



House of Representatives

General Assembly

File No. 7

February Session, 2010

House Bill No. 5009

House of Representatives, March 3, 2010

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

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:

1 Section 1. Section 38a-492j of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2011*):

3 Each individual health insurance policy providing coverage of the
4 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
5 469 delivered, issued for delivery, renewed, amended or continued in
6 this state [on or after October 1, 2000,] that provides coverage for
7 ostomy surgery shall include coverage, up to [one] five thousand
8 dollars annually, for medically necessary appliances and supplies
9 relating to an ostomy including, but not limited to, collection devices,
10 irrigation equipment and supplies, skin barriers and skin protectors.
11 As used in this section, "ostomy" includes colostomy, ileostomy and
12 urostomy. Payments under this section shall not be applied to any
13 policy maximums for durable medical equipment. Nothing in this
14 section shall be deemed to decrease policy benefits in excess of the

15 limits in this section.

16 Sec. 2. Section 38a-518j of the general statutes is repealed and the
17 following is substituted in lieu thereof (*Effective January 1, 2011*):

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

31 Sec. 3. (NEW) (*Effective January 1, 2011*) (a) As used in this section,
32 "prosthetic device" means an artificial limb device to replace, in whole
33 or in part, an arm or a leg, including a device that contains a
34 microprocessor if such microprocessor-equipped device is determined
35 by the insured's or enrollee's health care provider to be medically
36 necessary. "Prosthetic device" does not include a device that is
37 designed exclusively for athletic purposes.

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

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

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

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

64 (d) An insured or enrollee may appeal a denial of coverage for or
65 repair or replacement of a prosthetic device to the Insurance
66 Commissioner for an external, independent review pursuant to section
67 38a-478n of the general statutes.

68 Sec. 4. (NEW) (*Effective January 1, 2011*) (a) As used in this section,
69 "prosthetic device" means an artificial limb device to replace, in whole
70 or in part, an arm or a leg, including a device that contains a
71 microprocessor if such microprocessor-equipped device is determined
72 by the insured's or enrollee's health care provider to be medically
73 necessary. "Prosthetic device" does not include a device that is
74 designed exclusively for athletic purposes.

75 (b) (1) Each group health insurance policy providing coverage of the
76 types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
77 469 of the general statutes delivered, issued for delivery, renewed,
78 amended or continued in this state shall provide coverage for
79 prosthetic devices that is at least equivalent to that provided under

80 Medicare. Such coverage may be limited to a prosthetic device that is
81 determined by the insured's or enrollee's health care provider to be the
82 most appropriate to meet the medical needs of the insured or enrollee.
83 Such prosthetic device shall not be considered durable medical
84 equipment under such policy.

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

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

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

101 (d) An insured or enrollee may appeal a denial of coverage for or
102 repair or replacement of a prosthetic device to the Insurance
103 Commissioner for an external, independent review pursuant to section
104 38a-478n of the general statutes.

105 Sec. 5. Section 38a-490b of the general statutes is repealed and the
106 following is substituted in lieu thereof (*Effective January 1, 2011*):

107 Each individual health insurance policy providing coverage of the
108 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
109 469 delivered, issued for delivery, renewed, amended or continued in
110 this state [on or after October 1, 2001,] shall provide coverage for

111 hearing aids for children [twelve] eighteen years of age or younger.
112 Such hearing aids shall be considered durable medical equipment
113 under the policy and the policy may limit the hearing aid benefit to
114 one thousand dollars within a twenty-four-month period.

115 Sec. 6. Section 38a-516b of the general statutes is repealed and the
116 following is substituted in lieu thereof (*Effective January 1, 2011*):

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

125 Sec. 7. Section 38a-504 of the general statutes is repealed and the
126 following is substituted in lieu thereof (*Effective January 1, 2011*):

