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:

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

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn health care;

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

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

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

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

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

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

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

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

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

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

(A) Ambulatory patient services;

(B) Emergency services;

(C) Hospitalization;

(D) Maternity and newborn health care;

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

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices;

(H) Laboratory services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(N) Hepatitis B screening for any pregnant woman;

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

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

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

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

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

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

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

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

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

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

January 1, 2018.

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

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

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

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

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

(D) Breast cancer chemoprevention counseling for any woman who

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

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

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

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

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

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

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

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

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

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

(N) Hepatitis B screening for any pregnant woman;

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

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

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

woman;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section

Sec. 4	*January 1, 2019*	New section
Sec. 5	*January 1, 2019*	New section
Sec. 6	*January 1, 2019*	New section
Sec. 7	*January 1, 2019*	New section
Sec. 8	*January 1, 2019*	New section
Sec. 9	*January 1, 2019*	38a-482c(a)
Sec. 10	*January 1, 2019*	38a-512c(a)
Sec. 11	*January 1, 2019*	38a-503e
Sec. 12	*January 1, 2019*	38a-530e

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]

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

The Out Years

[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.

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.

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)