



General Assembly

Amendment

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LCO No. 8192

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Offered by:

REP. FONTANA, 87th Dist.

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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 shall provide coverage for
13 prosthetic devices that is at least equivalent to that provided under
14 Medicare. Such coverage may be limited to a prosthetic device that is

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

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

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

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

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

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

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

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

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

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

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

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

76 Each individual health insurance policy providing coverage of the

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

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

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

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

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

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

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

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

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

135 (a) Each insurance company, hospital service corporation, medical
136 service corporation, health care center or fraternal benefit society
137 [which] that delivers, [or] issues for delivery, renews, amends or
138 continues in this state group health insurance policies providing
139 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
140 of section 38a-469 shall provide coverage under such policies for

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

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

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

175 mammoplasty and mastopexy.

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

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

190 (c) Such policy shall:

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

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

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

202 Sec. 508. (NEW) (*Effective January 1, 2010*) (a) Subject to the
203 provisions of subsection (b) of this section, each group health
204 insurance policy providing coverage of the type specified in

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

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

216 (c) Such policy shall:

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

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

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

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

230 (a) Each individual health insurance policy providing coverage of
231 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
232 38a-469 delivered, issued for delivery, amended, renewed or continued
233 in this state [on or after October 1, 2001,] shall provide coverage for
234 colorectal cancer screening, including, but not limited to, (1) an annual

235 fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or
236 radiologic imaging, in accordance with the recommendations
237 established by the American College of Gastroenterology, after
238 consultation with the American Cancer Society, based on the ages,
239 family histories and frequencies provided in the recommendations.
240 [Benefits] Except as specified in subsection (b) of this section, benefits
241 under this section shall be subject to the same terms and conditions
242 applicable to all other benefits under such policies.

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

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

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

263 (b) No such policy shall impose a coinsurance, copayment,
264 deductible or other out-of-pocket expense for any additional
265 colonoscopy ordered in a policy year by a physician for an insured.
266 The provisions of this subsection shall not apply to a high deductible

267 health plan as that term is used in subsection (f) of section 38a-520.

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

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

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

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

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

296 [No] Except as provided in section 511 of this act, no insurance
297 company doing business in this state, or attorney, producer or any

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

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

319 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,
320 38a-488, 38a-825, as amended by this act, 38a-826, 38a-828 and 38a-829.
321 None of the following practices shall be considered discrimination
322 within the meaning of section 38a-446 or 38a-488 or a rebate within the
323 meaning of section 38a-825: (a) Paying bonuses to policyholders or
324 otherwise abating their premiums in whole or in part out of surplus
325 accumulated from nonparticipating insurance, provided any such
326 bonuses or abatement of premiums shall be fair and equitable to
327 policyholders and for the best interests of the company and its
328 policyholders; (b) in the case of policies issued on the industrial debit
329 plan, making allowance to policyholders who have continuously for a
330 specified period made premium payments directly to an office of the
331 insurer in an amount which fairly represents the saving in collection

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

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

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