127 (a) Each insurance company, hospital service corporation, medical
128 service corporation, health care center or fraternal benefit society
129 [which] that delivers, [or] issues for delivery, renews, amends or
130 continues in this state individual health insurance policies providing
131 coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and
132 (12) of section 38a-469, shall provide coverage under such policies for
133 the surgical removal of tumors and treatment of leukemia, including
134 outpatient chemotherapy, reconstructive surgery, cost of any
135 nondental prosthesis including any maxillo-facial prosthesis used to
136 replace anatomic structures lost during treatment for head and neck
137 tumors or additional appliances essential for the support of such
138 prosthesis, outpatient chemotherapy following surgical procedure in
139 connection with the treatment of tumors, and a wig if prescribed by (1)
140 a licensed oncologist for a patient who suffers hair loss as a result of
141 chemotherapy, or (2) a licensed physician or a licensed advanced
142 practice registered nurse for a patient who suffers hair loss due to a
143 diagnosed medical condition of alopecia areata other than as a result of

144 androgenetic alopecia. Such benefits shall be subject to the same terms
145 and conditions applicable to all other benefits under such policies.

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

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

164 Sec. 8. Section 38a-542 of the general statutes is repealed and the
165 following is substituted in lieu thereof (*Effective January 1, 2011*):

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

177 following surgical procedures in connection with the treatment of
178 tumors, a wig if prescribed by (1) a licensed oncologist for a patient
179 who suffers hair loss as a result of chemotherapy, or (2) a licensed
180 physician or a licensed advanced practice registered nurse for a patient
181 who suffers hair loss due to a diagnosed medical condition of alopecia
182 areata other than as a result of androgenetic alopecia, and costs of
183 removal of any breast implant which was implanted on or before July
184 1, 1994, without regard to the purpose of such implantation, which
185 removal is determined to be medically necessary. Such benefits shall
186 be subject to the same terms and conditions applicable to all other
187 benefits under such policies.

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

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

207 Sec. 9. (NEW) (Effective January 1, 2011) (a) Subject to the provisions
208 of subsection (b) of this section, each individual health insurance
209 policy providing coverage of the type specified in subdivisions (1), (2),

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

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

220 (c) Such policy shall:

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

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

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

232 Sec. 10. (NEW) (*Effective January 1, 2011*) (a) Subject to the provisions
233 of subsection (b) of this section, each group health insurance policy
234 providing coverage of the type specified in subdivisions (1), (2), (4),
235 (11) and (12) of section 38a-469 of the general statutes delivered, issued
236 for delivery, amended, renewed or continued in this state shall provide
237 coverage for expenses arising from human leukocyte antigen testing,
238 also referred to as histocompatibility locus antigen testing, for A, B and
239 DR antigens for utilization in bone marrow transplantation.

240 (b) No such policy shall impose a coinsurance, copayment,

241 deductible or other out-of-pocket expense for such testing in excess of
242 twenty per cent of the cost for such testing per year. The provisions of
243 this subsection shall not apply to a high deductible health plan as that
244 term is used in subsection (f) of section 38a-520 of the general statutes.

245 (c) Such policy shall:

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

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

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

257 Sec. 11. Section 38a-492k of the general statutes is repealed and the
258 following is substituted in lieu thereof (*Effective January 1, 2011*):

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

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

277 Sec. 12. Section 38a-518k of the general statutes is repealed and the
278 following is substituted in lieu thereof (*Effective January 1, 2011*):

279 (a) Each group health insurance policy providing coverage of the
280 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
281 469 delivered, issued for delivery, amended, renewed or continued in
282 this state [on or after October 1, 2001,] shall provide coverage for
283 colorectal cancer screening, including, but not limited to, (1) an annual
284 fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or
285 radiologic imaging, in accordance with the recommendations
286 established by the American College of Gastroenterology, after
287 consultation with the American Cancer Society, based on the ages,
288 family histories and frequencies provided in the recommendations.
289 [Benefits] Except as specified in subsection (b) of this section, benefits
290 under this section shall be subject to the same terms and conditions
291 applicable to all other benefits under such policies.

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

297 Sec. 13. (NEW) (*Effective January 1, 2011*) (a) Any insurer, health care
298 center, hospital service corporation, medical service corporation,
299 fraternal benefit society or other entity that delivers, issues for
300 delivery, renews, amends or continues in this state a group health
301 insurance policy providing coverage of the type specified in
302 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
303 statutes shall offer a reasonably designed health behavior wellness,
304 maintenance or improvement program that allows for a reward, a

305 health spending account contribution, a reduction in premiums or
306 reduced medical, prescription drug or equipment copayment,
307 coinsurance or deductible, or a combination of these incentives, for
308 participation in such program.

