



# House of Representatives

**File No. 651**

General Assembly

February Session, 2018

**(Reprint of File No. 146)**

Substitute House Bill No. 5210  
As Amended by House  
Amendment Schedule "A"

Approved by the Legislative Commissioner  
April 27, 2018

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

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

33 Sec. 2. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this  
34 section:

35 (1) "Employee" has the same meaning as specified in section 38a-564  
36 of the general statutes.

37 (2) "Essential health benefits" means health care services and  
38 benefits that fall within the following categories:

- 39 (A) Ambulatory patient services;
- 40 (B) Emergency services;
- 41 (C) Hospitalization;
- 42 (D) Maternity and newborn health care;
- 43 (E) Mental health and substance use disorder services, including,
- 44 but not limited to, behavioral health treatment;
- 45 (F) Prescription drugs;
- 46 (G) Rehabilitative and habilitative services and devices;
- 47 (H) Laboratory services;
- 48 (I) Preventive and wellness services and chronic disease
- 49 management; and
- 50 (J) Pediatric services, including, but not limited to, oral and vision
- 51 care.

52 (3) (A) "Small employer" means an employer that employed an  
53 average of at least one but not more than fifty employees on business  
54 days during the preceding calendar year and employs at least one  
55 employee on the first day of the group health insurance policy year.  
56 "Small employer" does not include a sole proprietorship that employs  
57 only the sole proprietor or the spouse of such sole proprietor.

58 (B) (i) For the purposes of subparagraph (A) of this subdivision, the  
59 number of employees shall be determined by adding (I) the number of  
60 full-time employees for each month who work a normal work week of  
61 thirty hours or more, and (II) the number of full-time equivalent  
62 employees, calculated for each month by dividing by one hundred  
63 twenty the aggregate number of hours worked for such month by  
64 employees who work a normal work week of less than thirty hours,  
65 and averaging such total for the calendar year.

66 (ii) If an employer was not in existence throughout the preceding  
67 calendar year, the number of employees shall be based on the average  
68 number of employees that such employer reasonably expects to  
69 employ in the current calendar year.

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

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

81 (d) The Insurance Commissioner may adopt regulations, in  
82 accordance with chapter 54 of the general statutes, to carry out the  
83 purposes of this section, including, but not limited to, regulations  
84 specifying the health care services and benefits that fall within each  
85 category set forth in subdivision (2) of subsection (a) of this section.

86 Sec. 3. (NEW) (*Effective January 1, 2019*) (a) (1) Except as provided in  
87 subdivision (2) of this subsection, each individual health insurance  
88 policy providing coverage of the type specified in subdivisions (1), (2),  
89 (4), (11) and (12) of section 38a-469 of the general statutes delivered,  
90 issued for delivery, renewed, amended or continued in this state shall  
91 provide coverage for the following benefits and services:

92 (A) Domestic and interpersonal violence screening and counseling  
93 for any woman;

94 (B) Tobacco use intervention and cessation counseling for any  
95 woman who consumes tobacco;

- 96 (C) Well-woman visits for any woman who is younger than sixty-  
97 five years of age;
- 98 (D) Breast cancer chemoprevention counseling for any woman who  
99 is at increased risk for breast cancer due to family history or prior  
100 personal history of breast cancer, positive genetic testing or other  
101 indications as determined by such woman's physician or advanced  
102 practice registered nurse;
- 103 (E) Breast cancer risk assessment, genetic testing and counseling;
- 104 (F) Chlamydia infection screening for any sexually-active woman;
- 105 (G) Cervical and vaginal cancer screening for any sexually-active  
106 woman;
- 107 (H) Gonorrhea screening for any sexually-active woman;
- 108 (I) Human immunodeficiency virus screening for any sexually-  
109 active woman;
- 110 (J) Human papillomavirus screening for any woman with normal  
111 cytology results who is thirty years of age or older;
- 112 (K) Sexually transmitted infections counseling for any sexually-  
113 active woman;
- 114 (L) Anemia screening for any pregnant woman and any woman  
115 who is likely to become pregnant;
- 116 (M) Folic acid supplements for any pregnant woman and any  
117 woman who is likely to become pregnant;
- 118 (N) Hepatitis B screening for any pregnant woman;
- 119 (O) Rhesus incompatibility screening for any pregnant woman and  
120 follow-up rhesus incompatibility testing for any pregnant woman who  
121 is at increased risk for rhesus incompatibility;

