



General Assembly

July Special Session, 2020

**Bill No. 6003**

LCO No. 3694



Referred to Committee on No Committee

Introduced by:

REP. ARESIMOWICZ, 30<sup>th</sup> Dist.

SEN. LOONEY, 11<sup>th</sup> Dist.

REP. RITTER M., 1<sup>st</sup> Dist.

SEN. DUFF, 25<sup>th</sup> Dist.

REP. KLARIDES, 114<sup>th</sup> Dist.

SEN. FASANO, 34<sup>th</sup> Dist.

***AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS.***

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

1 Section 1. (NEW) (*Effective from passage*) (a) For the purposes of this  
2 section:

3 (1) "Commissioner" means the Commissioner of Social Services;

4 (2) "Covered entity" has the same meaning as provided in Section  
5 340B of the Public Health Service Act, 42 USC 256b, as amended from  
6 time to time;

7 (3) "Covered outpatient drug" has the same meaning as said term is  
8 used in Section 340B of the Public Health Service Act, 42 USC 256b, as  
9 amended from time to time;

10 (4) "Department" means the Department of Social Services; and

11 (5) "Federally-qualified health center" has the same meaning as  
12 provided in Section 1905(l)(2)(B) of the Social Security Act, 42 USC  
13 1396d(l)(2)(B), as amended from time to time.

14 (b) (1) Not later than November 1, 2020, the commissioner shall  
15 establish a working group to:

16 (A) Determine whether the commissioner should establish a program  
17 to assist individuals in this state who have been diagnosed with diabetes  
18 by referring said individuals to federally-qualified health centers and  
19 other covered entities for treatment regardless of whether said  
20 individuals have health coverage; and

21 (B) If the working group determines that the commissioner should  
22 establish the program described in subparagraph (A) of this  
23 subdivision, develop the criteria that the department shall apply in  
24 recommending a federally-qualified health center or other covered  
25 entity to an individual described in said subparagraph based on the  
26 individual's diabetic condition, any medically necessary care for said  
27 condition, the individual's residence address and any other factors that  
28 the working group deems relevant to carry out the purposes of the  
29 program.

30 (2) The working group shall consist of the following members:

31 (A) Two members appointed by the chief executive officer of  
32 Community Health Center, Incorporated, or the legal successor to said  
33 entity;

34 (B) Two members appointed by the chief executive officer of  
35 Community Health Center Association of Connecticut, Incorporated, or  
36 the legal successor to said entity;

37 (C) One member appointed by the Senate chairman of the joint  
38 standing committee of the General Assembly having cognizance of  
39 matters relating to insurance, who shall be an advocate for insulin

40 coverage or public health;

41 (D) One member appointed by the House chairman of the joint  
42 standing committee of the General Assembly having cognizance of  
43 matters relating to insurance, who shall be an advocate for the interests  
44 of hospitals;

45 (E) One member appointed by the Senate ranking member of the joint  
46 standing committee of the General Assembly having cognizance of  
47 matters relating to insurance, who shall have experience with health  
48 care equity or be an advocate for the interests of hospitals;

49 (F) One member appointed by the House ranking member of the joint  
50 standing committee of the General Assembly having cognizance of  
51 matters relating to insurance, who shall be an advocate for insulin  
52 coverage or public health;

53 (G) The Commissioner of Social Services, or the Commissioner of  
54 Social Services' designee;

55 (H) The Commissioner of Public Health, or the Commissioner of  
56 Public Health's designee; and

57 (I) The Secretary of the Office of Policy and Management, or the  
58 secretary's designee.

59 (3) All initial appointments to the working group shall be made not  
60 later than November 1, 2020. Any vacancy shall be filled by the  
61 appointing authority.

62 (4) The commissioner shall select a chairperson of the working group  
63 from among the members of the working group. Such chairperson shall  
64 schedule the first meeting of the working group, which shall be held not  
65 later than January 11, 2021.

66 (5) A majority of the members of the working group shall constitute  
67 a quorum for the transaction of any business. Any action taken by the

68 working group shall be by majority vote of the members present.

69 (6) Not later than May 1, 2021, the working group shall, in accordance  
70 with the provisions of section 11-4a of the general statutes, submit its  
71 recommendation under subparagraph (A) of subdivision (1) of this  
72 subsection and criteria, if any, developed under subparagraph (B) of  
73 subdivision (1) of this subsection to the commissioner and the joint  
74 standing committee of the General Assembly having cognizance of  
75 matters relating to insurance. The working group shall terminate on the  
76 date on which the working group submits its recommendation and  
77 criteria, if any, pursuant to this subdivision or May 1, 2021, whichever  
78 is earlier.

79 (7) The commissioner may reestablish the working group after the  
80 date on which the working group submits its recommendation and  
81 criteria, if any, pursuant to subdivision (6) of this subsection or May 1,  
82 2021, whichever is earlier, to develop new criteria described in  
83 subparagraph (B) of subdivision (1) of this subsection in accordance  
84 with the requirements of subdivisions (1) to (6), inclusive, of this  
85 subsection, except as otherwise provided in this subdivision. The  
86 commissioner shall send notice to each appointing authority disclosing  
87 that the commissioner has reestablished the working group and the date  
88 on which the commissioner reestablished the working group. The  
89 appointing authorities shall appoint all members of the reestablished  
90 working group not later than sixty days after the date on which the  
91 commissioner reestablished the working group. The commissioner shall  
92 schedule the first meeting of the reestablished working group for a date  
93 that is not later than ninety days after the date on which the  
94 commissioner reestablished the working group. The reestablished  
95 working group shall submit its new criteria to the commissioner and the  
96 joint standing committee of the General Assembly having cognizance of  
97 matters relating to insurance, in accordance with the provisions of  
98 section 11-4a of the general statutes, not later than two hundred forty  
99 days after the commissioner reestablished the working group. The  
100 reestablished working group shall terminate on the date that it submits

101 said criteria or on that date that is two hundred forty days after the  
102 commissioner reestablished the working group, whichever is later.

103 (c) (1) Not later than January 1, 2022, the commissioner shall establish  
104 the program described in subparagraph (A) of subdivision (1) of  
105 subsection (b) of this section, and the department shall apply the criteria  
106 developed pursuant to subparagraph (B) of subdivision (1) of  
107 subsection (b) of this section, unless:

108 (A) The working group recommends, pursuant to subparagraph (A)  
109 of subdivision (1) of subsection (b) of this section, that the commissioner  
110 should not establish said program; or

111 (B) Not later than October 1, 2021, the commissioner submits, in  
112 accordance with section 11-4a of the general statutes, to the joint  
113 standing committee of the General Assembly having cognizance of  
114 matters relating to insurance:

115 (i) The commissioner's determination that the goals of said program  
116 would, in the commissioner's judgment, be more successfully  
117 accomplished by applying for a Medicaid research and demonstration  
118 waiver under Section 1115 of the Social Security Act, as amended from  
119 time to time; or

120 (ii) A memorandum prepared by the general counsel of the  
121 department detailing the barriers federal law poses to the establishment  
122 and successful implementation of said program.

123 (2) If the commissioner informs the joint standing committee of the  
124 General Assembly having cognizance of matters relating to insurance  
125 that the commissioner has determined that the goals of the program  
126 described in subparagraph (A) of subdivision (1) of subsection (b) of this  
127 section would, in the commissioner's judgment, be more successfully  
128 accomplished by applying for a Medicaid research and demonstration  
129 waiver under Section 1115 of the Social Security Act, as amended from  
130 time to time, the commissioner shall apply for such a waiver to establish

131 said program and, if the Centers for Medicare and Medicaid Services  
132 approves the commissioner's waiver application, establish said program  
133 in accordance with the terms of such waiver and all federal and state  
134 laws governing said program.

135 (d) If the commissioner establishes the program pursuant to  
136 subsection (c) of this section, the commissioner shall, as part of said  
137 program, establish and maintain an Internet web site to collect  
138 information from, and provide information to, each individual in this  
139 state who has been diagnosed with diabetes by referring the individual  
140 to a federally-qualified health center or other covered entity for  
141 treatment regardless of whether such individual has health coverage.  
142 The Internet web site shall, at a minimum:

143 (1) Enable the individual to disclose to the department the  
144 individual's name, residence address, age, contact information,  
145 including, but not limited to, electronic mail address or telephone  
146 number, income and race, whether the individual has been diagnosed  
147 with diabetes and the name of each outpatient prescription drug that  
148 has been prescribed to the individual for the treatment of diabetes; and

149 (2) Enable the department to:

150 (A) Determine whether each outpatient prescription drug disclosed  
151 to the department pursuant to subdivision (1) of this subsection is a  
152 covered outpatient drug that is available at a reduced cost to the  
153 individual through a federally-qualified health center that is a covered  
154 entity or any other covered entity;

155 (B) Disclose to the individual:

156 (i) The name, business address and telephone number of any  
157 federally-qualified health center that is a covered entity or any other  
158 covered entity that the department recommends to the individual  
159 according to the criteria established pursuant to subsection (b) of this  
160 section; and

161 (ii) General information regarding health care provided by the  
162 recommended federally-qualified health center or other covered entity  
163 described in subparagraph (B)(i) of this subdivision, including, but not  
164 limited to, any information that would assist the individual to obtain  
165 primary care through such federally-qualified health center or other  
166 covered entity; and

167 (C) Disclose to the recommended federally-qualified health center or  
168 other covered entity described in subparagraph (B)(i) of this subdivision  
169 the individual's name, contact information and a statement disclosing  
170 that the department has recommended the federally-qualified health  
171 center or other covered entity to the individual.