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

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

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

323 Sec. 14. Section 38a-825 of the general statutes is repealed and the
324 following is substituted in lieu thereof (*Effective January 1, 2011*):

325 [No] Except as provided in section 13 of this act, no insurance
326 company doing business in this state, or attorney, producer or any
327 other person shall pay or allow, or offer to pay or allow, as inducement
328 to insurance, any rebate of premium payable on the policy, or any
329 special favor or advantage in the dividends or other benefits to accrue
330 thereon, or any valuable consideration or inducement not specified in
331 the policy of insurance. [No] Except as provided in section 13 of this
332 act, no person shall receive or accept from any company, or attorney,
333 producer or any other person, as inducement to insurance, any such
334 rebate of premium payable on the policy, or any special favor or
335 advantage in the dividends or other benefit to accrue thereon, or any
336 valuable consideration or inducement not specified in the policy of

337 insurance. No person shall be excused from testifying or from
338 producing any books, papers, contracts, agreements or documents, at
339 the trial of any other person charged with the violation of any
340 provision of this section or of section 38a-446, on the ground that such
341 testimony or evidence may tend to incriminate him, but no person
342 shall be prosecuted for any act concerning which he is compelled to so
343 testify or produce documentary or other evidence, except for perjury
344 committed in so testifying.

345 Sec. 15. Subdivision (9) of section 38a-816 of the general statutes is
346 repealed and the following is substituted in lieu thereof (*Effective*
347 *January 1, 2011*):

348 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,
349 38a-488, 38a-825, as amended by this act, 38a-826, 38a-828 and 38a-829.
350 None of the following practices shall be considered discrimination
351 within the meaning of section 38a-446 or 38a-488 or a rebate within the
352 meaning of section 38a-825: (a) Paying bonuses to policyholders or
353 otherwise abating their premiums in whole or in part out of surplus
354 accumulated from nonparticipating insurance, provided any such
355 bonuses or abatement of premiums shall be fair and equitable to
356 policyholders and for the best interests of the company and its
357 policyholders; (b) in the case of policies issued on the industrial debit
358 plan, making allowance to policyholders who have continuously for a
359 specified period made premium payments directly to an office of the
360 insurer in an amount which fairly represents the saving in collection
361 expense; (c) readjustment of the rate of premium for a group insurance
362 policy based on loss or expense experience, or both, at the end of the
363 first or any subsequent policy year, which may be made retroactive for
364 such policy year; (d) paying a reward, making a health spending
365 account contribution, or allowing a reduction in premiums or reduced
366 medical, prescription drug or equipment copayment, coinsurance or
367 deductible, or a combination of these incentives to an insured or
368 enrollee in accordance with section 13 of this act.

369 Sec. 16. Section 38a-623 of the general statutes is repealed and the

370 following is substituted in lieu thereof (*Effective January 1, 2011*):

371 No society doing business in this state shall make or permit any
 372 unfair discrimination between insured members of the same class and
 373 equal expectation of life in the premiums charged for certificates of
 374 insurance, in the dividends or other benefits payable thereon or in any
 375 other of the terms and conditions of the contracts it makes. [No] Except
 376 as provided in section 13 of this act, no society, by itself, or any other
 377 party, and no agent or solicitor, personally, or by any other party, shall
 378 offer, promise, allow, give, set off or pay, directly or indirectly, any
 379 valuable consideration or inducement to or for insurance, on any risk
 380 authorized to be taken by such society [, which] that is not specified in
 381 the certificate. [No] Except as provided in section 13 of this act, no
 382 member shall receive or accept, directly or indirectly, any rebate of
 383 premium, or part thereof, or agent's or solicitor's commission thereon,
 384 payable on any certificate or receive or accept any favor or advantage
 385 or share in the dividends or other benefits to accrue on, or any
 386 valuable consideration or inducement not specified in, the contract of
 387 insurance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2011	38a-492j
Sec. 2	January 1, 2011	38a-518j
Sec. 3	January 1, 2011	New section
Sec. 4	January 1, 2011	New section
Sec. 5	January 1, 2011	38a-490b
Sec. 6	January 1, 2011	38a-516b
Sec. 7	January 1, 2011	38a-504
Sec. 8	January 1, 2011	38a-542
Sec. 9	January 1, 2011	New section
Sec. 10	January 1, 2011	New section
Sec. 11	January 1, 2011	38a-492k
Sec. 12	January 1, 2011	38a-518k
Sec. 13	January 1, 2011	New section
Sec. 14	January 1, 2011	38a-825
Sec. 15	January 1, 2011	38a-816(9)

