



Senate

General Assembly

January Session, 2015

File No. 427

Senate Bill No. 24

Senate, April 2, 2015

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT REQUIRING THE PROVISION OF CERTAIN INFORMATION CONCERNING HEALTH INSURANCE POLICY BENEFITS AND REQUIRING THE INSURANCE COMMISSIONER TO EVALUATE INSURERS' COMPLIANCE WITH THE AFFORDABLE CARE ACT.

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

1 Section 1. (NEW) (*Effective January 1, 2016*) (a) Each insurer, health
2 care center, hospital service corporation, medical service corporation,
3 fraternal benefit society or other entity that delivers, issues for
4 delivery, renews, amends or continues a health insurance policy
5 providing coverage of the type specified in subdivisions (1), (2), (4),
6 (11) and (12) of section 38a-469 of the general statutes delivered, issued
7 for delivery, renewed, amended or continued in this state, shall:

8 (1) Make available to consumers, in an easily readable and
9 understandable format, the following information for each such policy:
10 (A) Any coverage exclusions; (B) any restrictions on the use or quantity
11 of a covered benefit, including on prescription drugs or drugs
12 administered in a physician's office or a clinic; (C) a specific

13 description of how prescription drugs are included or excluded from
14 any applicable deductible, including a description of other out-of-
15 pocket expenses that apply to such drugs; and (D) the specific dollar
16 amount of any copayment and the percentage of any coinsurance
17 imposed on each covered benefit, including each covered prescription
18 drug;

19 (2) Make available to consumers a way to determine accurately (A)
20 whether a specific prescription drug is available under such policy's
21 drug formulary; (B) the coinsurance, copayment, deductible or other
22 out-of-pocket expense applicable to such drug; (C) whether such drug
23 is covered when dispensed by a physician or a clinic; (D) whether such
24 drug requires preauthorization or the use of step therapy; (E) whether
25 specific types of health care specialists are in-network; and (F) whether
26 a specific health care provider or hospital is in-network.

27 (b) (1) Each insurer, health care center, hospital service corporation,
28 medical service corporation, fraternal benefit society or other entity
29 shall make the information required under subsection (a) of this
30 section available to consumers at the time of enrollment and shall post
31 such information on its Internet web site.

32 (2) The Connecticut Health Insurance Exchange, established
33 pursuant to section 38a-1081 of the general statutes, shall post links on
34 its Internet web site to such information for each qualified health plan
35 that is offered or sold through the exchange.

36 (c) The Insurance Commissioner shall post links on its Internet web
37 site to any on-line tools or calculators to help consumers compare and
38 evaluate health insurance policies and plans.

39 Sec. 2. Section 38a-591 of the general statutes is repealed and the
40 following is substituted in lieu thereof (*Effective January 1, 2016*):

41 (a) For purposes of this section, "Affordable Care Act" means the
42 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
43 from time to time, and regulations adopted thereunder.

44 (b) Each insurance company, fraternal benefit society, hospital
45 service corporation, medical service corporation and health care center
46 licensed to do business in the state shall comply with Sections 1251,
47 1252 and 1304 of the Affordable Care Act and the following Sections of
48 the Public Health Service Act, as amended by the Affordable Care Act:
49 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
50 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

51 (c) This section shall apply, on and after the effective dates specified
52 in the Affordable Care Act, to insurance companies, fraternal benefit
53 societies, hospital service corporations, medical service corporations
54 and health care centers licensed to do business in the state.

55 (d) No provision of the general statutes concerning a requirement of
56 the Affordable Care Act shall be construed to supersede a provision of
57 the general statutes that provides greater protection to an insured,
58 except to the extent the latter prevents the application of a requirement
59 of the Affordable Care Act.

60 (e) (1) The Insurance Commissioner shall evaluate whether
61 insurance companies, fraternal benefit societies, hospital service
62 corporations, medical service corporations and health care centers
63 subject to the Affordable Care Act are in compliance with the
64 requirements under said act, including, but not limited to, the
65 prohibition against discriminatory benefit designs. Any such company,
66 society, corporation or center shall submit to the commissioner, upon
67 request, the following information for a specific health insurance
68 policy or plan: (A) The benefits covered under each of the categories of
69 the essential health benefits package, as defined by the Secretary of
70 Health and Human Services; (B) any coverage exclusions or
71 restrictions on covered benefits, including under the prescription drug
72 benefit; (C) any drug formulary used, the tier structure of such
73 formulary and a list of each prescription drug on such formulary and
74 its tier placement; (D) any applicable coinsurance, copayment,
75 deductible or other out-of-pocket expenses for each covered benefit;
76 and (E) any other information the commissioner deems necessary to

77 evaluate such company, society, corporation or center.