172 (e) Each federally-qualified health center or other covered entity that  
173 receives an individual's name, contact information and a statement  
174 disclosing that the department has recommended the federally-  
175 qualified health center or other covered entity to an individual pursuant  
176 to subparagraph (C) of subdivision (2) of subsection (d) of this section  
177 shall make a good faith effort to schedule an appointment for the  
178 individual on a date that is not later than thirty days after the date on  
179 which the department disclosed to the recommended federally-  
180 qualified health center or other covered entity the information described  
181 in subparagraph (C) of subdivision (2) of subsection (d) of this section.

182 (f) The commissioner may adopt regulations, in accordance with the  
183 provisions of chapter 54 of the general statutes, to carry out the purposes  
184 of this section.

185 Sec. 2. Section 20-571 of the general statutes is repealed and the  
186 following is substituted in lieu thereof (*Effective January 1, 2021*):

187 As used in sections 20-570 to 20-630, inclusive, unless the context  
188 otherwise requires:

189 (1) "Administer" means the direct application of a drug or device to  
190 the body of a patient or research subject by injection, inhalation,

191 ingestion or any other means;

192 (2) "Care-giving institution" means an institution that provides  
193 medical services and is licensed, operated, certified or approved by the  
194 Commissioner of Public Health, the Commissioner of Developmental  
195 Services or the Commissioner of Mental Health and Addiction Services;

196 (3) "Commission" means the Commission of Pharmacy appointed  
197 under the provisions of section 20-572;

198 (4) "Commissioner" means the Commissioner of Consumer  
199 Protection;

200 (5) "Compound" means to combine, mix or put together two or more  
201 ingredients pursuant to a prescription and includes the preparation of  
202 drugs or devices in anticipation of prescriptions based on routine,  
203 regularly-observed prescribing patterns;

204 (6) "Correctional or juvenile training institution" means a facility for  
205 the detention or incarceration of persons convicted or accused of crimes  
206 or offenses or for training of delinquent juveniles, including those state  
207 facilities under the jurisdiction of the Commissioner of Correction,  
208 training schools for delinquent juveniles and any other facilities  
209 operated by the state or municipalities for such detention, incarceration  
210 or training;

211 (7) "Device" means instruments, apparatuses and contrivances,  
212 including their components, parts and accessories, intended (A) for use  
213 in the diagnosis, cure, mitigation, treatment or prevention of disease in  
214 humans or other animals, or (B) to affect the structure or any function of  
215 the body of humans or other animals, but does not mean contact lenses;

216 (8) "Department" means the Department of Consumer Protection;

217 (9) "Dispense" means those acts of processing a drug or device for  
218 delivery or for administration for a patient pursuant to a prescription  
219 consisting of: (A) Comparing the directions on the label with the



220 directions on the prescription to determine accuracy; (B) the selection of  
221 the drug or device from stock to fill the prescription; (C) the counting,  
222 measuring, compounding or preparation of the drug or device; (D) the  
223 placing of the drug or device in the proper container; (E) the affixing of  
224 the label to the container; and (F) the addition to a written prescription  
225 of any required notations. "Dispense" does not include the acts of  
226 delivering a drug or device to a patient or of administering the drug or  
227 device to the patient;

228 (10) "Dispensing outpatient facility" means a facility operated by a  
229 corporation or municipality which provides medical services to patients  
230 on an outpatient basis and which maintains stocks of drugs for  
231 dispensing of drugs on a regular basis to patients for use off the  
232 premises;

233 (11) "Drug" means (A) an article recognized in the official United  
234 States Pharmacopoeia, official Homeopathic Pharmacopoeia of the  
235 United States or official National Formulary, or any supplement to any  
236 of them, (B) an article intended for use in the diagnosis, cure, mitigation,  
237 treatment or prevention of disease in humans or other animals, (C) an  
238 article, other than food, intended to affect the structure or any function  
239 of the body of humans or any other animal, and (D) an article intended  
240 for use as a component of any article specified in this subdivision, but  
241 does not include a device;

242 (12) "Institutional pharmacy" means that area within a care-giving  
243 institution or within a correctional or juvenile training institution,  
244 commonly known as the pharmacy, that is under the direct charge of a  
245 pharmacist and in which drugs are stored and dispensed;

246 (13) "Legend device" means a device that is required by applicable  
247 federal or state law to be dispensed pursuant only to a prescription or is  
248 restricted to use by prescribing practitioners only or that, under federal  
249 law, is required to bear either of the following legends: (A) "RX ONLY"  
250 IN ACCORDANCE WITH GUIDELINES ESTABLISHED IN THE

251 FEDERAL FOOD, DRUG AND COSMETIC ACT; or (B) "CAUTION:  
252 FEDERAL LAW RESTRICTS THIS DEVICE FOR USE BY OR ON THE  
253 ORDER OF A LICENSED VETERINARIAN.";

254 (14) "Legend drug" means a drug that is required by any applicable  
255 federal or state law to be dispensed pursuant only to a prescription or is  
256 restricted to use by prescribing practitioners only, or means a drug that,  
257 under federal law, is required to bear either of the following legends:  
258 (A) "RX ONLY" IN ACCORDANCE WITH GUIDELINES  
259 ESTABLISHED IN THE FEDERAL FOOD, DRUG AND COSMETIC  
260 ACT; or (B) "CAUTION: FEDERAL LAW RESTRICTS THIS DRUG FOR  
261 USE BY OR ON THE ORDER OF A LICENSED VETERINARIAN.";

262 (15) "Medical device and oxygen provider" means a person who  
263 distributes devices or oxygen pursuant to a medical order or  
264 prescription, except if such person already maintains an active  
265 pharmacy license;

266 (16) "Nonlegend device" means a device that is not a legend device;

267 ~~[(16)]~~ (17) "Nonlegend drug" means a drug that is not a legend drug;

268 ~~[(17)]~~ (18) "Person" means an individual, corporation, business trust,  
269 estate trust, partnership, association, joint venture or any other legal or  
270 commercial entity;

271 ~~[(18)]~~ (19) "Pharmacist" means an individual who is licensed to  
272 practice pharmacy under the provisions of section 20-590, 20-591, 20-592  
273 or 20-593, and who is thereby recognized as a health care provider by  
274 the state of Connecticut;

275 ~~[(19)]~~ (20) "Pharmacy" means a place of business where drugs and  
276 devices may be sold at retail and for which a pharmacy license has been  
277 issued to an applicant under the provisions of section 20-594;

278 ~~[(20)]~~ (21) "Pharmacy intern" means an individual registered under  
279 the provisions of section 20-598;

280 [(21)] (22) "Pharmacy technician" means an individual who is  
281 registered with the department and qualified in accordance with section  
282 20-598a;

283 [(22)] (23) "Practice of pharmacy" or "to practice pharmacy" means the  
284 sum total of knowledge, understanding, judgments, procedures,  
285 securities, controls and ethics used by a pharmacist to assure optimal  
286 safety and accuracy in the distributing, dispensing and use of drugs and  
287 devices;

288 [(23)] (24) "Prescribing practitioner" means an individual licensed by  
289 the state of Connecticut, any other state of the United States, the District  
290 of Columbia, the Commonwealth of Puerto Rico or any territory or  
291 insular possession subject to the jurisdiction of the United States who is  
292 authorized to issue a prescription within the scope of the individual's  
293 practice;

294 [(24)] (25) "Prescription" means a lawful order of a prescribing  
295 practitioner transmitted either orally, in writing or by electronic means  
296 for a drug or device for a specific patient;

297 [(25)] (26) "Sale" includes barter, exchange or gift or offer and each  
298 such transaction made by a person whether as principal proprietor,  
299 agent, servant or employee;

300 [(26)] (27) "Substitute" means to dispense without the prescribing  
301 practitioner's express authorization a different drug product than the  
302 drug product prescribed;

303 [(27)] (28) "Third-party logistics provider" means a person who  
304 distributes drugs, devices or cosmetics while taking possession of the  
305 drugs, devices or cosmetics but who does not take title of the drugs,  
306 devices or cosmetics;

307 [(28)] (29) "Virtual manufacturer" means a person who engages in the  
308 manufacture of drugs, devices or cosmetics for which such person: (A)

309 Owns the new drug application or abbreviated new drug application  
310 number, if a prescription drug; (B) owns the unique device identification  
311 number, as available, for a prescription device; (C) contracts with a  
312 contract manufacturing organization for the physical manufacture of  
313 the drugs, devices or cosmetics; (D) is not involved in the physical  
314 manufacture of the drugs, devices or cosmetics; and (E) at no time takes  
315 physical possession of or stores the drugs, devices or cosmetics; and

316 [(29)] (30) "Virtual wholesale distributor" means a person who  
317 facilitates or brokers the transfer of drugs, devices or cosmetics without  
318 taking physical possession of the drugs, devices or cosmetics.