Sec. 16	January 1, 2011	38a-623
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INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 11 \$	FY 12 \$
State Comptroller - Fringe Benefits	GF & TF- Cost	Potential	Potential
Department of Revenue Services	GF - Revenue Loss	Potential	Potential

Note:GF = General Fund; TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 11 \$	FY 12 \$
Various Municipalities	STATE MANDATE - Cost	Significant	Significant

Explanation - State Impact

Section 18 of P.A. 09-7 of the September Special Session required the Comptroller to convert the state employee health insurance plan to a self-insured arrangement for benefit periods on or after July 1, 2010. It is expected that this conversion will take place on schedule for July 1, 2010. Due to federal law, the state's FY 11 self-insured health plan would be exempt from state health insurance benefit mandates however in previous self-funded arrangements the state has traditionally adopted all state mandates. To the extent that the state continues this practice of voluntary mandate adoption, the following impacts would be anticipated at a total estimated annual cost to the state health plans of \$8.3 million however given this voluntary participation, the timing of these impacts remains unclear.

Secs. 1 & 2: Ostomy Supplies

The bill increases the annual limit related to mandated ostomy supply coverage from \$1,000 to \$5,000. This provision of the bill is not

anticipated to impact costs to the state health plans since the state plans currently provide this coverage.

Secs. 3 & 4: Prosthetic Parity

The bill requires a health insurance policy to provide coverage of prosthetic devices, defined as artificial limbs and including medically-necessary microprocessor-equipped devices. Prior authorization and copayments are permitted, provided they are no more restrictive than those imposed on other policy benefits. The estimated annualized cost to the state health plans is \$6 million as current coverage does not include microprocessor-equipped prosthetics.

Secs. 5 & 6: Hearing Aids

The expansion of insurance coverage for hearing aids for children ages 13 to 18 in the bill is not provided under the current state employee plans. The estimated annualized cost to the state health plans is \$550,000.

Secs. 7 & 8: Wigs

The expanded coverage of wigs for individuals with hair loss caused by a diagnosed medical condition (other than following chemotherapy) is not provided under the current state employee plans. The bill expands coverage to any prescribed wig for patients suffering hair loss due to a medical condition other than androgenetic alopecia (e.g., male-patterned baldness). There are a significant number of medical conditions that can cause either temporary or permanent hair loss. As a result it is estimated that there would be an annual cost of \$1.3 million associated with the expanded coverage of wigs mandated by the bill.

Secs. 9 & 10: Bone Marrow Testing

The bill's mandate requiring coverage of bone marrow testing is anticipated to impact state health plans at an annual cost of \$310,000 as this coverage does not currently exist. The bill requires payment for

bone marrow compatibility testing for all plan members - not only for those whom the test is medically necessary for matching purposes.

Secs. 11 & 12: Colonoscopies

The state health plan currently provides coverage for in-network colorectal cancer screening, with no copayments for surgery or testing and no limit as to the number of colorectal cancer screening tests, provided they are medically necessary. The state POS plans currently require a 20% copayment for out-of-network colorectal cancer screening, whereas state POE plans do not cover these benefits out-of-network.

The mandate prohibits coinsurance, copayment, deductible or other out-of-pocket expense for any additional medically necessary colorectal cancer screening ordered in a given year. This would prevent the POS plan from charging the 20% copayment for any out-of-network follow-up tests. As a result, the annual cost to the state plan would be approximately \$176,500. The bill prohibits imposing a copayment for colorectal cancer screening; however it does not require out-of-network coverage of these services. Therefore the mandate would not require the POE plans to begin offering this benefit out-of-network.