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

124 (Q) Urinary tract and other infection screening for any pregnant  
125 woman;

126 (R) Breastfeeding support and counseling for any pregnant or  
127 breastfeeding woman;

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

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

133 (U) Osteoporosis screening for any woman who is sixty years of age  
134 or older;

135 (V) Such additional evidence-based items or services not described  
136 in subparagraphs (A) to (U), inclusive, of this subdivision that receive  
137 a rating of "A" or "B" in any recommendations of the United States  
138 Preventive Services Task Force effective after January 1, 2018; and

139 (W) With respect to infants, children and adolescents, evidence-  
140 informed preventive care and screenings provided for in the  
141 comprehensive guidelines supported by the United States Health  
142 Resources and Services Administration, as effective on January 1, 2018,  
143 and such additional preventive care and screenings provided for in  
144 any comprehensive guidelines supported by said administration and  
145 effective after January 1, 2018.

146 (2) No policy described in subdivision (1) of this subsection shall be  
147 required to provide coverage for any benefit or service described in  
148 subparagraphs (A) to (U), inclusive, of said subdivision unless such  
149 benefit or service is an evidence-based item or service that had a rating  
150 of "A" or "B" in the recommendations of the United States Preventive  
151 Services Task Force as such recommendations were in effect on

152 January 1, 2018.

153 (b) No policy described in subsection (a) of this section shall impose  
154 a coinsurance, copayment, deductible or other out-of-pocket expense  
155 for the benefits and services required under said subsection. The  
156 provisions of this subsection shall apply to a high deductible plan, as  
157 that term is used in subsection (f) of section 38a-493 of the general  
158 statutes, to the maximum extent permitted by federal law, except if  
159 such plan is used to establish a health savings account, as that term is  
160 used in Section 223 of the Internal Revenue Code of 1986 or any  
161 subsequent corresponding internal revenue code of the United States,  
162 as amended from time to time, the provisions of this subsection shall  
163 apply to such plan to the maximum extent that (1) is permitted by  
164 federal law, and (2) does not disqualify such account for the deduction  
165 allowed under said Section 223. Nothing in this section shall preclude  
166 a policy that provides the coverage required under subsection (a) of  
167 this section and uses a provider network from imposing cost-sharing  
168 requirements for any benefit or service required under said subsection  
169 (a) that is delivered by an out-of-network provider.

170 Sec. 4. (NEW) (*Effective January 1, 2019*) (a) (1) Except as provided in  
171 subdivision (2) of this subsection, each group health insurance policy  
172 providing coverage of the type specified in subdivisions (1), (2), (4),  
173 (11) and (12) of section 38a-469 of the general statutes delivered, issued  
174 for delivery, renewed, amended or continued in this state shall provide  
175 coverage for the following benefits and services:

176 (A) Domestic and interpersonal violence screening and counseling  
177 for any woman;

178 (B) Tobacco use intervention and cessation counseling for any  
179 woman who consumes tobacco;

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

182 (D) Breast cancer chemoprevention counseling for any woman who

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

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

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

189 (G) Cervical and vaginal cancer screening for any sexually-active  
190 woman;

191 (H) Gonorrhea screening for any sexually-active woman;

192 (I) Human immunodeficiency virus screening for any sexually-  
193 active woman;

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

196 (K) Sexually transmitted infections counseling for any sexually-  
197 active woman;

198 (L) Anemia screening for any pregnant woman and any woman  
199 who is likely to become pregnant;

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

202 (N) Hepatitis B screening for any pregnant woman;

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

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

208 (Q) Urinary tract and other infection screening for any pregnant

209 woman;

210 (R) Breastfeeding support and counseling for any pregnant or  
211 breastfeeding woman;