319 Sec. 3. Section 20-616 of the general statutes is repealed and the  
320 following is substituted in lieu thereof (*Effective January 1, 2021*):

321 (a) As used in this section:

322 (1) "Diabetes device" means a device, including, but not limited to, a  
323 blood glucose test strip, glucometer, continuous glucometer, lancet,  
324 lancing device or insulin syringe, that is (A) a legend device or  
325 nonlegend device, and (B) used to cure, diagnose, mitigate, prevent or  
326 treat diabetes or low blood sugar;

327 (2) "Diabetic ketoacidosis device" means a device that is (A) a legend  
328 or nonlegend device, and (B) used to screen for or prevent diabetic  
329 ketoacidosis;

330 (3) "Glucagon drug" means a drug that contains glucagon and is (A)  
331 a legend drug or nonlegend drug, (B) prescribed for self-administration  
332 on an outpatient basis, and (C) approved by the federal Food and Drug  
333 Administration to treat low blood sugar;

334 (4) "Insulin drug" means a drug, including, but not limited to, an  
335 insulin pen, that contains insulin and is (A) a legend drug or nonlegend  
336 drug, (B) prescribed for self-administration on an outpatient basis, and  
337 (C) approved by the federal Food and Drug Administration to treat

338 diabetes; and

339 (5) "Usual customary charge to the public" means a charge for a  
340 particular prescription made by a provider to the patient group  
341 accounting for the largest number of prescriptions not covered by  
342 Medicaid, excluding charges made to third-party payors and special  
343 discounts offered to individuals, including, but not limited to, senior  
344 citizens.

345 [(a)] (b) Except as provided in subsection [(b)] (c) or (d) of this section,  
346 a prescription may be refilled only upon the written, oral or  
347 electronically-transmitted order of a prescribing practitioner.

348 [(b)] (c) A pharmacist may exercise his professional judgment in  
349 refilling a prescription that is not for a controlled drug, as defined in  
350 section 21a-240, without the authorization of the prescribing  
351 practitioner, provided (1) the pharmacist is unable to contact such  
352 practitioner after reasonable effort, (2) failure to refill the prescription  
353 might result in an interruption of a therapeutic regimen or create patient  
354 suffering, and (3) the pharmacist informs the patient or representative  
355 of the patient at the time of dispensing that the refill is being provided  
356 without such authorization and informs the practitioner at the earliest  
357 reasonable time that authorization of the practitioner is required for  
358 future refills. Prescriptions may be refilled once pursuant to this  
359 subsection for a quantity of drug not to exceed a seventy-two hour  
360 supply.

361 (d) (1) (A) Notwithstanding subsection (c) of this section, a  
362 pharmacist may immediately prescribe and dispense to a patient not  
363 more than a thirty-day supply of an insulin drug or glucagon drug, any  
364 diabetes devices that are necessary to administer such supply of such  
365 insulin drug or glucagon drug, or diabetic ketoacidosis device if:

366 (i) The patient informs the pharmacist that the patient has less than a  
367 seven-day supply of such insulin drug, glucagon drug, diabetes devices  
368 or diabetic ketoacidosis device;

369       (ii) The pharmacist determines, in the pharmacist's professional  
370 judgment, that the patient will likely suffer significant physical harm  
371 within seven days if the patient does not obtain an additional supply of  
372 such insulin drug, glucagon drug, diabetes devices or diabetic  
373 ketoacidosis device before the expiration of said seven days;

374       (iii) The pharmacist reviews the electronic prescription drug  
375 monitoring program established pursuant to section 21a-254 and  
376 determines that no pharmacist prescribed and dispensed a supply of  
377 such insulin drug, glucagon drug, diabetes devices or diabetic  
378 ketoacidosis device to the patient pursuant to this subsection during the  
379 twelve-month period immediately preceding, unless:

380           (I) The pharmacist determines, by contacting the pharmacy that filled  
381 the most recent prescription for such insulin drug, glucagon drug,  
382 diabetes devices or diabetic ketoacidosis device, by examining another  
383 prescription database or reviewing the most recent prescription for such  
384 insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis  
385 device or a prescription label containing the most recent prescription  
386 information for such insulin drug, glucagon drug, diabetes devices or  
387 diabetic ketoacidosis device, that no pharmacist dispensed a supply of  
388 such insulin drug, glucagon drug, diabetes devices or diabetic  
389 ketoacidosis device to the patient pursuant to this subsection during  
390 said twelve-month period; or

391           (II) The electronic prescription drug monitoring program established  
392 pursuant to section 21a-254 is unavailable; and

393       (iv) Not later than seventy-two hours after the pharmacist dispenses  
394 such insulin drug, glucagon drug, diabetes devices or diabetic  
395 ketoacidosis device the pharmacist, or the pharmacist's representative,  
396 provides notice to the practitioner who, other than the pharmacist, most  
397 recently prescribed such insulin drug, glucagon drug, diabetes devices  
398 or diabetic ketoacidosis device to the patient.

399       (B) A pharmacist shall immediately prescribe and dispense to a

400 patient not more than a thirty-day supply of an insulin drug or glucagon  
401 drug, and any diabetes devices that are necessary to administer such  
402 supply of the insulin drug or glucagon drug, or diabetic ketoacidosis  
403 device if the criteria established in subparagraphs (A)(i) to (A)(iv),  
404 inclusive, of this subdivision have been satisfied and the patient pays,  
405 or has health insurance coverage, for such insulin drug, glucagon drug,  
406 diabetes devices or diabetic ketoacidosis device.

407 (2) No pharmacist who prescribes and dispenses a supply of an  
408 insulin drug or glucagon drug, any diabetes devices that are necessary  
409 to administer such supply of the insulin drug or glucagon drug, or  
410 diabetic ketoacidosis device pursuant to subdivision (1) of this  
411 subsection shall require the patient to tender payment to the pharmacist  
412 for such supply in an amount that exceeds:

413 (A) The amount of the coinsurance, copayment, deductible or other  
414 out-of-pocket expense that the patient's health insurance coverage  
415 imposes for such supply of such insulin drug, glucagon drug, diabetes  
416 devices or diabetic ketoacidosis device; or

417 (B) The usual customary charge to the public for such supply of such  
418 insulin drug, glucagon drug, diabetes devices or diabetes ketoacidosis  
419 device if the patient does not have health insurance coverage for such  
420 supply of such insulin drug, glucagon drug, diabetes devices or diabetic  
421 ketoacidosis device.

422 (3) Nothing in subdivision (1) or (2) of this subsection shall be  
423 construed to prohibit a pharmacist from requiring a patient to submit to  
424 the pharmacist, before the pharmacist prescribes or dispenses a supply  
425 of an insulin drug or glucagon drug, any diabetes devices necessary to  
426 administer such insulin drug or glucagon drug, or diabetic ketoacidosis  
427 device pursuant to said subdivisions, proof of health insurance coverage  
428 for the patient, personal identification for the patient, contact  
429 information for a health care provider providing treatment to the  
430 patient, information concerning previous prescriptions issued to the

431 patient for the insulin drug, glucagon drug, diabetes devices or diabetic  
432 ketoacidosis device, a sworn statement by the patient stating that the  
433 patient is unable to timely obtain the insulin drug, glucagon drug,  
434 diabetes devices or diabetic ketoacidosis device that the patient is  
435 seeking pursuant to this subsection without suffering significant  
436 physical harm, and any amount required by the pharmacist under  
437 subdivision (2) of this subsection.

438 (4) Each pharmacist shall refer a patient who requests a supply of an  
439 insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis  
440 device pursuant to this subsection to a federally-qualified health center  
441 if:

442 (A) The pharmacist determines that the patient does not have health  
443 insurance coverage for such supply of such insulin drug, glucagon drug,  
444 diabetes devices or diabetic ketoacidosis device; or

445 (B) The patient informs the pharmacist that the patient is concerned  
446 that the net cost to the patient for such supply of such insulin drug,  
447 glucagon drug, diabetes devices or diabetic ketoacidosis device is  
448 unaffordable.