Secs. 13 - 16: Wellness Incentives

Requiring insurers to establish incentives for utilization of wellness programs will result in a General Fund revenue loss to the insurance premiums tax to the degree that insurers choose to provide a premium reduction to participating individuals. The revenue loss cannot be determined because it is not known to what extent insurers will offer this incentive as part of their plan.

This mandate is not anticipated to impact the state employee and retiree health plan. The state health plan currently offers wellness programs as value-added services such as membership discounts for gyms or weight loss programs. It is anticipated that there would be no increased cost for implementing a reward program. This is attributed

to the fact that the bill does not require the adoption of a particular incentive program. Additionally, studies indicate that wellness programs consistently result in reductions in health care costs and employee absenteeism, and therefore are typically worthwhile for both the provider and subscriber.

Municipal Impact

The bill's impact on municipal health insurance costs will vary by municipality depending on whether the municipality has a fully insured health plan and whether the plan currently provides the required level of coverage for 1) ostomy supplies; 2) prosthetic devices; 3) hearing aids; 4) wigs; 5) bone marrow testing; and/or 6) colorectal cancer screening.

Additionally, the mandate's wellness incentive provision may minimally increase premium costs to certain fully insured municipal plans which do not currently offer a wellness program, or associated reward system when municipalities enter into new health insurance contracts after January 1, 2011. Any additional cost would likely be minimized, as the bill gives municipalities flexibility in designing a program by not requiring a specific incentive. In addition, wellness programs are typically worthwhile for both the provider and subscriber as studies indicate consistent reductions in health care costs and employee absenteeism.

The mandate's coverage requirements effective January 1, 2011 may result in potentially significant increased premium costs when municipalities enter into new contracts for health insurance. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The Out Years

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

Sources: Office of the State Comptroller, Department of Insurance, Office of Legislative

Research, Municipal Employees Health Insurance Plan (MEHIP) Schedule of Benefits, State Employee Health Plan Subscriber Agreement, Wellness Council of America, WebMD.

**OLR Bill Analysis
HB 5009*****AN ACT CONCERNING WELLNESS PROGRAMS AND
EXPANSION OF HEALTH INSURANCE COVERAGE.*****SUMMARY:**

This bill (1) requires group health insurers to offer health wellness programs that provide insured people participation incentives and (2) allows the insurance commissioner, in consultation with the public health commissioner, to adopt regulations regarding such programs. It (1) requires health insurance policies to cover, subject to specified conditions, prosthetic devices and human leukocyte antigen (bone marrow) testing and (2) prohibits insurers from charging an insured person for a second or subsequent colonoscopy a physician orders for him or her in a policy year.

The bill expands the insurance coverage required for (1) medically necessary ostomy appliances and supplies, increasing the annual benefit from \$1,000 to \$5,000; (2) children's hearing aids, requiring coverage for children under age 19, instead of under age 13; and (3) wigs, requiring coverage of at least \$350 annually for people diagnosed with alopecia areata (a type of hair loss, which is often temporary), excluding androgenetic alopecia (i.e., female- or male-pattern baldness), in addition to people with hair loss due to chemotherapy, for whom the benefit is already law.

The bill also broadens the applicability of several health insurance benefits required by law, including ostomy supplies, treatment of tumors and leukemia, reconstructive surgery, nondental prostheses, chemotherapy, and wigs for chemotherapy patients. It does this by requiring all policies delivered, issued, renewed, amended, or continued in Connecticut to include the benefits, instead of only policies delivered or issued in the state.

EFFECTIVE DATE: January 1, 2011

§§ 13 - 16 — 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 incentives to participate in the program. The allowed incentives are a (1) reward; (2) health spending account contribution; (3) premium reduction; and (4) reduced copayment, coinsurance, or deductible. The bill prohibits the value of any reward or incentive from exceeding 20% of “paid premiums.” It requires them to comply with federal nondiscrimination requirements under the Health Insurance Portability and Accountability Act or its regulations.

The bill allows 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 permitted reward or incentive from the laws prohibiting rebates and discrimination in insurance.