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

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

217 (U) Osteoporosis screening for any woman who is sixty years of age  
218 or older;

219 (V) Such additional evidence-based items or services not described  
220 in subparagraphs (A) to (U), inclusive, of this subdivision that receive  
221 a rating of "A" or "B" in any recommendations of the United States  
222 Preventive Services Task Force effective after January 1, 2018; and

223 (W) With respect to infants, children and adolescents, evidence-  
224 informed preventive care and screenings provided for in the  
225 comprehensive guidelines supported by the United States Health  
226 Resources and Services Administration, as effective on January 1, 2018,  
227 and such additional preventive care and screenings provided for in  
228 any comprehensive guidelines supported by said administration and  
229 effective after January 1, 2018.

230 (2) No policy described in subdivision (1) of this subsection shall be  
231 required to provide coverage for any benefit or service described in  
232 subparagraphs (A) to (U), inclusive, of said subdivision unless such  
233 benefit or service is an evidence-based item or service that had a rating  
234 of "A" or "B" in the recommendations of the United States Preventive  
235 Services Task Force as such recommendations were in effect on  
236 January 1, 2018.

237 (b) No policy described in subsection (a) of this section shall impose  
238 a coinsurance, copayment, deductible or other out-of-pocket expense

239 for the benefits and services required under said subsection. The  
240 provisions of this subsection shall apply to a high deductible plan, as  
241 that term is used in subsection (f) of section 38a-493 of the general  
242 statutes, to the maximum extent permitted by federal law, except if  
243 such plan is used to establish a health savings account, as that term is  
244 used in Section 223 of the Internal Revenue Code of 1986 or any  
245 subsequent corresponding internal revenue code of the United States,  
246 as amended from time to time, the provisions of this subsection shall  
247 apply to such plan to the maximum extent that (1) is permitted by  
248 federal law, and (2) does not disqualify such account for the deduction  
249 allowed under said Section 223. Nothing in this section shall preclude  
250 a policy that provides the coverage required under subsection (a) of  
251 this section and uses a provider network from imposing cost-sharing  
252 requirements for any benefit or service required under said subsection  
253 (a) that is delivered by an out-of-network provider.

254 Sec. 5. (NEW) (*Effective January 1, 2019*) (a) Each individual health  
255 insurance policy providing coverage of the type specified in  
256 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
257 statutes delivered, issued for delivery, renewed, amended or  
258 continued in this state that provides coverage for prescription drugs  
259 shall provide coverage for (1) immunizations recommended by the  
260 American Academy of Pediatrics, American Academy of Family  
261 Physicians and the American College of Obstetricians and  
262 Gynecologists, and (2) immunizations that have in effect a  
263 recommendation from the Advisory Committee on Immunization  
264 Practices of the Centers for Disease Control and Prevention with  
265 respect to the individual involved.

266 (b) No policy described in subsection (a) of this section shall impose  
267 a coinsurance, copayment, deductible or other out-of-pocket expense  
268 for the benefits and services required under said subsection. The  
269 provisions of this subsection shall apply to a high deductible plan, as  
270 that term is used in subsection (f) of section 38a-493 of the general  
271 statutes, to the maximum extent permitted by federal law, except if  
272 such plan is used to establish a health savings account, as that term is

273 used in Section 223 of the Internal Revenue Code of 1986 or any  
274 subsequent corresponding internal revenue code of the United States,  
275 as amended from time to time, the provisions of this subsection shall  
276 apply to such plan to the maximum extent that (1) is permitted by  
277 federal law, and (2) does not disqualify such account for the deduction  
278 allowed under said Section 223. Nothing in this section shall preclude  
279 a policy that provides the coverage required under subsection (a) of  
280 this section and uses a provider network from imposing cost-sharing  
281 requirements for any benefit or service required under said subsection  
282 (a) that is delivered by an out-of-network provider.

