House of Representatives

File No. 1010

General Assembly

January Session, 2009

(Reprint of File No. 34)

Substitute House Bill No. 5021
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 28, 2009

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 Section 38a-492j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):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 Section 38a-518j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):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**]** <u>eighteen</u> 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.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2010*	38a-492j
Sec. 2	*January 1, 2010*	38a-518j
Sec. 3	*January 1, 2010*	New section
Sec. 4	*January 1, 2010*	New section
Sec. 5	*January 1, 2010*	38a-490b
Sec. 6	*January 1, 2010*	38a-516b
Sec. 7	*January 1, 2010*	38a-504
Sec. 8	*January 1, 2010*	38a-542
Sec. 9	*January 1, 2010*	New section
Sec. 10	*January 1, 2010*	New section
Sec. 11	*January 1, 2010*	38a-492k
Sec. 12	*January 1, 2010*	38a-518k
Sec. 13	*January 1, 2010*	New section
Sec. 14	*January 1, 2010*	38a-825

Sec. 15	*January 1, 2010*	38a-816(9)
Sec. 16	*January 1, 2010*	38a-623

OFA Fiscal Note

State Impact: None in FY 10 & FY 11; Significant Cost in Out Years

Municipal Impact: Potential Significant Cost

Explanation

The bill increases the annual limit related to mandated ostomy supply coverage from $1,000 to $5,000. This provision is not anticipated to impact costs to the state health plans since the state plans currently provide this coverage. The bill also adds mandated coverage for prosthetic limbs, hearing aids for children 18 years of age and under, wigs for hair loss associated with alopecia areata, and bone marrow testing. In addition, the bill prohibits copayments or other out-of-pocket expense for colonoscopies and requires wellness incentives to be provided to plan participants. These provisions of the bill are not anticipated to impact the state employee and retiree health plan until July 1, 2011 when the contract is renewed. It is anticipated the FY 12 cost of these mandates could be significant.

The bill's provisions may increase costs to fully-insured municipal plans which do not currently offer the coverage mandated. The coverage requirements may result in significant increased premium costs when municipalities enter into new health insurance contracts on or after January 1, 2010. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

House Amendment "A" adds the provisions mandating coverage for prosthetic limbs, hearing aids for children 18 years of age and under, wigs for hair loss associated with alopecia areata, bone marrow

testing, prohibits out-of-pocket expense for colonoscopies, requires wellness incentives to be provided to plan participants, and has the fiscal impact described above.

The Out Years

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

Sources: Municipal Employees Health Insurance Plan (MEHIP) Schedule of Benefits
Office of the State Comptroller
State Employee Health Plan Subscriber Agreement.

OLR Bill Analysis

sHB 5021 (as amended by House "A")*

AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR OSTOMY SUPPLIES.

SUMMARY:

The bill requires certain health insurance policies to include (1) coverage for prosthetic devices, and repairs and replacements to them, subject to specified conditions; (2) specified coverage for human leukocyte antigen testing; (3) a "reasonably designed" health behavior wellness, maintenance, or improvement program that gives participants one or more of the following: (a) a reward; (b) health spending account contribution; (c) premium reduction; or (d) reduced copayment, coinsurance, or deductible; and (4) coverage for licensed physician- or advanced practice registered nurse-prescribed wigs for a person with hair loss caused by a diagnosed medical condition other than androgenetic alopecia.

The bill also increases (1) the annual coverage amount required for medically necessary ostomy appliances and supplies, from $1,000 to $5,000 and (2) increases the age which certain insurance policies must cover hearing aids as durable medical equipment from 13 to 19.

The bill also prohibits certain health insurance policies from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a second or subsequent colonoscopy a physician orders for an insured person in a policy year.

*House Amendment "A" adds the provisions relating to prostheses, human leukocyte antigen testing, wellness incentives, wigs, hearing aids, and colonoscopies.

EFFECTIVE DATE: January 1, 2010

OSTOMY APPLIANCES AND SUPPLIES

The bill increases from $1,000 to $5,000 the annual coverage amount required in certain health insurance policies for medically necessary ostomy appliances and supplies, including collection devices, irrigation equipment and supplies, and skin barriers and protectors.

