House of Representatives

General Assembly

File No. 146

February Session, 2018

Substitute House Bill No. 5210

House of Representatives, April 3, 2018

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

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 health 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 is required to provide coverage for any health care service or benefit pursuant to 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 is required to 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 coverage 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 this section prevents the application of a requirement of the Affordable Care Act.

(e) The Insurance 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 health 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 is required to provide coverage for any health care service or benefit pursuant to 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 is required to 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 coverage 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 this section prevents the application of a requirement of the Affordable Care Act.

(e) The Insurance 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

INS *Joint Favorable Subst.*

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

Municipal Impact:

Municipalities	Effect	FY 19 $	FY 20 $
Various Municipalities	Potential Cost	See Below	See Below

Explanation

The bill is not anticipated to result in a fiscal impact to the state health plan, non-grandfathered fully-insured municipal plans, and self-insured municipal plans as these plans comply with the coverage requirements of the bill in accordance with current federal and state law or are exempt under federal law.

The bill's coverage provisions may result in increased premiums for grandfathered fully-insured municipal plans to comply with the coverage requirements of the bill to the extent they are outside of the plans' current plan design.[1] Any additional coverage requirements will be reflected in increased premium costs for the municipality when they enter into new health insurance contracts after January 1, 2019.[2]

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future and be reflected in future premiums.

[1] Grandfathered plans are exempt from certain coverage requirements articulated in the federal Affordable Care Act, including the essential health benefit provisions.

[2] Grandfathered plans include most group health insurance plans and some individual plans created or purchased on or before March 23, 2010.

OLR Bill Analysis

sHB 5210

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

SUMMARY

This bill requires certain health insurance policies to cover ten essential health benefits, which are the same benefits the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended) requires policies to cover. It authorizes the insurance commissioner to adopt related regulations.

The bill also requires these policies to cover certain women's health care services, including contraception; immunizations for children, adolescents, and adults; and preventive services for children and youth age 21 or younger. It generally requires policies to cover these services in full with no cost sharing (such as coinsurance, copayments, or deductibles), except for high deductible plans designed to be compatible with federally qualified health savings accounts. Policies may impose cost sharing on contraceptive methods and services rendered by an out-of-network provider. The ACA requires health insurance policies, except grandfathered ones, to cover these women's health services, immunizations, and preventive services with no cost sharing. (Grandfathered plans are those that existed before March 23, 2010 that have not made significant coverage changes since that date.)

With respect to contraception, the bill requires policies to cover a 12-month supply of a contraceptive approved by the U.S. Food and Drug Administration (FDA) when prescribed by a licensed physician, physician assistant, or advanced practice registered nurse (APRN). The supply may be dispensed at one time or at multiple times, but an insured person cannot receive a 12-month supply more than once per

plan year.

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 those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2019

§§ 1, 2, 9 & 10 — ESSENTIAL HEALTH BENEFITS

Coverage Requirement

The bill requires health insurance policies to cover "essential health benefits" and prohibits policies from including a lifetime limit on their dollar value.

"Essential health benefits" are health care services and benefits that fall within the following ten categories:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn health care;
5. mental health and substance use disorder services, including 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 oral and vision care.

Regulations

The bill authorizes the insurance commissioner to adopt related regulations. The regulations may specify the health care services and benefits that fall within each essential health benefits category.

Application

To the extent an existing state insurance law requires coverage of a health service or benefit that conflicts with the scope of an essential health benefit, the bill requires a policy to cover the service or benefit that provides greater coverage to the insured person, as determined by the insurance commissioner.

Under the bill, no existing state law regarding an ACA requirement supersedes this bill's essential health benefits requirement that provides greater protection to an insured person, unless the essential health benefits requirement prevents the application of an ACA requirement.

§§ 3 & 4 — WOMEN'S HEALTH SERVICES

Under the bill, health insurance policies must cover the following services:

1. domestic and interpersonal violence screening and counseling for women;

2. tobacco use intervention and cessation counseling for women who use tobacco;

3. well-woman visits for women younger than age 65;

4. breast cancer chemoprevention counseling for women 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 the woman's physician or

APRN;

5. breast cancer risk assessment, genetic testing, and counseling;

6. screening for chlamydia, cervical and vaginal cancer, gonorrhea, and human immunodeficiency virus for sexually active women;

7. human papillomavirus (HPV) screening for women age 30 or older with normal cytology results;

8. sexually transmitted infections counseling for sexually active women;

9. anemia screening and folic acid supplements for pregnant women and women likely to become pregnant;

10. for pregnant women, hepatitis B screening, rhesus incompatibility screening, and follow-up rhesus incompatibility testing if the women are at increased risk for it;

11. syphilis screening for pregnant women and women at increased risk for syphilis;

12. urinary tract and other infection screening for pregnant women;

13. breastfeeding support and counseling for women who are pregnant or breastfeeding;

14. breastfeeding supplies, including a breast pump, for women who are breastfeeding;

15. gestational diabetes screening for women who are 24 to 28 weeks pregnant and women at increased risk for gestational diabetes; and

16. osteoporosis screening for women age 60 or older.

§§ 5 & 6 — IMMUNIZATIONS

The bill requires health insurance policies that cover prescription

drugs to also cover the immunizations for children, adolescents, and adults recommended by the American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists. These include, for example, immunizations for influenza, meningitis, tetanus, HPV, hepatitis A and B, measles, mumps, rubella, and varicella.

§§ 7 & 8 — PREVENTIVE SERVICES FOR CHILDREN AND YOUTH

The bill requires health insurance policies to cover preventive services for people age 21 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*. These include services such as behavioral and developmental assessments; iron and fluoride supplements; and screening for autism, vision or hearing impairment, lipid disorders, and tuberculosis.

Existing law, unchanged by the bill, requires group health insurance policies to cover preventive pediatric care for a child through age six (CGS § 38a-535).

§§ 11 & 12 — CONTRACEPTIVE METHODS AND SERVICES

Current law requires health insurance policies that cover FDA-approved outpatient prescription drugs to also cover FDA-approved prescription contraceptive methods.

The bill instead requires all health insurance policies to cover the following contraceptive methods and services:

1. all FDA-approved contraceptive and sterilization methods;
2. counseling in FDA-approved contraceptive methods and the proper use of them; and
3. routine follow-up care concerning FDA-approved contraceptive methods.

Additionally, the bill requires policies to cover a 12-month supply of an FDA-approved contraceptive prescribed by a licensed physician,

physician assistant, or APRN. The supply may be dispensed once or at multiple times, but an insured person cannot receive a 12-month supply of the contraceptive more than once per plan year.

The bill prohibits policies from imposing cost-sharing requirements for these contraceptive methods and services, except (1) when out-of-network providers render them and (2) for high deductible plans designed to be compatible with federally qualified health savings accounts.

The bill allows health carriers (e.g., insurers and HMOs) to impose step therapy or prior authorization requirements on these contraceptive methods and services. (Step therapy is a protocol establishing the sequence for prescribing drugs that generally requires patients to try less expensive drugs before higher cost drugs.)

Under existing law, unchanged by the bill, religious employers and individuals may request that their insurance policies not cover prescriptive contraceptive methods if they are contrary to their bona fide religious tenets.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 4 (03/15/2018)