283 Sec. 6. (NEW) (*Effective January 1, 2019*) (a) Each group health  
284 insurance policy providing coverage of the type specified in  
285 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
286 statutes delivered, issued for delivery, renewed, amended or  
287 continued in this state that provides coverage for prescription drugs  
288 shall provide coverage for (1) immunizations recommended by the  
289 American Academy of Pediatrics, American Academy of Family  
290 Physicians and the American College of Obstetricians and  
291 Gynecologists, and (2) immunizations that have in effect a  
292 recommendation from the Advisory Committee on Immunization  
293 Practices of the Centers for Disease Control and Prevention with  
294 respect to the individual involved.

295 (b) No policy described in subsection (a) of this section shall impose  
296 a coinsurance, copayment, deductible or other out-of-pocket expense  
297 for the benefits and services required under said subsection. The  
298 provisions of this subsection shall apply to a high deductible plan, as  
299 that term is used in subsection (f) of section 38a-493 of the general  
300 statutes, to the maximum extent permitted by federal law, except if  
301 such plan is used to establish a health savings account, as that term is  
302 used in Section 223 of the Internal Revenue Code of 1986 or any  
303 subsequent corresponding internal revenue code of the United States,  
304 as amended from time to time, the provisions of this subsection shall  
305 apply to such plan to the maximum extent that (1) is permitted by  
306 federal law, and (2) does not disqualify such account for the deduction

307 allowed under said Section 223. Nothing in this section shall preclude  
308 a policy that provides the coverage required under subsection (a) of  
309 this section and uses a provider network from imposing cost-sharing  
310 requirements for any benefit or service required under said subsection  
311 (a) that is delivered by an out-of-network provider.

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

322 (b) No such policy shall impose a coinsurance, copayment,  
323 deductible or other out-of-pocket expense for the benefits and services  
324 required under subsection (a) of this section. The provisions of this  
325 subsection shall apply to a high deductible plan, as that term is used in  
326 subsection (f) of section 38a-493 of the general statutes, to the  
327 maximum extent permitted by federal law, except if such plan is used  
328 to establish a health savings account, as that term is used in Section 223  
329 of the Internal Revenue Code of 1986 or any subsequent corresponding  
330 internal revenue code of the United States, as amended from time to  
331 time, the provisions of this subsection shall apply to such plan to the  
332 maximum extent that (1) is permitted by federal law, and (2) does not  
333 disqualify such account for the deduction allowed under said Section  
334 223. Nothing in this section shall preclude a policy that provides the  
335 coverage required under subsection (a) of this section and uses a  
336 provider network from imposing cost-sharing requirements for any  
337 benefit or service required under said subsection (a) that is delivered  
338 by an out-of-network provider.

339 Sec. 8. (NEW) (*Effective January 1, 2019*) (a) Each group health

340 insurance policy providing coverage of the type specified in  
341 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
342 statutes delivered, issued for delivery, renewed, amended or  
343 continued in this state shall provide coverage for preventive care and  
344 screenings for individuals twenty-one years of age or younger in  
345 accordance with the most recent edition of the American Academy of  
346 Pediatrics' "Bright Futures: Guidelines for Health Supervision of  
347 Infants, Children, and Adolescents" or any subsequent corresponding  
348 publication.

349 (b) No such policy shall impose a coinsurance, copayment,  
350 deductible or other out-of-pocket expense for the benefits and services  
351 required under subsection (a) of this section. The provisions of this  
352 subsection shall apply to a high deductible plan, as that term is used in  
353 subsection (f) of section 38a-493 of the general statutes, to the  
354 maximum extent permitted by federal law, except if such plan is used  
355 to establish a health savings account, as that term is used in Section 223  
356 of the Internal Revenue Code of 1986 or any subsequent corresponding  
357 internal revenue code of the United States, as amended from time to  
358 time, the provisions of this subsection shall apply to such plan to the  
359 maximum extent that (1) is permitted by federal law, and (2) does not  
360 disqualify such account for the deduction allowed under said Section  
361 223. Nothing in this section shall preclude a policy that provides the  
362 coverage required under subsection (a) of this section and uses a  
363 provider network from imposing cost-sharing requirements for any  
364 benefit or service required under said subsection (a) that is delivered  
365 by an out-of-network provider.

