



General Assembly

February Session, 2010

Raised Bill No. 5009

LCO No. 28

* _____HB05009APP___041310_____*

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

**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 Section 38a-492j of the general statutes is repealed and the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 Section 38a-518j of the general statutes is repealed and the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	<i>January 1, 2011</i>	38a-492j
Sec. 2	<i>January 1, 2011</i>	38a-518j
Sec. 3	<i>January 1, 2011</i>	New section
Sec. 4	<i>January 1, 2011</i>	New section
Sec. 5	<i>January 1, 2011</i>	38a-490b
Sec. 6	<i>January 1, 2011</i>	38a-516b
Sec. 7	<i>January 1, 2011</i>	38a-504
Sec. 8	<i>January 1, 2011</i>	38a-542
Sec. 9	<i>January 1, 2011</i>	New section
Sec. 10	<i>January 1, 2011</i>	New section
Sec. 11	<i>January 1, 2011</i>	38a-492k

Sec. 12	<i>January 1, 2011</i>	38a-518k
Sec. 13	<i>January 1, 2011</i>	New section
Sec. 14	<i>January 1, 2011</i>	38a-825
Sec. 15	<i>January 1, 2011</i>	38a-816(9)
Sec. 16	<i>January 1, 2011</i>	38a-623

INS *Joint Favorable*

APP *Joint Favorable*