

State of Connecticut



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INSURANCE COMMISSIONER

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SEPTEMBER 1, 2006

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 OF NEW OR MODIFIED BENEFITS REQUIRED TO BE PROVIDED

This past legislative session, the General Assembly enacted several new laws applicable to group and individual health insurance policies delivered or issued for delivery in Connecticut. This bulletin, which provides written notice of those laws, is being sent pursuant to Section 35 of Public Act 06-188 which provides:

The Insurance Commissioner shall provide written notification to each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or any other entity that delivers or issues for delivery, in this state, any individual or group health insurance plan (1) of any benefits required to be provided in such plan pursuant to chapter 700c of the general statutes, or of any modification to such benefits on or after October 1, 2006, at least thirty days prior to the date such benefits or modification becomes effective, and (2) instructing such company, society, corporation, center or other entity to submit to the Insurance Commissioner, prior to the date such benefits or modification becomes effective or upon the renewal date of the plan, any necessary policy forms, in accordance with the provisions of section 38a-481 or 38a-513 of the general statutes, as applicable, that reflect such benefits or modification.

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 have previously been approved, you are asked to file an endorsement or amendatory rider to be attached to the approved policy to expedite the review process. Entities should file a red lined version as well as two clean copies along with a postage paid envelope of sufficient size to receive a stamped copy.

PA 06-38 An Act Concerning Health Insurance Coverage for Breast Cancer Screening

This act modifies the criteria when additional benefits for comprehensive ultrasound screenings are required to be covered. These additional benefits must be provided 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 the woman's physician or advance practice registered nurse. This applies to all individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of Connecticut General Statute (C.G.S.) section 38a-469 and all group health policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of Connecticut General Statute (C.G.S.) section 38a-469. Policies and certificates should be modified to contain this language. This change is effective October 1, 2006 for all policies.

PA 06-39 An Act Ensuring Payment for Health Care Services Rendered to Connecticut Residents With an Elevated Blood Alcohol Content

This act prohibits any health insurance policy of the type specified in subdivision (1), (2), (4), (11), and (12) of C.G.S. section 38a-469 from denying coverage for treatment of an injury sustained by an insured with an elevated blood alcohol content or while under the influence of intoxicating liquor or any drug. Elevated blood alcohol is defined as eight-hundredths of one percent or more of alcohol in the blood by weight. Exclusions for injuries sustained while committing or attempting to commit an assault or felony will need to be qualified to not conflict with this Public Act. This statute becomes effective for all health policies delivered, issued for delivery, amended, renewed or continued in this state on and after October 1, 2006.

PA 06-131 An Act Concerning Developmental Needs of Children and Youth With Cancer

All health insurance policies of the type specified in subdivision (1), (2), (4), (11), and (12) of C.G.S. section 38a-469 delivered, issued for delivery, amended, renewed or continued on or after October 1, 2006 must provide coverage for children diagnosed with cancer on or after January 1, 2000 for neuropsychological testing ordered by a licensed physician to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment. Such coverage is prohibited from being subjected to prior authorization. Any contractual provisions detailing requirements for prior authorization should be qualified to exclude these services. Such coverage may be subject to the same terms and conditions as other benefits under the contract. Inside dollar or visit limits are not permitted. Retrospective claim denials based on determinations of medical necessity are prohibited if the child was diagnosed with cancer on or after January 1, 2000.

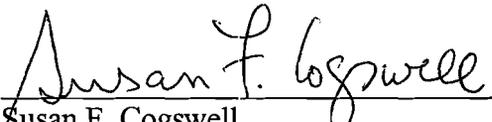
PA 06-180 An Act Concerning Access to Imaging Services

Effective October 1, 2006, health insurance policies that provide coverage for magnetic resonance imaging (MRI) or computed axial tomography (CAT) are prohibited from imposing copayments for these services that exceed three hundred seventy five dollars annually or that exceed seventy five dollars for each in-network MRI or CAT service provided the physician ordering the service is not the same physician nor in the same group practice as the physician rendering the service. If the imaging services are rendered by the prescribing physician during an office visit, only the office visit copayment, if any shall apply. This is consistent with other services that have specified copayments. An example is a contract that has an office visit copayment and an outpatient surgical copayment. The surgery performed in an office setting is subject to the office visit copayment, whereas the surgery performed in an ambulatory surgical center would be subject to the outpatient surgical copayment.

Effective October 1, 2006, health insurance policies that provide coverage for positron emission tomography (PET) are prohibited from imposing copayments for these services that exceed four hundred dollars annually or that exceed one hundred dollars for each in-network PET service provided the physician ordering the service is not the same physician nor in the same group practice as the physician rendering the service. If the imaging services are rendered by the prescribing physician during an office visit, only the office visit copayment, if any shall apply. This is consistent with other services that have specified copayments. An example is a contract that has an office visit copayment and an outpatient surgical copayment. The surgery performed in an office setting is subject to the office visit copayment, whereas the surgery performed in an ambulatory surgical center would be subject to the outpatient surgical copayment.

These provisions do not apply to high deductible health plans used to establish a "medical savings account," "Archer MSA," or health savings account 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 amended from time to time.

Please contact the Insurance Department Life & Health Division at ctinsdept.lifehealth@po.state.ct.us with any questions about the Public Acts discussed in this bulletin.


Susan F. Cogswell
Insurance Commissioner