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

369 (a) No individual health insurance policy providing coverage of the  
370 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
371 469 delivered, issued for delivery, amended, renewed or continued in  
372 this state shall include [a] an annual or lifetime limit on the dollar

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

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

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

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

392 (a) Each individual health insurance policy providing coverage of  
393 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
394 38a-469 delivered, issued for delivery, renewed, amended or continued  
395 in this state [that provides coverage for outpatient prescription drugs  
396 approved by the federal Food and Drug Administration shall not  
397 exclude coverage for prescription contraceptive methods approved by  
398 the federal Food and Drug Administration.] shall provide coverage for  
399 the following benefits and services:

400 (1) All contraceptive drugs, including, but not limited to, all over-  
401 the-counter contraceptive drugs, approved by the federal Food and  
402 Drug Administration. Such policy may require an insured to use, prior  
403 to using a contraceptive drug prescribed to the insured, a  
404 contraceptive drug that the federal Food and Drug Administration has

405 designated as therapeutically equivalent to the contraceptive drug  
406 prescribed to the insured, unless otherwise determined by the  
407 insured's prescribing health care provider.

408 (2) All contraceptive devices and products, excluding all over-the-  
409 counter contraceptive devices and products, approved by the federal  
410 Food and Drug Administration. Such policy may require an insured to  
411 use, prior to using a contraceptive device or product prescribed to the  
412 insured, a contraceptive device or product that the federal Food and  
413 Drug Administration has designated as therapeutically equivalent to  
414 the contraceptive device or product prescribed to the insured, unless  
415 otherwise determined by the insured's prescribing health care  
416 provider.

417 (3) If a contraceptive drug, device or product described in  
418 subdivision (1) or (2) of this subsection is prescribed by a licensed  
419 physician, physician assistant or advanced practice registered nurse, a  
420 twelve-month supply of such contraceptive drug, device or product  
421 dispensed at one time or at multiple times, unless the insured or the  
422 insured's prescribing health care provider requests less than a twelve-  
423 month supply of such contraceptive drug, device or product. No  
424 insured shall be entitled to receive a twelve-month supply of a  
425 contraceptive drug, device or product pursuant to this subdivision  
426 more than once during any policy year.

427 (4) All sterilization methods approved by the federal Food and Drug  
428 Administration for women.

429 (5) Routine follow-up care concerning contraceptive drugs, devices  
430 and products approved by the federal Food and Drug Administration.

431 (6) Counseling in (A) contraceptive drugs, devices and products  
432 approved by the federal Food and Drug Administration, and (B) the  
433 proper use of contraceptive drugs, devices and products approved by  
434 the federal Food and Drug Administration.

435 (b) No policy described in subsection (a) of this section shall impose

436 a coinsurance, copayment, deductible or other out-of-pocket expense  
437 for the benefits and services required under said subsection (a), except  
438 that any such policy that uses a provider network may require cost-  
439 sharing when such benefits and services are rendered by an out-of-  
440 network provider. The cost-sharing limits imposed under this  
441 subsection shall apply to a high deductible plan, as that term is used in  
442 subsection (f) of section 38a-493, to the maximum extent permitted by  
443 federal law, except if such plan is used to establish a health savings  
444 account, as that term is used in Section 223 of the Internal Revenue  
445 Code of 1986 or any subsequent corresponding internal revenue code  
446 of the United States, as amended from time to time, the provisions of  
447 this subsection shall apply to such plan to the maximum extent that (1)  
448 is permitted by federal law, and (2) does not disqualify such account  
449 for the deduction allowed under said Section 223.

450 [(b)] (c) (1) Notwithstanding any other provision of this section, any  
451 insurance company, hospital service corporation, medical service  
452 corporation, or health care center may issue to a religious employer an  
453 individual health insurance policy that excludes coverage for  
454 [prescription contraceptive methods] benefits and services required  
455 under subsection (a) of this section that are contrary to the religious  
456 employer's bona fide religious tenets.

