



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:

- 1 Section 1. (NEW) (*Effective January 1, 2019*) (a) For the purposes of
2 this section, "essential health benefits" means health care services and
3 benefits that fall within the following categories:
- 4 (1) Ambulatory patient services;
- 5 (2) Emergency services;
- 6 (3) Hospitalization;
- 7 (4) Maternity and newborn health care;
- 8 (5) Mental health and substance use disorder services, including,
9 but not limited to, behavioral health treatment;

- 10 (6) Prescription drugs;
- 11 (7) Rehabilitative and habilitative services and devices;
- 12 (8) Laboratory services;
- 13 (9) Preventive and wellness services and chronic disease
- 14 management; and
- 15 (10) Pediatric services, including, but not limited to, oral and vision
- 16 care.

17 (b) Each individual health insurance policy providing coverage of
18 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
19 38a-469 of the general statutes delivered, issued for delivery, amended,
20 renewed or continued in this state on or after January 1, 2019, shall
21 provide coverage for essential health benefits.

22 (c) If a policy described in subsection (b) of this section is required
23 to provide coverage for any health care service or benefit pursuant to
24 chapter 700c of the general statutes, and the scope of such health care
25 service or benefit conflicts with the scope of an essential health benefit
26 that such policy is required to cover pursuant to subsection (b) of this
27 section, such policy shall provide coverage for the health care service
28 or benefit that, in the opinion of the Insurance Commissioner, provides
29 greater coverage to the insured.

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

36 (e) The Insurance Commissioner may adopt regulations, in
37 accordance with chapter 54 of the general statutes, to carry out the
38 purposes of this section, including, but not limited to, regulations
39 specifying the health care services and benefits that fall within each

40 category set forth in subsection (a) of this section.

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

44 (1) Ambulatory patient services;

45 (2) Emergency services;

46 (3) Hospitalization;

47 (4) Maternity and newborn health care;

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

50 (6) Prescription drugs;

51 (7) Rehabilitative and habilitative services and devices;

52 (8) Laboratory services;

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

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

57 (b) Each group health insurance policy providing coverage of the
58 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
59 469 of the general statutes delivered, issued for delivery, amended,
60 renewed or continued in this state on or after January 1, 2019, shall
61 provide coverage for essential health benefits.

62 (c) If a policy described in subsection (b) of this section is required
63 to provide coverage for any health care service or benefit pursuant to
64 chapter 700c of the general statutes, and the scope of such health care
65 service or benefit conflicts with the scope of an essential health benefit
66 that such policy is required to cover pursuant to subsection (b) of this

67 section, such policy shall provide coverage for the health care service
68 or benefit that, in the opinion of the Insurance Commissioner, provides
69 greater coverage to the insured.

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

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

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

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

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

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

92 (4) Breast cancer chemoprevention counseling for any woman who
93 is at increased risk for breast cancer due to family history or prior
94 personal history of breast cancer, positive genetic testing or other
95 indications as determined by such woman's physician or advanced
96 practice registered nurse;

- 97 (5) Breast cancer risk assessment, genetic testing and counseling;
- 98 (6) Chlamydia infection screening for any sexually-active woman;
- 99 (7) Cervical and vaginal cancer screening for any sexually-active
100 woman;
- 101 (8) Gonorrhea screening for any sexually-active woman;
- 102 (9) Human immunodeficiency virus screening for any sexually-
103 active woman;
- 104 (10) Human papillomavirus screening for any woman with normal
105 cytology results who is thirty years of age or older;
- 106 (11) Sexually transmitted infections counseling for any sexually-
107 active woman;
- 108 (12) Anemia screening for any pregnant woman and any woman
109 who is likely to become pregnant;
- 110 (13) Folic acid supplements for any pregnant woman and any
111 woman who is likely to become pregnant;
- 112 (14) Hepatitis B screening for any pregnant woman;
- 113 (15) Rhesus incompatibility screening for any pregnant woman and
114 follow-up rhesus incompatibility testing for any pregnant woman who
115 is at increased risk for rhesus incompatibility;
- 116 (16) Syphilis screening for any pregnant woman and any woman
117 who is at increased risk for syphilis;
- 118 (17) Urinary tract and other infection screening for any pregnant
119 woman;
- 120 (18) Breastfeeding support and counseling for any pregnant or
121 breastfeeding woman;
- 122 (19) Breastfeeding supplies, including, but not limited to, a breast

123 pump for any breastfeeding woman;

