General Assembly

Raised Bill No. 5210

February Session, 2018

LCO No. **556**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT MANDATING INSURANCE COVERAGE OF ESSENTIAL HEALTH BENEFITS AND EXPANDING MANDATED HEALTH BENEFITS FOR WOMEN, CHILDREN AND ADOLESCENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this section, "essential health benefits" means health care services and benefits that fall within the following categories:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including, but not limited to, oral and vision care.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2019, shall provide coverage for essential health benefits.

(c) If a policy described in subsection (b) of this section must provide coverage for any health care service or benefit pursuant to another provision of chapter 700c of the general statutes, and the scope of such health care service or benefit conflicts with the scope of an essential health benefit that such policy must cover pursuant to subsection (b) of this section, such policy shall provide coverage for the health care service or benefit that, in the opinion of the Insurance Commissioner, provides greater protection to the insured.

(d) No provision of the general statutes concerning a requirement of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, shall be construed to supersede any provision of this section that provides greater protection to an insured, except to the extent the latter prevents the application of a requirement of the Affordable Care Act.

(e) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the purposes of this section, including, but not limited to, regulations specifying the health care services and benefits that fall within each category set forth in

subsection (a) of this section.

Sec. 2. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this section, "essential health benefits" means health care services and benefits that fall within the following categories:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including, but not limited to, oral and vision care.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2019, shall provide coverage for essential health benefits.

(c) If a policy described in subsection (b) of this section must provide coverage for any health care service or benefit pursuant to another provision of chapter 700c of the general statutes, and the scope

of such health care service or benefit conflicts with the scope of an essential health benefit that such policy must cover pursuant to subsection (b) of this section, such policy shall provide coverage for the health care service or benefit that, in the opinion of the Insurance Commissioner, provides greater protection to the insured.

(d) No provision of the general statutes concerning a requirement of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, shall be construed to supersede any provision of this section that provides greater protection to an insured, except to the extent the latter prevents the application of a requirement of the Affordable Care Act.

(e) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the purposes of this section, including, but not limited to, regulations specifying the health care services and benefits that fall within each category set forth in subsection (a) of this section.

Sec. 3. (NEW) (*Effective January 1, 2019*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for:

(1) Domestic and interpersonal violence screening and counseling for any woman;

(2) Tobacco use intervention and cessation counseling for any woman who consumes tobacco;

(3) Well-woman visits for any woman who is younger than sixty-five years of age;

(4) Breast cancer chemoprevention counseling for any woman who is at increased risk for breast cancer due to family history or prior

personal history of breast cancer, positive genetic testing or other indications as determined by such woman's physician or advanced practice registered nurse;

(5) Breast cancer risk assessment, genetic testing and counseling;

(6) Chlamydia infection screening for any sexually-active woman;

(7) Cervical and vaginal cancer screening for any sexually-active woman;

(8) Gonorrhea screening for any sexually-active woman;

(9) Human immunodeficiency virus screening for any sexually-active woman;

(10) Human papillomavirus screening for any woman with normal cytology results who is thirty years of age or older;

(11) Sexually transmitted infections counseling for any sexually-active woman;

(12) Anemia screening for any pregnant woman and any woman who is likely to become pregnant;

(13) Folic acid supplements for any pregnant woman and any woman who is likely to become pregnant;

(14) Hepatitis B screening for any pregnant woman;

(15) Rhesus incompatibility screening for any pregnant woman and follow-up rhesus incompatibility testing for any pregnant woman who is at increased risk for rhesus incompatibility;

(16) Syphilis screening for any pregnant woman and any woman who is at increased risk for syphilis;

(17) Urinary tract and other infection screening for any pregnant

woman;

(18) Breastfeeding support and counseling for any pregnant or breastfeeding woman;

(19) Breastfeeding supplies, including, but not limited to, a breast pump for any breastfeeding woman;

(20) Gestational diabetes screening for any woman who is twenty-four to twenty-eight weeks pregnant and any woman who is at increased risk for gestational diabetes; and

(21) Osteoporosis screening for any woman who is sixty years of age or older.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493 of the general statutes.

