCOPIC SERVICES BASED ON SITE OF SERVICE

This act requires that all individual and group policies of the type specified in subdivisions (1), (2), (4), (11), and (12) of section 38a-469 of the Connecticut General Statutes delivered, issued for delivery, amended, renewed or continued in this state provide coverage for the medically necessary treatment of prostate cancer in accordance with guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

This provision is effective January 1, 2012.

QUESTIONS

Please contact the Insurance Department Life and Health Division at cid.lh@ ct.gov with any questions about the Public Acts in this notice.

Thomas B. Leonardi
Insurance Commissioner