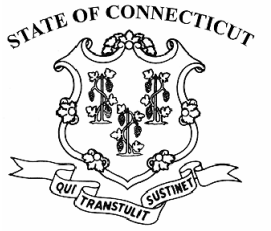

Substitute House Bill No. 5021

Public Act No. 09-188

AN ACT CONCERNING WELLNESS PROGRAMS AND EXPANSION OF HEALTH INSURANCE COVERAGE.

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

Section 1. Section 38a-492j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2000,**]** that provides coverage for ostomy surgery shall include coverage, up to **[**one**]** five thousand dollars annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy and urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

Sec. 2. Section 38a-518j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2000,**]** that provides coverage for ostomy surgery shall include coverage, up to **[**one**]** five thousand dollars annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy and urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

Sec. 3. (NEW) (*Effective January 1, 2010*) (a) As used in this section, "prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or a leg, including a device that contains a microprocessor if such microprocessor-equipped device is determined by the insured's or enrollee's health care provider to be medically necessary. "Prosthetic device" does not include a device that is designed exclusively for athletic purposes.

(b) (1) Each individual health insurance policy providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for prosthetic devices that is at least equivalent to that provided under Medicare. Such coverage may be limited to a prosthetic device that is determined by the insured's or enrollee's health care provider to be the most appropriate to meet the medical needs of the insured or enrollee. Such prosthetic device shall not be considered durable medical equipment under such policy.

(2) Such policy shall provide coverage for the medically necessary

repair or replacement of a prosthetic device, as determined by the insured's or enrollee's health care provider, unless such repair or replacement is necessitated by misuse or loss.

(3) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on substantially all other benefits provided under such policy, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, shall not be subject to the deductible limits set forth in this subdivision or under Medicare pursuant to subdivision (1) of this subsection.

(c) An individual health insurance policy may require prior authorization for prosthetic devices, provided it is required in the same manner and to the same extent as is required for other covered benefits under such policy.

(d) An insured or enrollee may appeal a denial of coverage for or repair or replacement of a prosthetic device to the Insurance Commissioner for an external, independent review pursuant to section 38a-478n of the general statutes.

Sec. 4. (NEW) (*Effective January 1, 2010*) (a) As used in this section, "prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or a leg, including a device that contains a microprocessor if such microprocessor-equipped device is determined by the insured's or enrollee's health care provider to be medically necessary. "Prosthetic device" does not include a device that is designed exclusively for athletic purposes.

(b) (1) Each group health insurance policy providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed,

amended or continued in this state shall provide coverage for prosthetic devices that is at least equivalent to that provided under Medicare. Such coverage may be limited to a prosthetic device that is determined by the insured's or enrollee's health care provider to be the most appropriate to meet the medical needs of the insured or enrollee. Such prosthetic device shall not be considered durable medical equipment under such policy.

(2) Such policy shall provide coverage for the medically necessary repair or replacement of a prosthetic device, as determined by the insured's or enrollee's health care provider, unless such repair or replacement is necessitated by misuse or loss.

(3) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on substantially all other benefits provided under such policy, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520 of the general statutes, shall not be subject to the deductible limits set forth in this subdivision or subdivision (1) of this subsection.

(c) A group health insurance policy may require prior authorization for prosthetic devices, provided it is required in the same manner and to the same extent as is required for other covered benefits under such policy.

(d) An insured or enrollee may appeal a denial of coverage for or repair or replacement of a prosthetic device to the Insurance Commissioner for an external, independent review pursuant to section 38a-478n of the general statutes.

Sec. 5. Section 38a-490b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

Each individual health insurance policy providing coverage of the

type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2001,**]** shall provide coverage for hearing aids for children **[**twelve**]** eighteen years of age or younger. Such hearing aids shall be considered durable medical equipment under the policy and the policy may limit the hearing aid benefit to one thousand dollars within a twenty-four-month period.

Sec. 6. Section 38a-516b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2001,**]** shall provide coverage for hearing aids for children **[**twelve**]** eighteen years of age or younger. Such hearing aids shall be considered durable medical equipment under the policy and the policy may limit the hearing aid benefit to one thousand dollars within a twenty-four-month period.

Sec. 7. Section 38a-504 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society **[**which**]** that delivers**,** **[**or**]** issues for delivery, renews, amends or continues in this state individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469, shall provide coverage under such policies for the surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such

prosthesis, outpatient chemotherapy following surgical procedure in connection with the treatment of tumors, and a wig if prescribed by (1) a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, or (2) a licensed physician or a licensed advanced practice registered nurse for a patient who suffers hair loss due to a diagnosed medical condition of alopecia areata other than as a result of androgenetic alopecia. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for such prosthesis shall be at least three hundred dollars for each breast removed.

(c) The coverage required by subsection (a) of this section shall provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 8. Section 38a-542 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society

[which**]** that delivers**,** **[**or**]** issues for delivery, renews, amends or continues in this state group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage under such policies for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, a wig if prescribed by (1) a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, or (2) a licensed physician or a licensed advanced practice registered nurse for a patient who suffers hair loss due to a diagnosed medical condition of alopecia areata other than as a result of androgenetic alopecia, and costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be medically necessary. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of one thousand dollars for the costs of removal of any breast implant, five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for such prosthesis shall be at least three hundred dollars for each breast removed.