78 (2) The commissioner shall report annually to the joint standing
79 committee of the General Assembly having cognizance of matters
80 relating to insurance on any insurance company, fraternal benefit
81 society, hospital service corporation, medical service corporation or
82 health care center evaluated pursuant to subdivision (1) of this section
83 in the preceding year and the findings of such evaluation.

84 [(e)] (f) The Insurance Commissioner may adopt regulations, in
85 accordance with the provisions of chapter 54, to implement the
86 provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2016	New section
Sec. 2	January 1, 2016	38a-591

INS *Joint Favorable*

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:

Agency Affected	Fund-Effect	FY 16 \$	FY 17 \$
Insurance Department	IF - Cost	At least \$100,000	At least \$100,000

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill requires the Department of Insurance to assess health insurers' compliance with the federal Affordable Care Act and annually report its findings to the General Assembly. It is anticipated that the department will require at least one additional research analyst with annual salary and fringe benefit costs of \$100,000 to perform this function. Additionally, the department must post links to any online tools or calculators to help consumers compare health insurance plans. It is unclear whether the department must simply post links to existing tools or create new tools itself. Should the department have to create new comparison tools on its website, additional information technology costs would be incurred.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**SB 24*****AN ACT REQUIRING THE PROVISION OF CERTAIN INFORMATION CONCERNING HEALTH INSURANCE POLICY BENEFITS AND REQUIRING THE INSURANCE COMMISSIONER TO EVALUATE INSURERS' COMPLIANCE WITH THE AFFORDABLE CARE ACT.*****SUMMARY:**

This bill requires the insurance commissioner to (1) evaluate insurers', HMOs', fraternal benefit societies', and hospital and medical service corporations' ("entities") compliance with the federal Affordable Care Act (ACA) (P.L. 111-148, as amended) and (2) report annually to the Insurance and Real Estate Committee on her findings. It requires the entities to give the commissioner certain information (e.g., a policy's covered benefits and exclusions) upon request to help her evaluate their compliance. The bill does not specify (1) how frequently she must evaluate the entities or (2) a due date for the annual report.

The bill also requires those entities that deliver, issue, renew, amend, or continue certain health insurance policies in Connecticut to (1) disclose specified information to consumers at enrollment and (2) post the information on their websites. The information includes copayments and coinsurance amounts for covered benefits and coverage exclusions or restrictions, including those related to prescription drugs, among other things. Under the bill, the Connecticut Health Insurance Exchange (Access Health CT) must post links on its website to the entities' information for each qualified health plan offered or sold through the exchange.

Lastly, the bill requires the insurance commissioner to post links on the Insurance Department's website to any online tools or calculators

available to help consumers compare and evaluate health insurance policies and plans. By law, the department must already post some tools on its website, including an annual *Consumer Report Card on Health Insurance Carriers in Connecticut*.

EFFECTIVE DATE: January 1, 2016

INFORMATION PROVIDED TO THE COMMISSIONER UPON REQUEST

The bill requires entities subject to the ACA to give the insurance commissioner, upon request, the following information for a specific health insurance policy or plan:

1. the benefits covered under each category of the essential health benefits package, defined by the U.S. Health and Human Services secretary;
2. any coverage exclusions or restrictions on covered benefits, including prescription drug benefits;
3. any prescription drug formulary (i.e., list of covered drugs) used, the tier structure of the formulary (tiers generally relate to the applicable copayments), and a list of each covered prescription drug and its tier placement;
4. the applicable coinsurance, copayment, deductible, or other out-of-pocket expense for each covered benefit; and
5. any other information the commissioner deems necessary to evaluate the entity's ACA compliance.

By law, the commissioner may adopt regulations to implement these provisions.

INFORMATION PROVIDED TO CONSUMERS

The bill requires entities that deliver, issue, renew, amend, or continue certain health insurance policies or plans in Connecticut to give specified information to consumers. The requirement applies to

plans that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, and (4) hospital and medical services.

Under the bill, the entities must disclose the following at enrollment for each applicable health insurance policy, in an easily readable and understandable format:

1. any coverage exclusions;
2. any restrictions on the use or quantity of a covered benefit, including prescription drugs;
3. a description of the deductible and other out-of-pocket expenses that apply to prescription drugs; and
4. the applicable copayment and coinsurance percentage for each covered benefit, including each covered prescription drug.

In addition, the entities must give consumers a way to accurately determine

1. whether a prescription drug is covered under the policy's drug formulary;
2. the coinsurance, copayment, deductible, or other out-of-pocket expense applicable to a prescription drug;
3. whether a prescription drug is covered when a physician or clinic dispenses it;
4. whether a prescription drug requires preauthorization or the use of step therapy (i.e., a protocol establishing the sequence for prescribing drugs for a specific medical condition) ; and
5. whether specific health care providers, specialists, or hospitals are in the policy's provider network.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 19 Nay 0 (03/19/2015)