



General Assembly

**Amendment**

January Session, 2015

LCO No. 6772



Offered by:

SEN. LOONEY, 11<sup>th</sup> Dist.

SEN. FASANO, 34<sup>th</sup> Dist.

To: Subst. Senate Bill No. 813

File No. 698

Cal. No. 417

**"AN ACT CONCERNING HEALTH CARE PRICE, COST AND  
QUALITY TRANSPARENCY."**

1 In line 213, after the semicolon strike "and" and insert the following  
2 in lieu thereof:

3 "(9) "Provider organization" means a corporation, partnership,  
4 business trust, association or organized group of persons that is in the  
5 business of health care delivery or management, whether or not  
6 incorporated, that represents one or more health care providers in  
7 contracting with health insurance carriers for the payments of health  
8 care services, including, but not limited to, a physician organization,  
9 independent practice association, provider network or accountable  
10 care organization; and"

11 In line 214, strike "(9)" and insert "(10)" in lieu thereof

12 In line 255, strike "October" and insert "April" in lieu thereof

13 After the last section, add the following and renumber sections and  
14 internal references accordingly:

15 "Sec. 501. (NEW) (*Effective January 1, 2016*) (a) Each insurer, health  
16 care center, hospital service corporation, medical service corporation,  
17 fraternal benefit society or other entity that delivers, issues for  
18 delivery, renews, amends or continues a health insurance policy  
19 providing coverage of the type specified in subdivisions (1), (2), (4),  
20 (11) and (12) of section 38a-469 of the general statutes delivered, issued  
21 for delivery, renewed, amended or continued in this state, shall:

22 (1) Make available to consumers, in an easily readable and  
23 understandable format, the following information for each such policy:  
24 (A) Any coverage exclusions; (B) any restrictions on the use or quantity  
25 of a covered benefit, including on prescription drugs or drugs  
26 administered in a physician's office or a clinic; (C) a specific  
27 description of how prescription drugs are included or excluded from  
28 any applicable deductible, including a description of other out-of-  
29 pocket expenses that apply to such drugs; and (D) the specific dollar  
30 amount of any copayment and the percentage of any coinsurance  
31 imposed on each covered benefit, including each covered prescription  
32 drug;

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

41 (b) (1) Each insurer, health care center, hospital service corporation,  
42 medical service corporation, fraternal benefit society or other entity  
43 shall make the information required under subsection (a) of this  
44 section available to consumers at the time of enrollment and shall post

45 such information on its Internet web site.

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

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

53 Sec. 502. Section 38a-591 of the general statutes is repealed and the  
54 following is substituted in lieu thereof (*Effective January 1, 2016*):

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

58 (b) Each insurance company, fraternal benefit society, hospital  
59 service corporation, medical service corporation and health care center  
60 licensed to do business in the state shall comply with Sections 1251,  
61 1252 and 1304 of the Affordable Care Act and the following Sections of  
62 the Public Health Service Act, as amended by the Affordable Care Act:  
63 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,  
64 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

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

69 (d) No provision of the general statutes concerning a requirement of  
70 the Affordable Care Act shall be construed to supersede a provision of  
71 the general statutes that provides greater protection to an insured,  
72 except to the extent the latter prevents the application of a requirement  
73 of the Affordable Care Act.

74 (e) (1) The Insurance Commissioner shall evaluate whether  
 75 insurance companies, fraternal benefit societies, hospital service  
 76 corporations, medical service corporations and health care centers  
 77 subject to the Affordable Care Act are in compliance with the  
 78 requirements under said act, including, but not limited to, the  
 79 prohibition against discriminatory benefit designs. Any such company,  
 80 society, corporation or center shall submit to the commissioner, upon  
 81 request, the following information for a specific health insurance  
 82 policy or plan: (A) The benefits covered under each of the categories of  
 83 the essential health benefits package, as defined by the Secretary of  
 84 Health and Human Services; (B) any coverage exclusions or  
 85 restrictions on covered benefits, including under the prescription drug  
 86 benefit; (C) any drug formulary used, the tier structure of such  
 87 formulary and a list of each prescription drug on such formulary and  
 88 its tier placement; (D) any applicable coinsurance, copayment,  
 89 deductible or other out-of-pocket expenses for each covered benefit;  
 90 and (E) any other information the commissioner deems necessary to  
 91 evaluate such company, society, corporation or center.

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

98 [(e)] (f) The Insurance Commissioner may adopt regulations, in  
 99 accordance with the provisions of chapter 54, to implement the  
 100 provisions of this section."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	January 1, 2016	New section
Sec. 502	January 1, 2016	38a-591