



General Assembly

**Amendment**

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LCO No. 8312

\*HB0502108312HDO\*

Offered by:

REP. FONTANA, 87<sup>th</sup> Dist.

SEN. CRISCO, 17<sup>th</sup> Dist.

To: Subst. House Bill No. 5021

File No. 34

Cal. No. 85

**"AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR OSTOMY SUPPLIES."**

1 After the last section, add the following and renumber sections and  
2 internal references accordingly:

3 "Sec. 501. (NEW) (*Effective January 1, 2010*) (a) As used in this  
4 section, "prosthetic device" means an artificial limb device to replace,  
5 in whole or in part, an arm or a leg, including a device that contains a  
6 microprocessor if such microprocessor-equipped device is determined  
7 by the insured's or enrollee's health care provider to be medically  
8 necessary. "Prosthetic device" does not include a device that is  
9 designed exclusively for athletic purposes.

10 (b) (1) Each individual health insurance policy providing coverage  
11 of the types specified in subdivisions (1), (2), (4), (11) and (12) of  
12 section 38a-469 of the general statutes delivered, issued for delivery,  
13 renewed, amended or continued in this state shall provide coverage  
14 for prosthetic devices that is at least equivalent to that provided under

15 Medicare. Such coverage may be limited to a prosthetic device that is  
16 determined by the insured's or enrollee's health care provider to be the  
17 most appropriate to meet the medical needs of the insured or enrollee.  
18 Such prosthetic device shall not be considered durable medical  
19 equipment under such policy.

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

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

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

36 (d) An insured or enrollee may appeal a denial of coverage for or  
37 repair or replacement of a prosthetic device to the Insurance  
38 Commissioner for an external, independent review pursuant to section  
39 38a-478n of the general statutes.

40 Sec. 502. (NEW) (*Effective January 1, 2010*) (a) As used in this section,  
41 "prosthetic device" means an artificial limb device to replace, in whole  
42 or in part, an arm or a leg, including a device that contains a  
43 microprocessor if such microprocessor-equipped device is determined  
44 by the insured's or enrollee's health care provider to be medically  
45 necessary. "Prosthetic device" does not include a device that is  
46 designed exclusively for athletic purposes.

47 (b) (1) Each group health insurance policy providing coverage of the  
48 types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
49 469 of the general statutes delivered, issued for delivery, renewed,  
50 amended or continued in this state shall provide coverage for  
51 prosthetic devices that is at least equivalent to that provided under  
52 Medicare. Such coverage may be limited to a prosthetic device that is  
53 determined by the insured's or enrollee's health care provider to be the  
54 most appropriate to meet the medical needs of the insured or enrollee.  
55 Such prosthetic device shall not be considered durable medical  
56 equipment under such policy.

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

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

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

72 (d) An insured or enrollee may appeal a denial of coverage for or  
73 repair or replacement of a prosthetic device to the Insurance  
74 Commissioner for an external, independent review pursuant to section  
75 38a-478n of the general statutes.

76 Sec. 503. Section 38a-490b of the general statutes is repealed and the  
77 following is substituted in lieu thereof (*Effective January 1, 2010*):

78 Each individual health insurance policy providing coverage of the  
79 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
80 469 delivered, issued for delivery, renewed, amended or continued in  
81 this state [on or after October 1, 2001,] shall provide coverage for  
82 hearing aids for children [twelve] eighteen years of age or younger.  
83 Such hearing aids shall be considered durable medical equipment  
84 under the policy and the policy may limit the hearing aid benefit to  
85 one thousand dollars within a twenty-four-month period.

86 Sec. 504. Section 38a-516b of the general statutes is repealed and the  
87 following is substituted in lieu thereof (*Effective January 1, 2010*):

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

96 Sec. 505. Section 38a-504 of the general statutes is repealed and the  
97 following is substituted in lieu thereof (*Effective January 1, 2010*):

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

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

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

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

135 Sec. 506. Section 38a-542 of the general statutes is repealed and the  
136 following is substituted in lieu thereof (*Effective January 1, 2010*):

137 (a) Each insurance company, hospital service corporation, medical  
138 service corporation, health care center or fraternal benefit society  
139 [which] that delivers, [or] issues for delivery, renews, amends or  
140 continues in this state group health insurance policies providing  
141 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)