457 (2) Notwithstanding any other provision of this section, upon the  
458 written request of an individual who states in writing that  
459 [prescription contraceptive methods] benefits and services required  
460 under subsection (a) of this section are contrary to such individual's  
461 religious or moral beliefs, any insurance company, hospital service  
462 corporation, medical service corporation or health care center may  
463 issue to the individual an individual health insurance policy that  
464 excludes coverage for [prescription contraceptive methods] benefits  
465 and services required under subsection (a) of this section.

466 [(c)] (d) Any health insurance policy issued pursuant to subsection  
467 [(b)] (c) of this section shall provide written notice to each insured or  
468 prospective insured that [prescription contraceptive methods] benefits

469 and services required under subsection (a) of this section are excluded  
470 from coverage pursuant to [said] subsection (c) of this section. Such  
471 notice shall appear, in not less than ten-point type, in the policy,  
472 application and sales brochure for such policy.

473 [(d)] (e) Nothing in this section shall be construed as authorizing an  
474 individual health insurance policy to exclude coverage for prescription  
475 contraceptive drugs, devices and products ordered by a health care  
476 provider with prescriptive authority for reasons other than  
477 contraceptive purposes.

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

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

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

493 (a) Each group health insurance policy providing coverage of the  
494 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
495 469 delivered, issued for delivery, renewed, amended or continued in  
496 this state [that provides coverage for outpatient prescription drugs  
497 approved by the federal Food and Drug Administration shall not  
498 exclude coverage for prescription contraceptive methods approved by  
499 the federal Food and Drug Administration.] shall provide coverage for  
500 the following benefits and services:

501 (1) All contraceptive drugs, including, but not limited to, all over-  
502 the-counter contraceptive drugs, approved by the federal Food and  
503 Drug Administration. Such policy may require an insured to use, prior  
504 to using a contraceptive drug prescribed to the insured, a  
505 contraceptive drug that the federal Food and Drug Administration has  
506 designated as therapeutically equivalent to the contraceptive drug  
507 prescribed to the insured, unless otherwise determined by the  
508 insured's prescribing health care provider.

509 (2) All contraceptive devices and products, excluding all over-the-  
510 counter contraceptive devices and products, approved by the federal  
511 Food and Drug Administration. Such policy may require an insured to  
512 use, prior to using a contraceptive device or product prescribed to the  
513 insured, a contraceptive device or product that the federal Food and  
514 Drug Administration has designated as therapeutically equivalent to  
515 the contraceptive device or product prescribed to the insured, unless  
516 otherwise determined by the insured's prescribing health care  
517 provider.

518 (3) If a contraceptive drug, device or product described in  
519 subdivision (1) or (2) of this subsection is prescribed by a licensed  
520 physician, physician assistant or advanced practice registered nurse, a  
521 twelve-month supply of such contraceptive drug, device or product  
522 dispensed at one time or at multiple times, unless the insured or the  
523 insured's prescribing health care provider requests less than a twelve-  
524 month supply of such contraceptive drug, device or product. No  
525 insured shall be entitled to receive a twelve-month supply of a  
526 contraceptive drug, device or product pursuant to this subdivision  
527 more than once during any policy year.

528 (4) All sterilization methods approved by the federal Food and Drug  
529 Administration for women.

530 (5) Routine follow-up care concerning contraceptive drugs, devices  
531 and products approved by the federal Food and Drug Administration.

532 (6) Counseling in (A) contraceptive drugs, devices and products

533 approved by the federal Food and Drug Administration, and (B) the  
534 proper use of contraceptive drugs, devices and products approved by  
535 the federal Food and Drug Administration.

536 (b) No policy described in subsection (a) of this section shall impose  
537 a coinsurance, copayment, deductible or other out-of-pocket expense  
538 for the benefits and services required under said subsection (a), except  
539 that any such policy that uses a provider network may require cost-  
540 sharing when such benefits and services are rendered by an out-of-  
541 network provider. The cost-sharing limits imposed under this  
542 subsection shall apply to a high deductible plan, as that term is used in  
543 subsection (f) of section 38a-493, to the maximum extent permitted by  
544 federal law, except if such plan is used to establish a health savings  
545 account, as that term is used in Section 223 of the Internal Revenue  
546 Code of 1986 or any subsequent corresponding internal revenue code  
547 of the United States, as amended from time to time, the provisions of  
548 this subsection shall apply to such plan to the maximum extent that (1)  
549 is permitted by federal law, and (2) does not disqualify such account  
550 for the deduction allowed under said Section 223.

