CONNECTICUT LEGISLATION UPDATE

Issued September 2018

We are happy to announce we are sharing updates with you on laws affecting the health care industry. Attached is an overview of legislation passed during the recent 2018 Connecticut legislative session. It is organized chronologically for easy reference according to the Effective Date that each Public Act (PA) becomes law. We've also included the PA number and helpful links to further information, should you need it.

We value your partnership and we will be sending more updates periodically as the Connecticut Legislature makes changes that affect our industry.

PA 18-13: Connecticut life and health insurance guaranty association.

Effective date July 1, 2018

Short summary: The law makes several changes to the Connecticut Life and Health Insurance Guaranty Association (CLHIGA), which pays claims when a member insurer defaults. The claims are paid through assessments on member insurers. The law primarily:

1. Adds HMOs as new members of the CLHIGA who will also be assessed for an impairment or insolvency. CLHIGA will also cover HMO members and enrollees for impairment or insolvency.
2. Equalizes the assessments for long-term care insurer insolvencies between accident and health insurers and life and annuity insurers.
3. Excludes from coverage Medicaid benefits and includes government entities as people who can be protected under CLHIGA.

Resources

PA 18-13 Connecticut life and health insurance guaranty association.

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PA 18-41 Prescription drug costs.

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PA 18-115: Disputes between health carriers and participating providers that are hospitals.

Effective date: July 1, 2018.

Short summary: The law will require ninety-day prior notice by either party initiating a termination or non-renewal of the carrier/hospital contract. It also requires a sixty-day extension of contract terms and payments in the event of a contract termination or non-renewal by the carrier or hospital.

PA 18-74: Biological products.

Effective date: October 1, 2018

Short summary: The law impacts retail pharmacies, mail order pharmacies and pharmacists licensed in CT. The law allows pharmacists to substitute a biological product for a prescribed biological product as long as the substitute is an interchangeable biological product and the prescribing practitioner has not prohibited the substitution. It extends to these substitutions many of the existing state law provisions associated with substituting brand-name drugs with generic ones.

It also establishes requirements applicable only to biological and interchangeable biological products, including: Providers to discuss with patients the treatment methods, alternatives to, and risks associated with using a biological product; the dispensing pharmacist is required to inform prescribers and patients of a substitution; and patients are given the option of signing for a product's delivery.

PA 18-69: Coverage for prosthetic devices.

Effective date: January 1, 2019

Short summary: The law requires coverage for prosthetic devices at the same cost-share as "substantially all other benefits" under the policy, and bars plans from applying durable medical equipment cost-share and benefit limits to the prosthetics.

PA 18-10: Coverage for EHBs and expanding mandated health benefits for women, children and adolescents.

Effective date: January 1, 2019

Short summary: For all group plans, the law will require no-cost-share coverage for all FDA-approved contraceptive drugs (including OTC drugs), and FDA-approved devices and products (excluding OTC items). Items prescribed by the customer's physician, physician assistant, or APRN must be covered for up to a 12-month supply, unless the prescribing provider requests less than 12-month's supply. The plan may provide an FDA-designated therapeutic equivalent of a prescribed item, unless "otherwise determined" by the prescribing provider. The law will also require all group plans to provide no-cost-share coverage for women's preventive screenings, and child immunizations and preventive screenings.

Although large group plans are not affected, this law also requires certain individual and small employer group health insurance plans to cover 10 essential health benefits, which are the same benefits as the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended.)

PA 18-159: Expanding the definition of mammogram to include additional imaging codes.

Effective date: January 1, 2019

Short summary: The law will require carrier coverage and claim policies to include/ensure coverage of all the specified codes.

PA 18-43: Establishing pregnancy as a qualifying event for purposes of coverage.

Effective date: January 1, 2019

Short summary: While the law does not apply to group insurance plans, it is of interest in general. The law will require pregnancy as a special enrollment event for HMO plans and the state's health care exchange. The law exempts pregnancy as a special enrollment event for municipal health plans, and the state employees' benefits program.

PA 18-41: Prescription drug costs.

Effective date: January 1, 2020.

Short summary: PA 18-41 makes several changes related to prescription drugs, pharmacy benefit managers (PBMs), and health carriers. Among other things, it requires:

1. PBMs to report information about drug formulary rebates to the insurance commissioner, who then must report aggregated data to the legislature's Insurance and Real Estate Committee.
2. Health carriers to submit to the insurance commissioner, and the commissioner to report to the Insurance and Real Estate Committee, information on covered outpatient prescription drugs, including the most frequently prescribed drugs and those provided at the greatest cost.
3. Health carriers to certify to the commissioner that they account for all rebates when calculating plan premiums.
4. HMOs to account for drug cost rebates in calculating premium rates offered on or after January 1, 2021.
5. Health carriers to include in their enrollment materials and web pages information regarding any process available to consumers, and all documents necessary, to seek coverage of a non-covered outpatient prescription drug.
6. A prescription drug "sponsor" (i.e., the entity responsible for its clinical trials) to notify the Office of Health Strategy (OHS) when it files certain applications for new drugs.
7. OHS to annually identify up to 10 outpatient prescription drugs provided at substantial state cost or critical to public health, and drug manufacturers to report information to OHS on those drugs.