PROSTHETIC DEVICES

The bill defines a "prosthetic device" as an artificial device to replace all or part of an arm or leg, including a device containing a microprocessor if determined to be medically necessary by the person's insurer or health care provider. It excludes a device designed exclusively for athletic purposes.

Under the bill, the coverage must be at least equivalent to the coverage Medicare provides for such devices, but may be limited to a prosthetic device that the person's health care provider determines is most appropriate to meet his or her medical needs. (Medicare covers 80% of the cost of prostheses, after a person pays his or her annual deductible.)

The bill prohibits a policy from considering a prosthetic device as durable medical equipment. (Thus, the amount covered cannot count toward a durable medical equipment maximum.)

Coverage Requirements

The bill requires a policy to cover repairs to or replacements of prosthetic devices that the person's heath care provider determines are medically necessary. It excludes coverage of repairs or replacements needed because of misuse or loss of the device. The bill permits a person who is denied coverage for a prosthetic device, or device repair or replacement, to file an external appeal with the insurance commissioner in accordance with law.

The bill prohibits a policy from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a prosthetic device that

is more restrictive than that imposed on most other policy benefits. It specifies that the deductible limit does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

The bill permits a policy to require prior authorization for prosthetic devices, but only in the same manner and to the same extent as prior authorization is required for other policy benefits.

HEARING AIDS

The bill increases the age which certain insurance policies must cover hearing aids as durable medical equipment. Current law requires coverage for children under age 13. The bill requires coverage for children under age 19. By law, a policy may limit coverage to $1,000 in a 24-month period.

BONE MARROW TESTING

Coverage Requirements for Bone Marrow Testing

The bill requires coverage for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens, to determine compatibility for bone marrow transplants. It permits a policy to limit coverage to one covered test in a person's lifetime.

It prohibits a policy, except for a high-deductible policy, from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for the testing that exceeds 20% of the cost for testing per year.

The bill requires a policy to (1) require bone marrow testing be done at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics, or its successor and (2) limit coverage to people who sign up for the National Marrow Donor Program when being tested.

COLONOSCOPIES

The bill prohibits certain health insurance policies from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a second or subsequent colonoscopy a physician orders for an insured person in a policy year. It specifies that this prohibition does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

By law, policies must cover colorectal cancer screening, including (1) an annual fecal occult blood test and (2) colonoscopy, flexible sigmoidoscopy, or radiologic imaging, in accordance with recommendations the American College of Gastroenterology, in consultation with the American Cancer Society, based on age, family history, and frequency. Benefits are subject to the same terms and conditions that apply to policy benefits.

WELLNESS INCENTIVES

The bill requires an insurer or other entity writing group health insurance in Connecticut to offer a "reasonably designed" health behavior wellness, maintenance, or improvement program that gives participants one or more of the following: (1) a reward; (2) health spending account contribution; (3) premium reduction; or (4) reduced copayment, coinsurance, or deductible. It prohibits the value of any reward or incentive from exceeding 20% of "paid premiums" and requires them to comply with federal nondiscrimination requirements (see BACKGROUND).

The bill requires the insurance commissioner, in consultation with the public health commissioner, to adopt regulations to establish criteria for such programs and procedures for approving them. It requires an insured person or plan enrollee to give the insurer or entity proof of program participation in a manner the insurance commissioner approves.

The bill exempts a reward or incentive allowed under its provisions from the laws prohibiting rebates. It also makes technical and conforming changes.

WIGS

The bill expands current law regarding health insurance coverage for wigs. By law, certain health insurance policies must provide coverage for an oncologist-prescribed wig for a person with hair loss resulting from chemotherapy. The coverage must be subject to the same terms and conditions applicable to all other policy benefits, but be at least a yearly benefit of $350. The bill requires that the coverage also include a licensed physician- or advanced practice registered nurse-prescribed wig for a person with hair loss caused by a diagnosed medical condition, except androgenetic alopecia (e.g., male-pattern baldness).

The bill applies certain insurance coverage requirements (i.e., treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients) to policies renewed, amended, or continued in Connecticut on or after January 1, 2010. The requirements already apply to policies issued or delivered in the state.