449 [(c)] (e) Any prescription that is not for a controlled drug, as defined  
450 in section 21a-240, may be transferred orally or electronically between  
451 pharmacies, provided:

452 (1) The prescribing practitioner has authorized the original  
453 prescription to be refilled in accordance with subsection [(a)] (b) of this  
454 section;

455 (2) The pharmacist transferring the prescription shall cancel the  
456 original prescription in such pharmacist's records and shall indicate in  
457 such records the name of the pharmacy to which the prescription is  
458 transferred and the date of the transfer, provided, such cancellation  
459 shall not be required in the case of any transfer between pharmacies  
460 which electronically access the same prescription records and utilize the



461 same computer or other electronic prescription transfer system; and

462 (3) The pharmacist receiving the prescription shall indicate in such  
463 pharmacist's records, in addition to any other information required by  
464 law, (A) the fact that the prescription has been transferred and the  
465 names of the transferring pharmacy and pharmacist, (B) the date of  
466 issuance and the prescription number of the original prescription, (C)  
467 the date the original prescription was first dispensed, (D) the number of  
468 refills authorized by the original prescription and the complete refill  
469 record for the prescription as of the date of the transfer, and (E) the  
470 number of valid refills remaining as of the date of the transfer.

471 Sec. 4. (*Effective from passage*) Not later than October 1, 2020, the  
472 Commissioner of Consumer Protection shall send a notice to each  
473 pharmacy disclosing the requirements established in subsection (d) of  
474 section 20-616 of the general statutes, as amended by section 3 of this  
475 act. For the purposes of this section, "pharmacy" has the same meaning  
476 as provided in section 20-571 of the general statutes, as amended by  
477 section 2 of this act.

478 Sec. 5. Subsection (j) of section 21a-254 of the 2020 supplement to the  
479 general statutes is repealed and the following is substituted in lieu  
480 thereof (*Effective January 1, 2021*):

481 (j) (1) The commissioner shall, within available appropriations,  
482 establish an electronic prescription drug monitoring program to collect,  
483 by electronic means, prescription information for schedules II, III, IV  
484 and V controlled substances that are dispensed by pharmacies,  
485 nonresident pharmacies, as defined in section 20-627, outpatient  
486 pharmacies in hospitals or institutions or by any other dispenser. The  
487 program shall be designed to provide information regarding the  
488 prescription of controlled substances in order to prevent the improper  
489 or illegal use of the controlled substances and shall not infringe on the  
490 legitimate prescribing of a controlled substance by a prescribing  
491 practitioner acting in good faith and in the course of professional

492 practice.

493 (2) The commissioner may identify other products or substances to  
494 be included in the electronic prescription drug monitoring program  
495 established pursuant to subdivision (1) of this subsection.

496 (3) Prior to July 1, 2016, each pharmacy, nonresident pharmacy, as  
497 defined in section 20-627, outpatient pharmacy in a hospital or  
498 institution and dispenser shall report to the commissioner, at least  
499 weekly, by electronic means or, if a pharmacy or outpatient pharmacy  
500 does not maintain records electronically, in a format approved by the  
501 commissioner, the following information for all controlled substance  
502 prescriptions dispensed by such pharmacy or outpatient pharmacy: (A)  
503 Dispenser identification number; (B) the date the prescription for the  
504 controlled substance was filled; (C) the prescription number; (D)  
505 whether the prescription for the controlled substance is new or a refill;  
506 (E) the national drug code number for the drug dispensed; (F) the  
507 amount of the controlled substance dispensed and the number of days'  
508 supply of the controlled substance; (G) a patient identification number;  
509 (H) the patient's first name, last name and street address, including  
510 postal code; (I) the date of birth of the patient; (J) the date the  
511 prescription for the controlled substance was issued by the prescribing  
512 practitioner and the prescribing practitioner's Drug Enforcement  
513 Agency's identification number; and (K) the type of payment.

514 (4) (A) Except as provided in this subdivision, on and after July 1,  
515 2016, each pharmacy, nonresident pharmacy, as defined in section 20-  
516 627, outpatient pharmacy in a hospital or institution, and dispenser shall  
517 report to the commissioner by electronic means, in a format approved  
518 by the commissioner, the following information for all controlled  
519 substance prescriptions dispensed by such pharmacy or outpatient  
520 pharmacy immediately upon, but in no event later than the next  
521 business day after, dispensing such prescriptions: (i) Dispenser  
522 identification number; (ii) the date the prescription for the controlled  
523 substance was filled; (iii) the prescription number; (iv) whether the

524 prescription for the controlled substance is new or a refill; (v) the  
525 national drug code number for the drug dispensed; (vi) the amount of  
526 the controlled substance dispensed and the number of days' supply of  
527 the controlled substance; (vii) a patient identification number; (viii) the  
528 patient's first name, last name and street address, including postal code;  
529 (ix) the date of birth of the patient; (x) the date the prescription for the  
530 controlled substance was issued by the prescribing practitioner and the  
531 prescribing practitioner's Drug Enforcement Agency's identification  
532 number; and (xi) the type of payment.

533 (B) If the electronic prescription drug monitoring program is not  
534 operational, such pharmacy or dispenser shall report the information  
535 described in this subdivision not later than the next business day after  
536 regaining access to such program. For purposes of this subdivision,  
537 "business day" means any day during which the pharmacy is open to  
538 the public.

539 (C) Each veterinarian, licensed pursuant to chapter 384, who  
540 dispenses a controlled substance prescription shall report to the  
541 commissioner the information described in subparagraph (A) of this  
542 subdivision, at least weekly, by electronic means or, if the veterinarian  
543 does not maintain records electronically, in a format approved by the  
544 commissioner.

545 (5) The commissioner may contract with a vendor for purposes of  
546 electronically collecting such controlled substance prescription  
547 information. The commissioner and any such vendor shall maintain the  
548 information in accordance with the provisions of chapter 400j.

549 (6) The commissioner and any such vendor shall not disclose  
550 controlled substance prescription information reported pursuant to  
551 subdivisions (3) and (4) of this subsection, except as authorized  
552 pursuant to the provisions of sections 21a-240 to 21a-283, inclusive. Any  
553 person who knowingly violates any provision of this subdivision or  
554 subdivision (5) of this subsection shall be guilty of a class D felony.

555 (7) The commissioner shall provide, upon request, controlled  
556 substance prescription information obtained in accordance with  
557 subdivisions (3) and (4) of this subsection to the following: (A) The  
558 prescribing practitioner or such practitioner's authorized agent, who is  
559 treating or has treated a specific patient, provided the information is  
560 obtained for purposes related to the treatment of the patient, including  
561 the monitoring of controlled substances obtained by the patient; (B) the  
562 prescribing practitioner with whom a patient has made contact for the  
563 purpose of seeking medical treatment or such practitioner's authorized  
564 agent, provided the request is accompanied by a written consent, signed  
565 by the prospective patient, for the release of controlled substance  
566 prescription information; or (C) the pharmacist who is dispensing  
567 controlled substances for a patient, or such pharmacist's authorized  
568 pharmacy technician, provided the information is obtained for purposes  
569 related to the scope of the pharmacist's practice and management of the  
570 patient's drug therapy, including the monitoring of controlled  
571 substances obtained by the patient. The prescribing practitioner, such  
572 practitioner's authorized agent, the pharmacist or such pharmacist's  
573 authorized pharmacy technician shall submit a written and signed  
574 request to the commissioner for controlled substance prescription  
575 information. Such prescribing practitioner, pharmacist or pharmacist's  
576 authorized pharmacy technician shall not disclose any such request  
577 except as authorized pursuant to sections 20-570 to 20-630, inclusive, or  
578 sections 21a-240 to 21a-283, inclusive.

579 (8) No person or employer shall prohibit, discourage or impede a  
580 prescribing practitioner, pharmacist or pharmacist's authorized  
581 pharmacy technician from requesting controlled substance prescription  
582 information pursuant to this subsection.

583 (9) Prior to prescribing greater than a seventy-two-hour supply of any  
584 controlled substance to any patient, the prescribing practitioner or such  
585 practitioner's authorized agent shall review the patient's records in the  
586 electronic prescription drug monitoring program established pursuant  
587 to this subsection. Whenever a prescribing practitioner prescribes a

588 controlled substance, other than a schedule V nonnarcotic controlled  
589 substance, for the continuous or prolonged treatment of any patient,  
590 such prescriber, or such prescriber's authorized agent, shall review, not  
591 less than once every ninety days, the patient's records in such  
592 prescription drug monitoring program. Whenever a prescribing  
593 practitioner prescribes a schedule V nonnarcotic controlled substance,  
594 for the continuous or prolonged treatment of any patient, such  
595 prescribing practitioner, or such prescribing practitioner's authorized  
596 agent, shall review, not less than annually, the patient's records in such  
597 prescription drug monitoring program. If such electronic prescription  
598 drug monitoring program is not operational, such prescribing  
599 practitioner may prescribe greater than a seventy-two-hour supply of a  
600 controlled substance to a patient during the time of such program's  
601 inoperability, provided such prescribing practitioner or such authorized  
602 agent reviews the records of such patient in such program not more than  
603 twenty-four hours after regaining access to such program.