Sec. 4. (NEW) (*Effective January 1, 2019*) (a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for:

(1) Domestic and interpersonal violence screening and counseling for any woman;

(2) Tobacco use intervention and cessation counseling for any woman who consumes tobacco;

(3) Well-woman visits for any woman who is younger than sixty-five years of age;

(4) Breast cancer chemoprevention counseling for any woman who

is at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by such woman's physician or advanced practice registered nurse;

(5) Breast cancer risk assessment, genetic testing and counseling;

(6) Chlamydia infection screening for any sexually-active woman;

(7) Cervical and vaginal cancer screening for any sexually-active woman;

(8) Gonorrhea screening for any sexually-active woman;

(9) Human immunodeficiency virus screening for any sexually-active woman;

(10) Human papillomavirus screening for any woman with normal cytology results who is thirty years of age or older;

(11) Sexually transmitted infections counseling for any sexually-active woman;

(12) Anemia screening for any pregnant woman and any woman who is likely to become pregnant;

(13) Folic acid supplements for any pregnant woman and any woman who is likely to become pregnant;

(14) Hepatitis B screening for any pregnant woman;

(15) Rhesus incompatibility screening for any pregnant woman and follow-up rhesus incompatibility testing for any pregnant woman who is at increased risk for rhesus incompatibility;

(16) Syphilis screening for any pregnant woman and any woman who is at increased risk for syphilis;

(17) Urinary tract and other infection screening for any pregnant woman;

(18) Breastfeeding support and counseling for any pregnant or breastfeeding woman;

(19) Breastfeeding supplies, including, but not limited to, a breast pump for any breastfeeding woman;

(20) Gestational diabetes screening for any woman who is twenty-four to twenty-eight weeks pregnant and any woman who is at increased risk for gestational diabetes; and

(21) Osteoporosis screening for any woman who is sixty years of age or older.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493 of the general statutes.

Sec. 5. (NEW) (*Effective January 1, 2019*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs shall provide coverage for immunizations recommended by the American Academy of Pediatrics, American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall not apply to a high deductible plan as that term is

used in subsection (f) of section 38a-493 of the general statutes.

Sec. 6. (NEW) (*Effective January 1, 2019*) (a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs shall provide coverage for immunizations recommended by the American Academy of Pediatrics, American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493 of the general statutes.

Sec. 7. (NEW) (*Effective January 1, 2019*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for preventive care and screenings for individuals twenty-one years of age or younger in accordance with the most recent edition of the American Academy of Pediatrics' "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents".

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493 of the general statutes.

Sec. 8. (NEW) (*Effective January 1, 2019*) (a) Each group health insurance policy providing coverage of the type specified in

subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for preventive care and screenings for individuals twenty-one years of age or younger in accordance with the most recent edition of the American Academy of Pediatrics' "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents".

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493 of the general statutes.

Sec. 9. Subsection (a) of section 38a-482c of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall include a lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential health benefits, as defined in (1) the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, or regulations adopted thereunder, or (2) section 1 of this act, or regulations adopted thereunder.

Sec. 10. Subsection (a) of section 38a-512c of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall include a lifetime limit on the dollar value of benefits for a

covered individual, for covered benefits that are essential health benefits, as defined in (1) the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, or regulations adopted thereunder, or (2) section 2 of this act, or regulations adopted thereunder.

Sec. 11. Section 38a-503e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**that provides coverage for outpatient prescription drugs approved by the federal Food and Drug Administration shall not exclude coverage for prescription contraceptive methods approved by the federal Food and Drug Administration.**]** shall provide coverage for the following contraceptive methods and related services:

(1) All contraceptive methods approved by the federal Food and Drug Administration;

(2) If a contraceptive method described in subdivision (1) of this subsection is prescribed by a licensed physician, physician assistant or advanced practice registered nurse, a twelve-month supply of such contraceptive method dispensed at one time or at multiple times, provided an insured shall not be entitled to receive a twelve-month supply of such contraceptive method more than once during any plan year;

(3) All sterilization methods approved by the federal Food and Drug Administration;

(4) Counseling in (A) contraceptive methods approved by the federal Food and Drug Administration, and (B) the proper use of contraceptive methods approved by the federal Food and Drug Administration; and

(5) Routine follow-up care concerning contraceptive methods approved by the federal Food and Drug Administration.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the methods and services required under subsection (a) of this section, except that any such policy that uses a provider network may require cost-sharing when such methods and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493.