OTHER COVERAGE REQUIREMENTS

The bill requires certain health insurance policies renewed, amended, or continued in Connecticut to provide coverage for:

1. surgical removal of tumors and outpatient chemotherapy following the surgery;

2. treatment of leukemia, including outpatient chemotherapy;

3. reconstructive surgery, including reconstructive surgery (such as augmentation or reduction mammoplasty and mastopexy) on a breast on which a mastectomy was performed and a nondiseased breast for symmetry;

4. 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 a prosthesis; and

5. an oncologist-prescribed wig for a patient with hair loss resulting from chemotherapy.

Coverage must be subject to the same terms and conditions applicable to other benefits under the policy. But the policy must provide at least a yearly benefit of $500 for the surgical removal of tumors, $500 for reconstructive surgery, $500 for outpatient chemotherapy, $350 for a wig, and $300 for a nondental prosthesis, unless the prosthesis is due to the surgical removal of breasts because of tumors, in which case the yearly benefit must be at least $300 for each breast.

By law, policies issued or delivered in Connecticut must include these benefits.

APPLICABILITY

The coverage requirements relating to ostomy supplies, prosthetic parity, hearing aids, colonoscopies, bone marrow testing, and wellness incentives apply to individual and group health insurance policies delivered, issued, renewed, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. The bill also applies the requirement to amended policies including such coverage.

Due to federal law, state insurance benefit mandates do not apply to self-insured benefit plans.

Applicability of Wig Coverage Requirement

The bill's wig coverage requirement applies to each insurer, hospital or medical service corporation, HMO, or fraternal benefit society that delivers, issues, renews, amends, or continues in Connecticut, on and after January 1, 2010, (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; and (d) hospital or medical services, including coverage under an HMO plan, and (2) individual

health insurance policies that provide limited benefit health coverage.

BACKGROUND

Ostomy and Related Surgeries

By law, policies that cover ostomy, colostomy, ileostomy, or urostomy surgery must include the benefit. The law prohibits insurers from applying any payments for ostomy appliances and supplies toward any durable medical equipment benefit maximum. And such payments cannot be used to decrease policy benefits that exceed the required coverage amount.

An ostomy is a surgically formed artificial opening in the bowel or intestine. A colostomy is an artificial opening in the colon. An ileostomy is an artificial opening in the small intestine or ileum. An urostomy is an artificial opening in the tubes that run from the kidney to the bladder.

Medically Necessary

The law defines "medically necessary" as health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;

2. clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease;

3. not primarily for the convenience of the patient, physician, or other health care provider; and

4. and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

"Generally accepted standards of medical practice" means standards that are (1) based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or (2) otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Related Bills

sHB 5093 (File 93), favorably reported by the Insurance Committee, requires a health insurance policy to cover prosthetic devices, and repairs and replacements to them, subject to specified conditions.

sHB 5672 (File 10), favorably reported by the Insurance Committee, increases the age, from 13 to 19, for which certain insurance policies must cover hearing aids as durable medical equipment.

sHB 5673 (File 11), favorably reported by the Insurance Committee, expands current law regarding health insurance coverage for wigs by requiring that the coverage include a licensed physician- or advanced practice registered nurse-prescribed wig for a person with hair loss caused by a diagnosed medical condition, except androgenetic alopecia (e.g., male-pattern baldness).

sSB 290 (File 5), favorably reported by the Insurance Committee and passed by the Senate, requires certain health insurance policies to provide specified coverage for human leukocyte antigen testing, which determines compatibility for bone marrow transplants.

sSB 638 (File 119), favorably reported by the Insurance Committee and passed by the Senate, prohibits certain health insurance policies from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a second or subsequent colonoscopy a physician orders for an insured person in a policy year.

sSB 962 (File 127), favorably reported by the Insurance Committee and passed by the Senate, requires certain health insurance policies to cover "routine patient care" costs incurred while a patient is participating in a clinical trial.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 15 Nay 4 (02/19/2009)

Appropriations Committee

Joint Favorable
Yea 42 Nay 8 (04/13/2009)