604 (10) (A) A prescribing practitioner may designate an authorized  
605 agent to review the electronic prescription drug monitoring program  
606 and patient controlled substance prescription information on behalf of  
607 the prescribing practitioner. The prescribing practitioner shall ensure  
608 that any authorized agent's access to such program and patient  
609 controlled substance prescription information is limited to the purposes  
610 described in this section and occurs in a manner that protects the  
611 confidentiality of information that is accessed through such program.  
612 The prescribing practitioner and any authorized agent shall be subject  
613 to the provisions of 45 CFR 164.308, as amended from time to time,  
614 concerning administrative safeguards for the protection of electronic  
615 protected health information. A prescribing practitioner may be subject  
616 to disciplinary action for acts of the authorized agent as provided in  
617 section 21a-322.

618 (B) Notwithstanding the provisions of subparagraph (A) of this  
619 subdivision, a prescribing practitioner who is employed by or provides  
620 professional services to a hospital shall, prior to designating an

621 authorized agent to review the electronic prescription drug monitoring  
622 program and patient controlled substance prescription information on  
623 behalf of the prescribing practitioner, (i) submit a request to designate  
624 one or more authorized agents for such purposes and a written protocol  
625 for oversight of the authorized agent or agents to the commissioner, in  
626 the form and manner prescribed by the commissioner, and (ii) receive  
627 the commissioner's approval to designate such authorized agent or  
628 agents and of such written protocol. Such written protocol shall  
629 designate either the hospital's medical director, a hospital department  
630 head, who is a prescribing practitioner, or another prescribing  
631 practitioner as the person responsible for ensuring that the authorized  
632 agent's or agents' access to such program and patient controlled  
633 substance prescription information is limited to the purposes described  
634 in this section and occurs in a manner that protects the confidentiality  
635 of information that is accessed through such program. A hospital  
636 medical director, a hospital department head, who is a prescribing  
637 practitioner, or another prescribing practitioner designated as the  
638 person responsible for overseeing an authorized agent's or agents'  
639 access to such program and information in the written protocol  
640 approved by the commissioner may be subject to disciplinary action for  
641 acts of the authorized agent or agents as provided in section 21a-322.  
642 The commissioner may inspect hospital records to determine  
643 compliance with written protocols approved in accordance with this  
644 section.

645 (C) A pharmacist may designate a pharmacy technician to access the  
646 electronic prescription drug monitoring program and patient controlled  
647 substance prescription information on behalf of the pharmacist only for  
648 the purposes of facilitating the pharmacist's review of such patient  
649 information. The pharmacist shall ensure that any such pharmacy  
650 technician's access to such program and patient controlled substance  
651 prescription information is limited to the purposes described in this  
652 section and occurs in a manner that protects the confidentiality of  
653 information that is accessed through such program. The pharmacist and

654 any authorized pharmacy technician shall be subject to the provisions  
655 of 45 CFR 164.308, as amended from time to time, concerning  
656 administrative safeguards for the protection of electronic protected  
657 health information. A pharmacist may be subject to disciplinary action  
658 for acts of the authorized pharmacy technician.

659 (D) Prior to designating a pharmacy technician to access the  
660 electronic prescription drug monitoring program and patient controlled  
661 substance prescription information on behalf of the pharmacist, the  
662 supervising pharmacist shall provide training for the authorized  
663 pharmacy technicians. Such training shall designate a pharmacist as the  
664 person responsible for ensuring that the authorized pharmacy  
665 technician's access to such program and patient controlled substance  
666 prescription information is limited to the purposes described in this  
667 section and occurs in a manner that protects the confidentiality of  
668 information that is accessed through such program. A pharmacist  
669 designated as the person responsible for overseeing the pharmacy  
670 technician's access to such program may be subject to disciplinary action  
671 for acts of the authorized pharmacy technician. The commissioner may  
672 inspect records to document pharmacy technician training, that  
673 pharmacy technicians have access to the program and that patient  
674 controlled substance prescription information has been limited in  
675 accordance with the provisions of this section.

676 (11) The commissioner shall adopt regulations, in accordance with  
677 chapter 54, concerning the reporting, evaluation, management and  
678 storage of electronic controlled substance prescription information.

679 (12) The provisions of this section shall not apply to (A) samples of  
680 controlled substances dispensed by a physician to a patient, or (B) any  
681 controlled substances dispensed to hospital inpatients.

682 (13) The provisions of this section shall not apply to any institutional  
683 pharmacy or pharmacist's drug room operated by a facility, licensed  
684 under section 19a-495 and regulations adopted pursuant to said section

685 19a-495, that dispenses or administers directly to a patient an opioid  
686 agonist for treatment of a substance use disorder.

687 (14) The commissioner may provide controlled substance  
688 prescription information obtained in accordance with subdivisions (3)  
689 and (4) of this subsection to other state agencies, pursuant to an  
690 agreement between the commissioner and the head of such agency,  
691 provided the information is obtained for a study of disease prevention  
692 and control related to opioid abuse or the study of morbidity and  
693 mortality caused by overdoses of controlled substances. The provision  
694 of such information shall be in accordance with all applicable state and  
695 federal confidentiality requirements.

696 (15) Nothing in this section shall prohibit a prescribing practitioner  
697 or such prescribing practitioner's authorized agent from disclosing  
698 controlled substance prescription information submitted pursuant to  
699 subdivisions (3) and (4) of this subsection to the Department of Social  
700 Services for the purposes of administering any of said department's  
701 medical assistance programs.

702 (16) Each pharmacy, nonresident pharmacy, as defined in section 20-  
703 627, outpatient pharmacy in a hospital or institution, and dispenser shall  
704 report to the commissioner, at least daily, by electronic means or, if a  
705 pharmacy or outpatient pharmacy does not maintain records  
706 electronically, in a format approved by the commissioner information  
707 for all insulin drugs, glucagon drugs, diabetes devices and diabetic  
708 ketoacidosis devices prescribed and dispensed by such pharmacy or  
709 outpatient pharmacy. Such pharmacy or outpatient pharmacy shall  
710 report such information to the commissioner in a manner that is  
711 consistent with the manner in which such pharmacy or outpatient  
712 pharmacy reports information for controlled substance prescriptions  
713 pursuant to subdivision (4) of this subsection. For the purposes of this  
714 subdivision, "insulin drug", "glucagon drug", "diabetes devices" and  
715 "diabetic ketoacidosis device" have the same meanings as provided in  
716 section 20-616.



717 Sec. 6. Subsection (b) of section 21a-65 of the general statutes is  
718 repealed and the following is substituted in lieu thereof (*Effective January*  
719 *1, 2021*):

720 (b) Except as provided in subsection (a) of this section, no licensed  
721 manufacturer, licensed wholesaler or licensed pharmacist shall sell and  
722 no person shall buy a hypodermic needle or syringe except upon a  
723 prescription of a prescribing practitioner, as defined in subdivision  
724 [(22)] (24) of section 20-571, in a quantity greater than ten. Any such  
725 prescription shall be retained on file by the seller for a period of not less  
726 than three years and shall be accessible to any public officer engaged in  
727 the enforcement of this section. Such a prescription shall be valid for one  
728 year from the date thereof and purchases and sales may be made  
729 thereunder during such period, provided the seller shall confirm the  
730 continued need for such sales with such practitioner at least every six  
731 months if sales continue to be made thereunder. Hypodermic needles  
732 and syringes in a quantity of ten or less without a prescription may be  
733 provided or sold at retail only by the following: (1) By a pharmacy  
734 licensed in accordance with section 20-594 and in such pharmacy only  
735 by a licensed pharmacist or under his direct supervision; (2) by a syringe  
736 services program established pursuant to section 19a-124; and (3) by a  
737 health care facility or a licensed health care practitioner for use by their  
738 own patients.