551 [(b)] (c) (1) Notwithstanding any other provision of this section, any  
552 insurance company, hospital service corporation, medical service  
553 corporation or health care center may issue to a religious employer a  
554 group health insurance policy that excludes coverage for [prescription  
555 contraceptive methods] benefits and services required under  
556 subsection (a) of this section that are contrary to the religious  
557 employer's bona fide religious tenets.

558 (2) Notwithstanding any other provision of this section, upon the  
559 written request of an individual who states in writing that  
560 [prescription contraceptive methods] benefits and services required  
561 under subsection (a) of this section are contrary to such individual's  
562 religious or moral beliefs, any insurance company, hospital service  
563 corporation, medical service corporation or health care center may  
564 issue to or on behalf of the individual a policy or rider thereto that  
565 excludes coverage for [prescription contraceptive methods] benefits

566 and services required under subsection (a) of this section.

567 [(c)] (d) Any health insurance policy issued pursuant to subsection  
 568 [(b)] (c) of this section shall provide written notice to each insured or  
 569 prospective insured that [prescription contraceptive methods] benefits  
 570 and services required under subsection (a) of this section are excluded  
 571 from coverage pursuant to [said] subsection (c) of this section. Such  
 572 notice shall appear, in not less than ten-point type, in the policy,  
 573 application and sales brochure for such policy.

574 [(d)] (e) Nothing in this section shall be construed as authorizing a  
 575 group health insurance policy to exclude coverage for prescription  
 576 contraceptive drugs, devices and products ordered by a health care  
 577 provider with prescriptive authority for reasons other than  
 578 contraceptive purposes.

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

589 [(f)] (g) As used in this section, "religious employer" means an  
 590 employer that is a "qualified church-controlled organization" as  
 591 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	<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

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.<sup>1</sup> 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.<sup>2</sup>

House “A” struck the underlying bill and its associated fiscal impact and results in the impact identified above.

**The Out Years**

<sup>1</sup> Grandfathered plans are exempt from certain coverage requirements articulated in the federal Affordable Care Act, including the essential health benefit provisions.

<sup>2</sup> Grandfathered plans include most group health insurance plans and some individual plans created or purchased on or before March 23, 2010.

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

*The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does 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.*

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**OLR Bill Analysis****sHB 5210 (as amended by House "A")\******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 10 essential health benefits, which are the same benefits the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended) requires most policies to cover. It authorizes the insurance commissioner to adopt related regulations.

The bill also requires certain health insurance policies to cover specified benefits and services, including preventive health care services; immunizations; and contraceptive drugs, devices, and products approved by the U.S. Food and Drug Administration (FDA). It generally requires the policies to cover these benefits and services in full with no cost sharing (such as coinsurance, copayments, or deductibles), except policies may impose cost sharing when an out-of-network provider renders the benefits and services. The bill provides that high deductible plans designed to be compatible with federally qualified health savings accounts must comply with the cost-sharing prohibition to the extent permitted by federal law without disqualifying the account for the applicable federal tax deduction.

The ACA generally requires health insurance policies, except grandfathered ones, to cover these benefits and 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 an FDA-approved contraceptive drug, device, or product 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 generally 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. However, only individual policies and group policies covering small employers (up to 50 employees) must cover the 10 essential health benefits. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

\*House Amendment "A" replaces the underlying bill with similar provisions. Among other things, it revises the contraception coverage requirement and associated religious exemption (§§ 11 & 12). It also (1) limits the applicability of the essential health benefits requirement to individual and small employer group insurance policies (§§ 1 & 2), (2) prohibits policies from including annual limits on the dollar value of essential health benefits (§§ 9 & 10), (3) clarifies the applicability of the cost-sharing prohibition to high deductible plans (§§ 3-12), and (4) allows cost sharing for the required benefits and services when they are rendered by out-of-network providers (§§ 3-10).