(c) Any insurance company, hospital service corporation, medical service corporation, health care center or other entity providing coverage of the type specified in subsection (a) of this section may use step therapy, as defined in section 38a-510, within a contraceptive method or require prior authorization within a contraceptive method for the methods and services required under subsection (a) of this section.

[(b)**]** (d) (1) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation, or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for prescription contraceptive methods that are contrary to the religious employer's bona fide religious tenets.

(2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that prescription contraceptive methods are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to the individual an individual health insurance policy that excludes coverage for prescription contraceptive methods.

[(c)**]** (e) Any health insurance policy issued pursuant to subsection

[(b)**]** (d) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

[(d)**]** (f) Nothing in this section shall be construed as authorizing an individual health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

[(e)**]** (g) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation or health care center that is owned, operated or substantially controlled by a religious organization that has religious or moral tenets that conflict with the requirements of this section may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

[(f)**]** (h) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121 or a church-affiliated organization.

Sec. 12. Section 38a-530e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**that provides coverage for outpatient prescription drugs approved by the federal Food and Drug Administration shall not exclude coverage for prescription contraceptive methods approved by the federal Food and Drug Administration.**]** shall provide coverage for

the following contraceptive methods and related services:

(1) All contraceptive methods approved by the federal Food and Drug Administration;

(2) If a contraceptive method described in subdivision (1) of this subsection is prescribed by a licensed physician, physician assistant or advanced practice registered nurse, a twelve-month supply of such contraceptive method dispensed at one time or at multiple times, provided an insured shall not be entitled to receive a twelve-month supply of such contraceptive method more than once during any plan year;

(3) All sterilization methods approved by the federal Food and Drug Administration;

(4) Counseling in (A) contraceptive methods approved by the federal Food and Drug Administration, and (B) the proper use of contraceptive methods approved by the federal Food and Drug Administration; and

(5) Routine follow-up care concerning contraceptive methods approved by the federal Food and Drug Administration.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the methods and services required under subsection (a) of this section, except that any such policy that uses a provider network may require cost-sharing when such methods and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall not apply to a high deductible plan as that term is used in subsection (f) of section 38a-493.

(c) Any insurance company, hospital service corporation, medical service corporation, health care center or other entity providing coverage of the type specified in subsection (a) of this section may use

step therapy, as defined in section 38a-510, within a contraceptive method or require prior authorization within a contraceptive method for the methods and services required under subsection (a) of this section.

[(b)**]** (d) (1) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer a group health insurance policy that excludes coverage for prescription contraceptive methods that are contrary to the religious employer's bona fide religious tenets.

(2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that prescription contraceptive methods are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for prescription contraceptive methods.

[(c)**]** (e) Any health insurance policy issued pursuant to subsection **[**(b)**]** (d) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

[(d)**]** (f) Nothing in this section shall be construed as authorizing a group health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

[(e)**]** (g) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation or health care center that is owned, operated or substantially controlled by a religious organization that has religious

or moral tenets that conflict with the requirements of this section may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

[(f)**]** (h) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121 or a church-affiliated organization.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section
Sec. 4	*January 1, 2019*	New section
Sec. 5	*January 1, 2019*	New section
Sec. 6	*January 1, 2019*	New section
Sec. 7	*January 1, 2019*	New section
Sec. 8	*January 1, 2019*	New section
Sec. 9	*January 1, 2019*	38a-482c(a)
Sec. 10	*January 1, 2019*	38a-512c(a)
Sec. 11	*January 1, 2019*	38a-503e
Sec. 12	*January 1, 2019*	38a-530e

Statement of Purpose:

To (1) mandate insurance coverage of essential health benefits, (2) expand mandated health benefits for women, children and adolescents, and (3) expand mandated contraception benefits.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]