739 Sec. 7. Subsection (a) of section 21a-70 of the 2020 supplement to the  
740 general statutes is repealed and the following is substituted in lieu  
741 thereof (*Effective January 1, 2021*):

742 (a) As used in this section: (1) "Drugs", "devices" and "cosmetics" have  
743 the same meanings as defined in section 21a-92, "wholesaler" or  
744 "distributor" means a person, including, but not limited to, a medical  
745 device and oxygen provider, a third-party logistics provider, a virtual  
746 manufacturer or a virtual wholesale distributor, as such terms are  
747 defined in section 20-571, whether within or without the boundaries of  
748 the state of Connecticut, who supplies drugs, devices or cosmetics

749 prepared, produced or packaged by manufacturers, to other  
750 wholesalers, manufacturers, distributors, hospitals, prescribing  
751 practitioners, as defined in subdivision [(22)] (24) of section 20-571,  
752 pharmacies, federal, state or municipal agencies, clinics or any other  
753 person as permitted under subsection (h) of this section, except that: (A)  
754 A retail pharmacy or a pharmacy within a licensed hospital that  
755 supplies to another such pharmacy a quantity of a noncontrolled drug  
756 or a schedule II, III, IV or V controlled substance normally stocked by  
757 such pharmacies to provide for the immediate needs of a patient  
758 pursuant to a prescription or medication order of an authorized  
759 practitioner, (B) a pharmacy within a licensed hospital that supplies  
760 drugs to another hospital or an authorized practitioner for research  
761 purposes, (C) a retail pharmacy that supplies a limited quantity of a  
762 noncontrolled drug or of a schedule II, III, IV or V controlled substance  
763 for emergency stock to a practitioner who is a medical director of a  
764 chronic and convalescent nursing home, of a rest home with nursing  
765 supervision or of a state correctional institution, and (D) a pharmacy  
766 within a licensed hospital that contains another hospital wholly within  
767 its physical structure that supplies to such contained hospital a quantity  
768 of a noncontrolled drug or a schedule II, III, IV, or V controlled  
769 substance normally stocked by such hospitals to provide for the needs  
770 of a patient, pursuant to a prescription or medication order of an  
771 authorized practitioner, receiving inpatient care on a unit that is  
772 operated by the contained hospital shall not be deemed a wholesaler  
773 under this section; (2) "manufacturer" means (A) a person, whether  
774 within or without the boundaries of the state of Connecticut, who  
775 produces, prepares, cultivates, grows, propagates, compounds,  
776 converts or processes, directly or indirectly, by extraction from  
777 substances of natural origin or by means of chemical synthesis or by a  
778 combination of extraction and chemical synthesis, or who packages,  
779 repackages, labels or relabels a container under such manufacturer's  
780 own or any other trademark or label any drug, device or cosmetic for  
781 the purpose of selling such items, or (B) a sterile compounding  
782 pharmacy, as defined in section 20-633b, that dispenses sterile

783 pharmaceuticals without a prescription or a patient-specific medical  
784 order; (3) "drug", "device" and "cosmetic" have the same meanings as  
785 provided in section 21a-92; and (4) "commissioner" means the  
786 Commissioner of Consumer Protection or his or her designee.

787 Sec. 8. Subsection (j) of section 21a-249 of the general statutes is  
788 repealed and the following is substituted in lieu thereof (*Effective January*  
789 *1, 2021*):

790 (j) A pharmacy may sell and dispense controlled substances upon the  
791 prescription of a prescribing practitioner, as defined in subdivision  
792 [(22)] (24) of section 20-571.

793 Sec. 9. Section 38a-492a of the general statutes is repealed and the  
794 following is substituted in lieu thereof (*Effective January 1, 2021*):

795 Each individual health insurance policy providing coverage of the  
796 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section  
797 38a-469, delivered, issued for delivery, renewed, amended or continued  
798 in this state shall provide coverage for hypodermic needles or syringes  
799 prescribed by a prescribing practitioner, as defined in subdivision [(22)]  
800 (24) of section 20-571, for the purpose of administering medications for  
801 medical conditions, provided such medications are covered under the  
802 policy. Such benefits shall be subject to any policy provisions that apply  
803 to other services covered by such policy.

804 Sec. 10. Section 38a-518a of the general statutes is repealed and the  
805 following is substituted in lieu thereof (*Effective January 1, 2021*):

806 Each group health insurance policy providing coverage of the type  
807 specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-  
808 469, delivered, issued for delivery, renewed, amended or continued in  
809 this state shall provide coverage for hypodermic needles or syringes  
810 prescribed by a prescribing practitioner, as defined in subdivision [(22)]  
811 (24) of section 20-571, for the purpose of administering medications for  
812 medical conditions, provided such medications are covered under the

813 policy. Such benefits shall be subject to any policy provisions that apply  
814 to other services covered by such policy.

815 Sec. 11. Subdivision (1) of subsection (b) of section 53a-13 of the 2020  
816 supplement to the general statutes is repealed and the following is  
817 substituted in lieu thereof (*Effective January 1, 2021*):

818 (b) (1) It shall not be a defense under this section if such mental  
819 disease or defect was proximately caused by the voluntary ingestion,  
820 inhalation or injection of intoxicating liquor or any drug or substance,  
821 or any combination thereof, unless such drug was prescribed for the  
822 defendant by a prescribing practitioner, as defined in subdivision [(22)]  
823 (24) of section 20-571, and was used in accordance with the directions of  
824 such prescription.

825 Sec. 12. Subsection (l) of section 20-619 of the general statutes is  
826 repealed and the following is substituted in lieu thereof (*Effective January*  
827 *1, 2021*):

828 (l) Upon the initial filling or renewal of a prescription that contains a  
829 statistical information code based upon the most recent edition of the  
830 International Classification of Diseases indicating the prescribed drug is  
831 used for the treatment of epilepsy or to prevent seizures, a pharmacist  
832 shall not fill the prescription by using a different drug manufacturer or  
833 distributor of the prescribed drug or biological product, unless the  
834 pharmacist (1) provides prior notice of the use of a different drug or  
835 biological product manufacturer or distributor to the patient and the  
836 prescribing practitioner, and (2) obtains the written consent of the  
837 patient's prescribing practitioner. For purposes of obtaining the consent  
838 of the patient's prescribing practitioner required by this subsection, a  
839 pharmacist shall notify the prescribing practitioner via electronic mail  
840 or facsimile transmission. If the prescribing practitioner does not  
841 provide the necessary consent, the pharmacist shall fill the prescription  
842 without such substitution or use of a different drug or biological  
843 product manufacturer or distributor or return the prescription to the

844 patient or to the patient's representative for filling at another pharmacy.  
845 If a pharmacist is unable to contact the patient's prescribing practitioner  
846 after making reasonable efforts to do so, such pharmacist may exercise  
847 professional judgment in refilling a prescription in accordance with the  
848 provisions of subsection [(b)] (c) of section 20-616. For purposes of this  
849 subsection, "pharmacy" means a place of business where drugs and  
850 devices may be sold at retail and for which a pharmacy license was  
851 issued pursuant to section 20-594, including a hospital-based pharmacy  
852 when such pharmacy is filling prescriptions for employees and  
853 outpatient care, and a mail order pharmacy licensed by this state to  
854 distribute in this state. "Pharmacy" does not include a pharmacy serving  
855 patients in a long-term care facility, other institutional facility or a  
856 pharmacy that provides prescriptions for inpatient hospitals.

857 Sec. 13. Section 38a-492d of the general statutes is repealed and the  
858 following is substituted in lieu thereof (*Effective January 1, 2022*):

859 (a) For the purposes of this section:

860 (1) "Diabetes device" has the same meaning as provided in section 20-  
861 616 of the general statutes;

862 (2) "Diabetic ketoacidosis device" has the same meaning as provided  
863 in section 20-616 of the general statutes;

864 (3) "Glucagon drug" has the same meaning as provided in section 20-  
865 616 of the general statutes;

866 (4) "High deductible health plan" has the same meaning as that term  
867 is used in subsection (f) of section 38a-493;

868 (5) "Insulin drug" has the same meaning as provided in section 20-  
869 616 of the general statutes;

870 (6) "Noninsulin drug" means a drug, including, but not limited to, a  
871 glucagon drug, glucose tablet or glucose gel, that does not contain  
872 insulin and is approved by the federal Food and Drug Administration

873 to treat diabetes; and

874 (7) "Prescribing practitioner" has the same meaning as provided in  
875 section 20-571.

876 [(a) Each] (b) Notwithstanding the provisions of section 38a-492a,  
877 each individual health insurance policy providing coverage of the type  
878 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
879 delivered, issued for delivery, [or] renewed, amended or continued in  
880 this state shall provide coverage for [laboratory] the treatment of all  
881 types of diabetes. Such coverage shall include, but need not be limited  
882 to, coverage for medically necessary:

883 (1) Laboratory and diagnostic [tests] testing and screening, including,  
884 but not limited to, hemoglobin A1c testing and retinopathy screening,  
885 for all types of diabetes;

886 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)  
887 prescribed and dispensed pursuant to subsection (d) of section 20-616  
888 once during a policy year;

889 (3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or  
890 (B) prescribed and dispensed pursuant to subsection (d) of section 20-  
891 616 once during a policy year if the noninsulin drug is a glucagon drug;

892 (4) Diabetes devices in accordance with the insured's diabetes  
893 treatment plan, including, but not limited to, diabetes devices  
894 prescribed and dispensed pursuant to subsection (d) of section 20-616  
895 once during a policy year; and

896 (5) Diabetic ketoacidosis devices in accordance with the insured's  
897 diabetes treatment plan, including, but not limited to, diabetic  
898 ketoacidosis devices prescribed and dispensed pursuant to subsection  
899 (d) of section 20-616 once during a policy year.