142 of section 38a-469 shall provide coverage under such policies for  
143 treatment of leukemia, including outpatient chemotherapy,  
144 reconstructive surgery, cost of any nondental prosthesis, including any  
145 maxillo-facial prosthesis used to replace anatomic structures lost  
146 during treatment for head and neck tumors or additional appliances  
147 essential for the support of such prosthesis, outpatient chemotherapy  
148 following surgical procedures in connection with the treatment of  
149 tumors, a wig if prescribed by (1) a licensed oncologist for a patient  
150 who suffers hair loss as a result of chemotherapy, or (2) a licensed  
151 physician or a licensed advanced practice registered nurse for a patient  
152 who suffers hair loss due to a diagnosed medical condition of alopecia  
153 areata other than as a result of androgenetic alopecia, and costs of  
154 removal of any breast implant which was implanted on or before July  
155 1, 1994, without regard to the purpose of such implantation, which  
156 removal is determined to be medically necessary. Such benefits shall  
157 be subject to the same terms and conditions applicable to all other  
158 benefits under such policies.

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

169 (c) The coverage required by subsection (a) of this section shall  
170 provide benefits for the reasonable costs of reconstructive surgery on  
171 each breast on which a mastectomy has been performed, and  
172 reconstructive surgery on a nondiseased breast to produce a  
173 symmetrical appearance. Such benefits shall be subject to the same  
174 terms and conditions applicable to all other benefits under such  
175 policies. For the purposes of this subsection, reconstructive surgery

176 includes, but is not limited to, augmentation mammoplasty, reduction  
177 mammoplasty and mastopexy.

178 Sec. 507. (NEW) (*Effective January 1, 2010*) (a) Subject to the  
179 provisions of subsection (b) of this section, each individual health  
180 insurance policy providing coverage of the type specified in  
181 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
182 statutes delivered, issued for delivery, amended, renewed or  
183 continued in this state shall provide coverage for expenses arising  
184 from human leukocyte antigen testing, also referred to as  
185 histocompatibility locus antigen testing, for A, B and DR antigens for  
186 utilization in bone marrow transplantation.

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

192 (c) Such policy shall:

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

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

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

204 Sec. 508. (NEW) (*Effective January 1, 2010*) (a) Subject to the  
205 provisions of subsection (b) of this section, each group health

206 insurance policy providing coverage of the type specified in  
207 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
208 statutes delivered, issued for delivery, amended, renewed or  
209 continued in this state shall provide coverage for expenses arising  
210 from human leukocyte antigen testing, also referred to as  
211 histocompatibility locus antigen testing, for A, B and DR antigens for  
212 utilization in bone marrow transplantation.

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

218 (c) Such policy shall:

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

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

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

230 Sec. 509. Section 38a-492k of the general statutes is repealed and the  
231 following is substituted in lieu thereof (*Effective January 1, 2010*):

232 (a) Each individual health insurance policy providing coverage of  
233 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
234 38a-469 delivered, issued for delivery, amended, renewed or continued  
235 in this state [on or after October 1, 2001,] shall provide coverage for



236 colorectal cancer screening, including, but not limited to, (1) an annual  
237 fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or  
238 radiologic imaging, in accordance with the recommendations  
239 established by the American College of Gastroenterology, after  
240 consultation with the American Cancer Society, based on the ages,  
241 family histories and frequencies provided in the recommendations.  
242 [Benefits] Except as specified in subsection (b) of this section, benefits  
243 under this section shall be subject to the same terms and conditions  
244 applicable to all other benefits under such policies.

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

250 Sec. 510. Section 38a-518k of the general statutes is repealed and the  
251 following is substituted in lieu thereof (*Effective January 1, 2010*):

252 (a) Each group health insurance policy providing coverage of the  
253 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
254 469 delivered, issued for delivery, amended, renewed or continued in  
255 this state [on or after October 1, 2001,] shall provide coverage for  
256 colorectal cancer screening, including, but not limited to, (1) an annual  
257 fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or  
258 radiologic imaging, in accordance with the recommendations  
259 established by the American College of Gastroenterology, after  
260 consultation with the American Cancer Society, based on the ages,  
261 family histories and frequencies provided in the recommendations.  
262 [Benefits] Except as specified in subsection (b) of this section, benefits  
263 under this section shall be subject to the same terms and conditions  
264 applicable to all other benefits under such policies.

265 (b) No such policy shall impose a coinsurance, copayment,  
266 deductible or other out-of-pocket expense for any additional  
267 colonoscopy ordered in a policy year by a physician for an insured.

268 The provisions of this subsection shall not apply to a high deductible  
269 health plan as that term is used in subsection (f) of section 38a-520.