EFFECTIVE DATE: January 1, 2019

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

### ***Coverage Requirement***

The bill requires certain health insurance policies to cover 10 “essential health benefits” and prohibits policies from including annual or lifetime limits on their dollar value.

“Essential health benefits” are 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 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 of Existing Law***

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.

### ***Applicability of Requirement***

The bill’s requirement to cover 10 essential health benefits (§§ 1 & 2)

applies to individual and small employer 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.

The bill's prohibition on annual or lifetime limits on the dollar value of essential health benefits (§§ 9 & 10) applies to these individual and small employer group policies, as well as other 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.

The bill defines a "small employer" as an employer that employed an average of no more than 50 employees on business days in the preceding calendar year and employs at least one employee on the first day of the policy year. It excludes a (1) sole proprietorship that employs only the sole proprietor or his or her spouse and (2) partner of a partnership and his or her spouse.

Under the bill, an employer determines its number of employees by adding the number of full-time employees working at least 30 hours a week and the number of full-time equivalent (FTE) employees, then averaging the total for the calendar year. FTE employees are calculated for each month by dividing by 120 the total number of hours worked during the month by employees working less than 30 hours a week. If an employer did not exist in the preceding calendar year, it determines its number of employees based on the average number of employees it reasonably expects to employ in the calendar year.

### **§§ 3 & 4 — PREVENTIVE HEALTH SERVICES**

Under the bill, health insurance policies must cover the following benefits and services if they are evidence-based items and services recommended by the U.S. Preventive Services Task Force (USPSTF) with an "A" or "B" rating as of January 1, 2018:

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.

The bill also requires policies to cover the following benefits and services:

1. additional evidence-based items or services not described above that receive an “A” or “B” rating from the USPSTF after January 1, 2018 and
2. evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in guidelines supported by the U.S. Health Resources and Services Administration in effect as of January 1, 2018, and those effective after that date.

#### **§§ 5 & 6 — IMMUNIZATIONS**

The bill requires health insurance policies that cover prescription drugs to also cover certain immunizations for children, adolescents, and adults. Specifically, they must cover immunizations (1) recommended by the American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists and (2) that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention with respect to the individual involved. 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* or any subsequent corresponding publication. 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 BENEFITS AND SERVICES**

### ***Required Benefits and Services***

Current state 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 affected health insurance policies to cover the following contraceptive benefits and services:

1. all FDA-approved contraceptive drugs, including over-the-counter ones;
2. all FDA-approved contraceptive devices and products, excluding over-the-counter ones;
3. all FDA-approved sterilization methods for women;
4. routine follow-up care concerning FDA-approved contraceptive drugs, devices, and products; and
5. counseling in FDA-approved contraceptive drugs, devices, and products and the proper use of them.

The bill allows a policy to require an insured person, before using a prescribed contraceptive drug, device, or product, to use a drug, device, or product the FDA designates as therapeutically equivalent to

the prescribed one, unless the prescribing provider determines otherwise.

Additionally, the bill requires policies to cover a 12-month supply of an FDA-approved contraceptive drug, device, or product prescribed by a licensed physician, physician assistant, or APRN, unless the insured person or prescribing provider requests less than a 12-month supply. A 12-month supply may be dispensed once or at multiple times, but an insured person cannot receive a 12-month supply of a contraceptive drug, device, or product more than once per policy year.

### ***Religious Exemption***

Under current law, religious employers and individuals may request in writing to their health carrier (e.g., insurer or HMO) that their policies not cover prescriptive contraceptive methods if they are contrary to their bona fide religious tenets. The bill instead allows religious employers and individuals to request that their policies not cover the contraceptive benefits and services described above.

As under existing law, when a policy is written to exclude contraceptive benefits and services, the health carrier must include a notice of the exclusion in the policy, application, and sales brochure.

Also, under existing law, a religious exemption does not allow a policy to exclude coverage of drugs prescribed by a provider for non-contraceptive purposes. The bill extends this to apply to prescription contraceptive devices and products, as well.

### **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 17 Nay 4 (03/15/2018)