900 [(b) Notwithstanding the provisions of section 38a-492a, each  
901 individual health insurance policy providing coverage of the type

902 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
903 delivered, issued for delivery or renewed in this state shall provide  
904 medically necessary coverage for the treatment of insulin-dependent  
905 diabetes, insulin-using diabetes, gestational diabetes and non-insulin-  
906 using diabetes. Such coverage shall include medically necessary  
907 equipment, in accordance with the insured person's treatment plan,  
908 drugs and supplies prescribed by a prescribing practitioner, as defined  
909 in section 20-571.]

910 (c) Notwithstanding the provisions of section 38a-492a, no policy  
911 described in subsection (b) of this section shall impose coinsurance,  
912 copayments, deductibles and other out-of-pocket expenses on an  
913 insured that exceed:

914 (1) Twenty-five dollars for each thirty-day supply of a medically  
915 necessary covered insulin drug (A) prescribed to the insured by a  
916 prescribing practitioner, or (B) prescribed and dispensed pursuant to  
917 subsection (d) of section 20-616 once during a policy year;

918 (2) Twenty-five dollars for each thirty-day supply of a medically  
919 necessary covered noninsulin drug (A) prescribed to the insured by a  
920 prescribing practitioner, or (B) prescribed and dispensed pursuant to  
921 subsection (d) of section 20-616 once during a policy year if such  
922 noninsulin drug is a glucagon drug;

923 (3) One hundred dollars for a thirty-day supply of all medically  
924 necessary covered diabetes devices and diabetic ketoacidosis devices for  
925 such insured that are in accordance with such insured's diabetes  
926 treatment plan, including, but not limited to, diabetes devices and  
927 diabetic ketoacidosis devices prescribed and dispensed pursuant to  
928 subsection (d) of section 20-616 once during a policy year.

929 (d) The provisions of subsection (c) of this section shall apply to a  
930 high deductible health plan to the maximum extent permitted by federal  
931 law, except if such plan is used to establish a medical savings account  
932 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code

933 of 1986, or any subsequent corresponding internal revenue code of the  
934 United States, as amended from time to time, or a health savings account  
935 pursuant to Section 223 of said Internal Revenue Code, as amended  
936 from time to time, the provisions of said subsection (c) shall apply to  
937 such plan to the maximum extent that (1) is permitted by federal law,  
938 and (2) does not disqualify such account for the deduction allowed  
939 under said Section 220 or 223, as applicable.

940 Sec. 14. Section 38a-518d of the general statutes is repealed and the  
941 following is substituted in lieu thereof (*Effective January 1, 2022*):

942 (a) For the purposes of this section:

943 (1) "Diabetes device" has the same meaning as provided in section 20-  
944 616 of the general statutes;

945 (2) "Diabetic ketoacidosis device" has the same meaning as provided  
946 in section 20-616 of the general statutes;

947 (3) "Glucagon drug" has the same meaning as provided in section 20-  
948 616 of the general statutes;

949 (4) "High deductible health plan" has the same meaning as that term  
950 is used in subsection (f) of section 38a-520;

951 (5) "Insulin drug" has the same meaning as provided in section 20-  
952 616 of the general statutes;

953 (6) "Noninsulin drug" means a drug, including, but not limited to, a  
954 glucagon drug, glucose tablet or glucose gel, that does not contain  
955 insulin and is approved by the federal Food and Drug Administration  
956 to treat diabetes; and

957 (7) "Prescribing practitioner" has the same meaning as provided in  
958 section 20-571.

959 [(a) Each] (b) Notwithstanding the provisions of section 38a-518a,



960 each group health insurance policy providing coverage of the type  
961 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
962 delivered, issued for delivery, [or] renewed, amended or continued in  
963 this state shall provide coverage for [laboratory] the treatment of all  
964 types of diabetes. Such coverage shall include, but need not be limited  
965 to, coverage for medically necessary:

966 (1) Laboratory and diagnostic [tests] testing and screening, including,  
967 but not limited to, hemoglobin A1c testing and retinopathy screening,  
968 for all types of diabetes;

969 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)  
970 prescribed and dispensed pursuant to subsection (d) of section 20-616  
971 once during a policy year;

972 (3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or  
973 (B) prescribed and dispensed pursuant to subsection (d) of section 20-  
974 616 once during a policy year if the noninsulin drug is a glucagon drug;

975 (4) Diabetes devices in accordance with the insured's diabetes  
976 treatment plan, including, but not limited to, diabetes devices  
977 prescribed and dispensed pursuant to subsection (d) of section 20-616  
978 once during a policy year; and

979 (5) Diabetic ketoacidosis devices in accordance with the insured's  
980 diabetes treatment plan, including, but not limited to, diabetic  
981 ketoacidosis devices prescribed and dispensed pursuant to subsection  
982 (d) of section 20-616 once during a policy year.

983 [(b) Notwithstanding the provisions of section 38a-518a, each group  
984 health insurance policy providing coverage of the type specified in  
985 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,  
986 issued for delivery or renewed in this state shall provide medically  
987 necessary coverage for the treatment of insulin-dependent diabetes,  
988 insulin-using diabetes, gestational diabetes and non-insulin-using  
989 diabetes. Such coverage shall include medically necessary equipment,

990 in accordance with the insured person's treatment plan, drugs and  
991 supplies prescribed by a prescribing practitioner, as defined in section  
992 20-571.]

993 (c) Notwithstanding the provisions of section 38a-518a, no policy  
994 described in subsection (b) of this section shall impose coinsurance,  
995 copayments, deductibles and other out-of-pocket expenses on an  
996 insured that exceed:

997 (1) Twenty-five dollars for each thirty-day supply of a medically  
998 necessary covered insulin drug (A) prescribed to the insured by a  
999 prescribing practitioner, or (B) prescribed and dispensed pursuant to  
1000 subsection (d) of section 20-616 once during a policy year;

1001 (2) Twenty-five dollars for each thirty-day supply of a medically  
1002 necessary covered noninsulin drug (A) prescribed to the insured by a  
1003 prescribing practitioner, or (B) prescribed and dispensed pursuant to  
1004 subsection (d) of section 20-616 once during a policy year if such  
1005 noninsulin drug is a glucagon drug;

1006 (3) One hundred dollars for a thirty-day supply of all medically  
1007 necessary covered diabetes devices and diabetic ketoacidosis devices for  
1008 such insured that are in accordance with such insured's diabetes  
1009 treatment plan, including, but not limited to, diabetes devices and  
1010 diabetic ketoacidosis devices prescribed and dispensed pursuant to  
1011 subsection (d) of section 20-616 once during a policy year.

1012 (d) The provisions of subsection (c) of this section shall apply to a  
1013 high deductible health plan to the maximum extent permitted by federal  
1014 law, except if such plan is used to establish a medical savings account  
1015 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code  
1016 of 1986, or any subsequent corresponding internal revenue code of the  
1017 United States, as amended from time to time, or a health savings account  
1018 pursuant to Section 223 of said Internal Revenue Code, as amended  
1019 from time to time, the provisions of said subsection (c) shall apply to  
1020 such plan to the maximum extent that (1) is permitted by federal law,

1021 and (2) does not disqualify such account for the deduction allowed  
1022 under said Section 220 or 223, as applicable.

1023       Sec. 15. Subsection (f) of section 38a-493 of the general statutes is  
1024 repealed and the following is substituted in lieu thereof (*Effective October*  
1025 *1, 2020*):

1026       (f) Home health care benefits may be subject to an annual deductible  
1027 of not more than fifty dollars for each person covered under a policy  
1028 and may be subject to a coinsurance provision that provides for  
1029 coverage of not less than seventy-five per cent of the reasonable charges  
1030 for such services. Such policy may also contain reasonable limitations  
1031 and exclusions applicable to home health care coverage. A high  
1032 deductible health plan, as defined in Section 220(c)(2) or Section  
1033 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent  
1034 corresponding internal revenue code of the United States, as amended  
1035 from time to time, used to establish a medical savings account or an  
1036 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a  
1037 health savings account pursuant to Section 223 of said Internal Revenue  
1038 Code shall not be subject to the deductible limits set forth in this  
1039 subsection.

1040       Sec. 16. Subsection (b) of section 38a-490a of the general statutes is  
1041 repealed and the following is substituted in lieu thereof (*Effective October*  
1042 *1, 2020*):

1043       (b) No such policy shall impose a coinsurance, copayment, deductible  
1044 or other out-of-pocket expense for such services, except that a high  
1045 deductible health plan, as that term is used in subsection (f) of section  
1046 38a-493, shall not be subject to the deductible limits set forth in this  
1047 section.