§§ 3 & 4 — PROSTHETIC DEVICES

The bill defines a “prosthetic device” as an artificial device to replace all or part of an arm or leg. It includes a device containing a microprocessor that an insured person’s health care provider determines is medically necessary, but excludes a device designed exclusively for athletic purposes.

The bill requires a health insurance policy to provide coverage for prosthetic devices that is at least equivalent to the coverage Medicare provides for such devices. (Medicare covers 80% of the cost of prostheses, after a person pays his or her annual deductible.) It allows a policy to (1) limit coverage to a prosthetic device that a person’s health care provider determines is most appropriate to meet his or her

medical needs and (2) to require prior authorization for prosthetic devices, but only in the same manner and to the same extent as it requires prior authorization for other policy benefits.

The bill requires a policy to cover repairs to or replacements of prosthetic devices that the person's health 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 a deductible limit does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

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

§§ 9 & 10 — BONE MARROW TESTING

The bill requires health insurance policies to cover 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. Under the bill, a policy (1) may limit coverage to one covered test in a person's lifetime and (2) cannot impose a coinsurance, copayment, deductible, or other out-of-pocket expense for the testing that exceeds 20% of the cost for testing per year, unless it is a high-deductible policy designed to be compatible with federally qualified health savings accounts.

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.

§§ 11 & 12 — COLONOSCOPIES

By law, health insurance 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.

The bill prohibits 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. Other than this prohibition, benefits are subject to the same terms and conditions that apply to policy benefits. The bill specifies that its prohibition does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

§§ 1 & 2 — OSTOMY APPLIANCES AND SUPPLIES

By law, policies that cover ostomy surgery must also cover medically necessary ostomy appliances and supplies, including collection devices, irrigation equipment and supplies, and skin barriers and protectors. Ostomy includes colostomy, ileostomy, and urostomy.

The bill increases the maximum annual coverage amount for ostomy appliances and supplies from \$1,000 to \$5,000. 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.

The bill applies this coverage requirement to policies issued, delivered, renewed, amended, or continued in Connecticut. Current law does not apply to policies amended in the state.

§§ 5 & 6 — HEARING AIDS

The bill requires health insurance policies to cover hearing aids for children under age 19, up from those under age 13. By law, a policy (1) must consider hearing aids as durable medical equipment and (2) may limit coverage to \$1,000 in a 24-month period.

§§ 7 & 8 — WIGS

The bill requires health insurance policies to provide a yearly benefit of at least \$350 to cover a wig a licensed physician or advanced practice registered nurse prescribes for a person with hair loss caused by a diagnosed medical condition of alopecia areata, excluding androgenetic alopecia. The coverage must be subject to the same terms and conditions applicable to all other policy benefits.

By law, policies must provide a yearly benefit of at least \$350 for an oncologist-prescribed wig for a person with hair loss resulting from chemotherapy, subject to the same terms and conditions as other policy benefits.

§§ 7 & 8 — EXPANDED APPLICABILITY OF REQUIREMENTS

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

1. the surgical removal of tumors and related outpatient chemotherapy;
2. treatment of leukemia, including outpatient chemotherapy;
3. reconstructive surgery, including on a breast on which a mastectomy was performed and a nondiseased breast for symmetry (such as augmentation or reduction mammoplasty and mastopexy);
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;

5. an oncologist-prescribed wig for a patient with hair loss resulting from chemotherapy; and
6. if a group health insurance policy, medically necessary removal of breast implants that were implanted before July 2, 1994.

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: (1) \$500 each for the surgical removal of tumors, reconstructive surgery, and outpatient chemotherapy; (2) \$350 for a wig; (3) \$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; and (4) if a group policy, \$1,000 for a breast implant removal.

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

APPLICABILITY OF THE BILL

The bill's coverage requirements for prosthetic devices, bone marrow testing, colonoscopy, ostomy supplies, and hearing aids apply to individual and group health insurance policies delivered, issued, renewed, amended, 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 wig coverage and tumor, leukemia, and related benefit requirements also apply to individual health insurance policies that provide limited benefit health coverage. The wellness program requirement and related provisions apply only to group health insurance policies.

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

BACKGROUND

Medically Necessary

The law requires policies to include the following definition of “medically necessary.” Medically necessary services are 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. 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.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 12 Nay 7 (02/16/2010)