



# House of Representatives

**File No. 817**

General Assembly

January Session, 2011

**(Reprint of File No. 108)**

Substitute House Bill No. 6472  
As Amended by House Amendment  
Schedule "A"

Approved by the Legislative Commissioner  
May 19, 2011

**AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR  
OSTOMY SUPPLIES.**

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 Section 38a-492j of the general statutes is repealed and the  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, 2012*):

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 that provides coverage for ostomy surgery shall include  
7 coverage, up to [one thousand] two thousand five hundred dollars  
8 annually, for medically necessary appliances and supplies relating to  
9 an ostomy including, but not limited to, collection devices, irrigation  
10 equipment and supplies, skin barriers and skin protectors. As used in  
11 this section, "ostomy" includes colostomy, ileostomy and urostomy.  
12 Payments under this section shall not be applied to any policy  
13 maximums for durable medical equipment. Nothing in this section  
14 shall be deemed to decrease policy benefits in excess of the limits in  
15 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 Section 38a-518j of the general statutes is repealed and the  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, 2012*):

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 that provides coverage for ostomy surgery shall include coverage,  
22 up to [one thousand] two thousand five hundred dollars annually, for  
23 medically necessary appliances and supplies relating to an ostomy  
24 including, but not limited to, collection devices, irrigation equipment  
25 and supplies, skin barriers and skin protectors. As used in this section,  
26 "ostomy" includes colostomy, ileostomy and urostomy. Payments  
27 under this section shall not be applied to any policy maximums for  
28 durable medical equipment. Nothing in this section shall be deemed to  
29 decrease policy benefits in excess of the limits in this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2012</i>	38a-492j
Sec. 2	<i>January 1, 2012</i>	38a-518j

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:** None, See Below for Out Years Impact

#### **Municipal Impact:**

<b>Municipalities</b>	<b>Effect</b>	<b>FY 12 \$</b>	<b>FY 13 \$</b>
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

### **Explanation**

The bill results in no fiscal impact to the state. The state employee health plan currently provides coverage for medically necessary ostomy supplies at no cost to the patient.

The bill may increase costs to certain fully insured, municipal plans that do not currently provide annual coverage for ostomy supplies up to \$2,500. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2012. Due to federal law, municipalities with self-insured plans are exempt from state health insurance benefit mandates.

Many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordable Care Act (PPACA)<sup>1</sup>. It is unclear what effect the adoption of certain health

<sup>1</sup> Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an

mandates will have on the grandfathered status municipal plans PPACA<sup>2</sup>.

House "A" changes the coverage limit from \$1,500 to \$2,500 for ostomy supplies. The change results in the fiscal impact explained herein.

### ***The Out Years***

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

The federal health care reform act prohibits, effective January 1, 2014, all non-grandfathered group health plans from imposing annual coverage limits on essential health benefits as defined in section 1302(b) of the PPACA.

The federal health care reform act requires that, effective January 1, 2014; all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. However, neither the agency nor mechanism for the state to pay these costs has been established.

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unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. ([www.healthcare.gov](http://www.healthcare.gov))

<sup>2</sup> According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. ([www.healthcare.gov](http://www.healthcare.gov))

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**OLR Bill Analysis****sHB 6472 (as amended by House "A")\******AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR OSTOMY SUPPLIES.*****SUMMARY:**

By law, certain health insurance 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.

This bill increases the maximum annual coverage amount for ostomy appliances and supplies from \$1,000 to \$2,500. 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 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; or (4) hospital or medical services, including coverage under an HMO plan.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

\*House Amendment "A" increases the annual coverage amount for ostomy appliances and supplies to \$2,500 from \$1,500 as in the original file (File 108).

EFFECTIVE DATE: January 1, 2012

## **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 (CGS §§ 38a-482a and 38a-513c).

## **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 13 Nay 7 (03/08/2011)

Appropriations Committee

Joint Favorable

Yea 32 Nay 17 (04/25/2011)