270 Sec. 511. (NEW) (*Effective January 1, 2010*) (a) Any insurer, health  
271 care center, hospital service corporation, medical service corporation,  
272 fraternal benefit society or other entity that delivers, issues for  
273 delivery, renews, amends or continues in this state a group health  
274 insurance policy providing coverage of the type specified in  
275 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
276 statutes shall offer a reasonably designed health behavior wellness,  
277 maintenance or improvement program that allows for a reward, a  
278 health spending account contribution, a reduction in premiums or  
279 reduced medical, prescription drug or equipment copayment,  
280 coinsurance or deductible, or a combination of these incentives, for  
281 participation in such program.

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

287 (c) The insured or enrollee shall provide evidence of participation in  
288 such program to the insurer, health care center or other entity set forth  
289 in subsection (a) of this section in a manner approved by the Insurance  
290 Commissioner.

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

296 Sec. 512. Section 38a-825 of the general statutes is repealed and the  
297 following is substituted in lieu thereof (*Effective January 1, 2010*):

298 [No] Except as provided in section 511 of this act, no insurance

299 company doing business in this state, or attorney, producer or any  
300 other person shall pay or allow, or offer to pay or allow, as inducement  
301 to insurance, any rebate of premium payable on the policy, or any  
302 special favor or advantage in the dividends or other benefits to accrue  
303 thereon, or any valuable consideration or inducement not specified in  
304 the policy of insurance. [No] Except as provided in section 511 of this  
305 act, no person shall receive or accept from any company, or attorney,  
306 producer or any other person, as inducement to insurance, any such  
307 rebate of premium payable on the policy, or any special favor or  
308 advantage in the dividends or other benefit to accrue thereon, or any  
309 valuable consideration or inducement not specified in the policy of  
310 insurance. No person shall be excused from testifying or from  
311 producing any books, papers, contracts, agreements or documents, at  
312 the trial of any other person charged with the violation of any  
313 provision of this section or of section 38a-446, on the ground that such  
314 testimony or evidence may tend to incriminate him, but no person  
315 shall be prosecuted for any act concerning which he is compelled to so  
316 testify or produce documentary or other evidence, except for perjury  
317 committed in so testifying.

318 Sec. 513. Subdivision (9) of section 38a-816 of the general statutes is  
319 repealed and the following is substituted in lieu thereof (*Effective*  
320 *January 1, 2010*):

321 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,  
322 38a-488, 38a-825, as amended by this act, 38a-826, 38a-828 and 38a-829.  
323 None of the following practices shall be considered discrimination  
324 within the meaning of section 38a-446 or 38a-488 or a rebate within the  
325 meaning of section 38a-825: (a) Paying bonuses to policyholders or  
326 otherwise abating their premiums in whole or in part out of surplus  
327 accumulated from nonparticipating insurance, provided any such  
328 bonuses or abatement of premiums shall be fair and equitable to  
329 policyholders and for the best interests of the company and its  
330 policyholders; (b) in the case of policies issued on the industrial debit  
331 plan, making allowance to policyholders who have continuously for a  
332 specified period made premium payments directly to an office of the

333 insurer in an amount which fairly represents the saving in collection  
334 expense; (c) readjustment of the rate of premium for a group insurance  
335 policy based on loss or expense experience, or both, at the end of the  
336 first or any subsequent policy year, which may be made retroactive for  
337 such policy year; (d) paying a reward, making a health spending  
338 account contribution, or allowing a reduction in premiums or reduced  
339 medical, prescription drug or equipment copayment, coinsurance or  
340 deductible, or a combination of these incentives to an insured or  
341 enrollee in accordance with section 511 of this act.

342 Sec. 514. Section 38a-623 of the general statutes is repealed and the  
343 following is substituted in lieu thereof (*Effective January 1, 2010*):

344 No society doing business in this state shall make or permit any  
345 unfair discrimination between insured members of the same class and  
346 equal expectation of life in the premiums charged for certificates of  
347 insurance, in the dividends or other benefits payable thereon or in any  
348 other of the terms and conditions of the contracts it makes. [No] Except  
349 as provided in section 511 of this act, no society, by itself, or any other  
350 party, and no agent or solicitor, personally, or by any other party, shall  
351 offer, promise, allow, give, set off or pay, directly or indirectly, any  
352 valuable consideration or inducement to or for insurance, on any risk  
353 authorized to be taken by such society [, which] that is not specified in  
354 the certificate. [No] Except as provided in section 511 of this act, no  
355 member shall receive or accept, directly or indirectly, any rebate of  
356 premium, or part thereof, or agent's or solicitor's commission thereon,  
357 payable on any certificate or receive or accept any favor or advantage  
358 or share in the dividends or other benefits to accrue on, or any  
359 valuable consideration or inducement not specified in, the contract of  
360 insurance."