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

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

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

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

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

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

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

145 (4) Breast cancer chemoprevention counseling for any woman who
146 is at increased risk for breast cancer due to family history or prior
147 personal history of breast cancer, positive genetic testing or other
148 indications as determined by such woman's physician or advanced
149 practice registered nurse;

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

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

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

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

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

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

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

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

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

165 (14) Hepatitis B screening for any pregnant woman;

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

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

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

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

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

177 (20) Gestational diabetes screening for any woman who is twenty-
178 four to twenty-eight weeks pregnant and any woman who is at

179 increased risk for gestational diabetes; and

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

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

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

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

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

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

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

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

229 Sec. 8. (NEW) (*Effective January 1, 2019*) (a) Each group health
230 insurance policy providing coverage of the type specified in
231 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
232 statutes delivered, issued for delivery, renewed, amended or
233 continued in this state shall provide coverage for preventive care and
234 screenings for individuals twenty-one years of age or younger in
235 accordance with the most recent edition of the American Academy of
236 Pediatrics' "Bright Futures: Guidelines for Health Supervision of
237 Infants, Children, and Adolescents".

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

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

246 (a) No individual health insurance policy providing coverage of the
247 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
248 469 delivered, issued for delivery, amended, renewed or continued in
249 this state shall include a lifetime limit on the dollar value of benefits for
250 a covered individual, for covered benefits that are essential health
251 benefits, as defined in (1) the Patient Protection and Affordable Care
252 Act, P.L. 111-148, as amended from time to time, or regulations
253 adopted thereunder, or (2) section 1 of this act, or regulations adopted
254 thereunder.

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

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

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

269 (a) Each individual health insurance policy providing coverage of
270 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
271 38a-469 delivered, issued for delivery, renewed, amended or continued
272 in this state [that provides coverage for outpatient prescription drugs
273 approved by the federal Food and Drug Administration shall not
274 exclude coverage for prescription contraceptive methods approved by

275 the federal Food and Drug Administration.] shall provide coverage for
276 the following contraceptive methods and related services:

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

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

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

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

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

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

302 (c) Any insurance company, hospital service corporation, medical
303 service corporation, health care center or other entity providing
304 coverage of the type specified in subsection (a) of this section may use
305 step therapy, as defined in section 38a-510, within a contraceptive

306 method or require prior authorization within a contraceptive method
307 for the methods and services required under subsection (a) of this
308 section.

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

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

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

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

332 [(e)] (g) Notwithstanding any other provision of this section, any
333 insurance company, hospital service corporation, medical service
334 corporation or health care center that is owned, operated or
335 substantially controlled by a religious organization that has religious
336 or moral tenets that conflict with the requirements of this section may
337 provide for the coverage of prescription contraceptive methods as

338 required under this section through another such entity offering a
339 limited benefit plan. The cost, terms and availability of such coverage
340 shall not differ from the cost, terms and availability of other
341 prescription coverage offered to the insured.

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

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

347 (a) Each group health insurance policy providing coverage of the
348 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
349 469 delivered, issued for delivery, renewed, amended or continued in
350 this state [that provides coverage for outpatient prescription drugs
351 approved by the federal Food and Drug Administration shall not
352 exclude coverage for prescription contraceptive methods approved by
353 the federal Food and Drug Administration.] shall provide coverage for
354 the following contraceptive methods and related services:

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

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

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

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

369 Administration; and

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

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

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

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

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

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

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

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

420 [(f)] (h) As used in this section, "religious employer" means an
 421 employer that is a "qualified church-controlled organization" as
 422 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 | <i>January 1, 2019</i> | New section |
| Sec. 2 | <i>January 1, 2019</i> | New section |
| Sec. 3 | <i>January 1, 2019</i> | New section |
| Sec. 4 | <i>January 1, 2019</i> | New section |
| Sec. 5 | <i>January 1, 2019</i> | New section |
| Sec. 6 | <i>January 1, 2019</i> | New section |
| Sec. 7 | <i>January 1, 2019</i> | New section |
| Sec. 8 | <i>January 1, 2019</i> | New section |

| | | |
|---------|------------------------|-------------|
| Sec. 9 | <i>January 1, 2019</i> | 38a-482c(a) |
| Sec. 10 | <i>January 1, 2019</i> | 38a-512c(a) |
| Sec. 11 | <i>January 1, 2019</i> | 38a-503e |
| Sec. 12 | <i>January 1, 2019</i> | 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)