(c) The coverage required by subsection (a) of this section shall

provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 9. (NEW) (*Effective January 1, 2010*) (a) Subject to the provisions of subsection (b) of this section, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state shall provide coverage for expenses arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such testing in excess of twenty per cent of the cost for such testing per year. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493 of the general statutes.

(c) Such policy shall:

(1) Require that such testing be performed in a facility (A) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and (B) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time; and

(2) Limit coverage to individuals who, at the time of such testing, complete and sign an informed consent form that also authorizes the

results of the test to be used for participation in the National Marrow Donor Program.

(d) Such policy may limit such coverage to a lifetime maximum benefit of one testing.

Sec. 10. (NEW) (*Effective January 1, 2010*) (a) Subject to the provisions of subsection (b) of this section, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state shall provide coverage for expenses arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such testing in excess of twenty per cent of the cost for such testing per year. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520 of the general statutes.

(c) Such policy shall:

(1) Require that such testing be performed in a facility (A) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and (B) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time; and

(2) Limit coverage to individuals who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

(d) Such policy may limit such coverage to a lifetime maximum

benefit of one testing.

Sec. 11. Section 38a-492k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state **[**on or after October 1, 2001,**]** shall provide coverage for colorectal cancer screening, including, but not limited to, (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. **[**Benefits**]** Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493.

Sec. 12. Section 38a-518k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state **[**on or after October 1, 2001,**]** shall provide coverage for colorectal cancer screening, including, but not limited to, (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or

radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. **[**Benefits**]** Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520.

Sec. 13. (NEW) (*Effective January 1, 2010*) (a) Any insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state a group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall offer a reasonably designed health behavior wellness, maintenance or improvement program that allows for a reward, a health spending account contribution, a reduction in premiums or reduced medical, prescription drug or equipment copayment, coinsurance or deductible, or a combination of these incentives, for participation in such program.

(b) Any such incentive or reward shall not exceed twenty per cent of the paid premiums and shall comply with all nondiscrimination requirements under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, or regulations adopted thereunder.

(c) The insured or enrollee shall provide evidence of participation in

such program to the insurer, health care center or other entity set forth in subsection (a) of this section in a manner approved by the Insurance Commissioner.

(d) The Insurance Commissioner, in consultation with the Commissioner of Public Health, may adopt regulations, in accordance with chapter 54 of the general statutes, to establish the criteria and procedures for the approval of such health behavior wellness, maintenance or improvement programs.

Sec. 14. Section 38a-825 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

[No**]** Except as provided in section 13 of this act, no insurance company doing business in this state, or attorney, producer or any other person shall pay or allow, or offer to pay or allow, as inducement to insurance, any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement not specified in the policy of insurance. **[**No**]** Except as provided in section 13 of this act, no person shall receive or accept from any company, or attorney, producer or any other person, as inducement to insurance, any such rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the policy of insurance. No person shall be excused from testifying or from producing any books, papers, contracts, agreements or documents, at the trial of any other person charged with the violation of any provision of this section or of section 38a-446, on the ground that such testimony or evidence may tend to incriminate him, but no person shall be prosecuted for any act concerning which he is compelled to so testify or produce documentary or other evidence, except for perjury committed in so testifying.

Sec. 15. Subdivision (9) of section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, as amended by this act, 38a-826, 38a-828 and 38a-829. None of the following practices shall be considered discrimination within the meaning of section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-825: (a) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; (c) readjustment of the rate of premium for a group insurance policy based on loss or expense experience, or both, at the end of the first or any subsequent policy year, which may be made retroactive for such policy year; (d) paying a reward, making a health spending account contribution, or allowing a reduction in premiums or reduced medical, prescription drug or equipment copayment, coinsurance or deductible, or a combination of these incentives to an insured or enrollee in accordance with section 13 of this act.

Sec. 16. Section 38a-623 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

No society doing business in this state shall make or permit any unfair discrimination between insured members of the same class and equal expectation of life in the premiums charged for certificates of insurance, in the dividends or other benefits payable thereon or in any other of the terms and conditions of the contracts it makes. **[**No**]** Except

as provided in section 13 of this act, no society, by itself, or any other party, and no agent or solicitor, personally, or by any other party, shall offer, promise, allow, give, set off or pay, directly or indirectly, any valuable consideration or inducement to or for insurance, on any risk authorized to be taken by such society **[**, which**]** that is not specified in the certificate. **[**No**]** Except as provided in section 13 of this act, no member shall receive or accept, directly or indirectly, any rebate of premium, or part thereof, or agent's or solicitor's commission thereon, payable on any certificate or receive or accept any favor or advantage or share in the dividends or other benefits to accrue on, or any valuable consideration or inducement not specified in, the contract of insurance.

Vetoed July 2, 2009