



**House Bill No. 6982**

**Public Act No. 07-54**

**AN ACT MAKING MINOR AND TECHNICAL CHANGES TO THE INSURANCE STATUTES.**

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

Section 1. Subsection (e) of section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) Each insurance company or health care center doing business in this state shall include in all reports required to be filed with the commissioner under this section a certification by an actuary or reserve specialist of all reserve liabilities prepared in accordance with regulations which shall be adopted by the commissioner in accordance with chapter 54. The regulations shall: (1) Specify the contents and scope of the certification; (2) provide for the availability to the commissioner of the workpapers of the actuary or loss reserve specialist; and (3) provide for [exemptions to the] granting companies or centers exemptions from compliance with the requirements of this subsection. The commissioner shall maintain, as confidential, all workpapers of the actuary or loss reserve specialist and the actuarial report and actuarial opinion summary provided in support of the certification. Such workpapers, reports and summaries shall not be subject to subpoena or disclosure under the Freedom of Information

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Act, as defined in section 1-200.

Sec. 2. Subsection (c) of section 38a-479 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The procedure established by a contracting health organization shall also permit a physician, physician group or physician organization to request and view fee-for-service dollar amounts the contracting health organization reimburses for current procedural terminology codes for which a physician, physician group or physician organization actually bills or intends to bill the contracting health organization, provided such codes are within the physician's, group's or organization's specialty or subspecialty.

Sec. 3. Subsections (a) and (b) of section 38a-511 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under an individual health insurance policy or contract for magnetic resonance imaging or computed axial tomography may (1) require total copayments in excess of three hundred seventy-five dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of seventy-five dollars for each in-network magnetic resonance imaging or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services [is] are not the same person or [is] are not participating in the same group practice.

(b) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society

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that provides coverage under an individual health insurance policy or contract for positron emission tomography may (1) require total copayments in excess of four hundred dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of one hundred dollars for each in-network positron emission tomography, provided the physician ordering the radiological service and the physician rendering such service [is] are not the same person or [is] are not participating in the same group practice.

Sec. 4. Subsections (a) and (b) of section 38a-550 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a group health insurance policy or contract for magnetic resonance imaging or computed axial tomography may (1) require total copayments in excess of three hundred seventy-five dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of seventy-five dollars for each in-network magnetic resonance imaging or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services [is] are not the same person or [is] are not participating in the same group practice.

(b) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a group health insurance policy or contract for positron emission tomography may (1) require total copayments in excess of four hundred dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of one hundred dollars for each in-network positron emission tomography, provided the physician ordering the radiological service

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and the physician rendering such service [is] are not the same person  
or [is] are not participating in the same group practice.

Approved May 22, 2007