1048       Sec. 17. Subdivision (2) of subsection (b) of section 38a-492k of the  
1049 general statutes is repealed and the following is substituted in lieu  
1050 thereof (*Effective October 1, 2020*):

1051 (2) A coinsurance, copayment, deductible or other out-of-pocket  
1052 expense for any additional colonoscopy ordered in a policy year by a  
1053 physician for an insured. The provisions of this subdivision shall not  
1054 apply to a high deductible health plan as that term is used in subsection  
1055 (f) of section 38a-493.

1056 Sec. 18. Subsection (b) of section 38a-492o of the general statutes is  
1057 repealed and the following is substituted in lieu thereof (*Effective October*  
1058 *1, 2020*):

1059 (b) No such policy shall impose a coinsurance, copayment, deductible  
1060 or other out-of-pocket expense for such testing in excess of twenty per  
1061 cent of the cost for such testing per year. The provisions of this  
1062 subsection shall not apply to a high deductible health plan as that term  
1063 is used in subsection (f) of section 38a-493.

1064 Sec. 19. Subsection (b) of section 38a-492r of the general statutes is  
1065 repealed and the following is substituted in lieu thereof (*Effective October*  
1066 *1, 2020*):

1067 (b) No policy described in subsection (a) of this section shall impose  
1068 a coinsurance, copayment, deductible or other out-of-pocket expense for  
1069 the benefits and services required under said subsection. The provisions  
1070 of this subsection shall apply to a high deductible health plan, as that  
1071 term is used in subsection (f) of section 38a-493, to the maximum extent  
1072 permitted by federal law, except if such plan is used to establish a  
1073 medical savings account or an Archer MSA pursuant to Section 220 of  
1074 the Internal Revenue Code of 1986, or any subsequent corresponding  
1075 internal revenue code of the United States, as amended from time to  
1076 time, or a health savings account [ , as that term is used in] pursuant to  
1077 Section 223 of [the] said Internal Revenue Code, [of 1986 or any  
1078 subsequent corresponding internal revenue code of the United States,]  
1079 as amended from time to time, the provisions of this subsection shall  
1080 apply to such plan to the maximum extent that (1) is permitted by  
1081 federal law, and (2) does not disqualify such account for the deduction

1082 allowed under said Section 220 or 223, as applicable. Nothing in this  
1083 section shall preclude a policy that provides the coverage required  
1084 under subsection (a) of this section and uses a provider network from  
1085 imposing cost-sharing requirements for any benefit or service required  
1086 under said subsection (a) that is delivered by an out-of-network  
1087 provider.

1088 Sec. 20. Subsection (b) of section 38a-492s of the general statutes is  
1089 repealed and the following is substituted in lieu thereof (*Effective October*  
1090 *1, 2020*):

1091 (b) No such policy shall impose a coinsurance, copayment, deductible  
1092 or other out-of-pocket expense for the benefits and services required  
1093 under subsection (a) of this section. The provisions of this subsection  
1094 shall apply to a high deductible health plan, as that term is used in  
1095 subsection (f) of section 38a-493, to the maximum extent permitted by  
1096 federal law, except if such plan is used to establish a medical savings  
1097 account or an Archer MSA pursuant to Section 220 of the Internal  
1098 Revenue Code of 1986, or any subsequent corresponding internal  
1099 revenue code of the United States, as amended from time to time, or a  
1100 health savings account [ , as that term is used in] pursuant to Section 223  
1101 of [the] said Internal Revenue Code, [of 1986 or any subsequent  
1102 corresponding internal revenue code of the United States,] as amended  
1103 from time to time, the provisions of this subsection shall apply to such  
1104 plan to the maximum extent that (1) is permitted by federal law, and (2)  
1105 does not disqualify such account for the deduction allowed under said  
1106 Section 220 or 223, as applicable. Nothing in this section shall preclude  
1107 a policy that provides the coverage required under subsection (a) of this  
1108 section and uses a provider network from imposing cost-sharing  
1109 requirements for any benefit or service required under said subsection  
1110 (a) that is delivered by an out-of-network provider.

1111 Sec. 21. Subdivision (3) of subsection (b) of section 38a-492t of the  
1112 general statutes is repealed and the following is substituted in lieu  
1113 thereof (*Effective October 1, 2020*):

1114 (3) No such policy shall impose a coinsurance, copayment, deductible  
1115 or other out-of-pocket expense for a prosthetic device that is more  
1116 restrictive than that imposed on substantially all other benefits provided  
1117 under such policy, except that a high deductible health plan, as that term  
1118 is used in subsection (f) of section 38a-493, shall not be subject to the  
1119 deductible limits set forth in this subdivision or under Medicare  
1120 pursuant to subdivision (1) of this subsection.

1121 Sec. 22. Subsection (c) of section 38a-503 of the 2020 supplement to  
1122 the general statutes is repealed and the following is substituted in lieu  
1123 thereof (*Effective October 1, 2020*):

1124 (c) Benefits under this section shall be subject to any policy provisions  
1125 that apply to other services covered by such policy, except that no such  
1126 policy shall impose a coinsurance, copayment, deductible or other out-  
1127 of-pocket expense for such benefits. The provisions of this subsection  
1128 shall apply to a high deductible health plan, as that term is used in  
1129 subsection (f) of section 38a-493, to the maximum extent permitted by  
1130 federal law, except if such plan is used to establish a medical savings  
1131 account or an Archer MSA pursuant to Section 220 of the Internal  
1132 Revenue Code of 1986 or any subsequent corresponding internal  
1133 revenue code of the United States, as amended from time to time, or a  
1134 health savings account pursuant to Section 223 of said Internal Revenue  
1135 Code, as amended from time to time, the provisions of this subsection  
1136 shall apply to such plan to the maximum extent that (1) is permitted by  
1137 federal law, and (2) does not disqualify such account for the deduction  
1138 allowed under said Section 220 or 223, as applicable.

1139 Sec. 23. Subsection (b) of section 38a-503e of the general statutes is  
1140 repealed and the following is substituted in lieu thereof (*Effective October*  
1141 *1, 2020*):

1142 (b) No policy described in subsection (a) of this section shall impose  
1143 a coinsurance, copayment, deductible or other out-of-pocket expense for  
1144 the benefits and services required under said subsection (a), except that

1145 any such policy that uses a provider network may require cost-sharing  
1146 when such benefits and services are rendered by an out-of-network  
1147 provider. The cost-sharing limits imposed under this subsection shall  
1148 apply to a high deductible health plan, as that term is used in subsection  
1149 (f) of section 38a-493, to the maximum extent permitted by federal law,  
1150 except if such plan is used to establish a medical savings account or an  
1151 Archer MSA pursuant to Section 220 of the Internal Revenue Code of  
1152 1986 or any subsequent corresponding internal revenue code of the  
1153 United States, as amended from time to time, or a health savings account  
1154 [, as that term is used in] pursuant to Section 223 of [the] said Internal  
1155 Revenue Code, [of 1986 or any subsequent corresponding internal  
1156 revenue code of the United States,] as amended from time to time, the  
1157 provisions of this subsection shall apply to such plan to the maximum  
1158 extent that (1) is permitted by federal law, and (2) does not disqualify  
1159 such account for the deduction allowed under said Section 220 or 223,  
1160 as applicable.

1161 Sec. 24. Subsection (b) of section 38a-503f of the general statutes is  
1162 repealed and the following is substituted in lieu thereof (*Effective October*  
1163 *1, 2020*):

1164 (b) No policy described in subsection (a) of this section shall impose  
1165 a coinsurance, copayment, deductible or other out-of-pocket expense for  
1166 the benefits and services required under said subsection. The provisions  
1167 of this subsection shall apply to a high deductible health plan, as that  
1168 term is used in subsection (f) of section 38a-493, to the maximum extent  
1169 permitted by federal law, except if such plan is used to establish a  
1170 medical savings account or an Archer MSA pursuant to Section 220 of  
1171 the Internal Revenue Code of 1986 or any subsequent corresponding  
1172 internal revenue code of the United States, as amended from time to  
1173 time, or a health savings account [, as that term is used in] pursuant to  
1174 Section 223 of [the] said Internal Revenue Code, [of 1986 or any  
1175 subsequent corresponding internal revenue code of the United States,]  
1176 as amended from time to time, the provisions of this subsection shall  
1177 apply to such plan to the maximum extent that (1) is permitted by

1178 federal law, and (2) does not disqualify such account for the deduction  
1179 allowed under said Section 220 or 223, as applicable. Nothing in this  
1180 section shall preclude a policy that provides the coverage required  
1181 under subsection (a) of this section and uses a provider network from  
1182 imposing cost-sharing requirements for any benefit or service required  
1183 under said subsection (a) that is delivered by an out-of-network  
1184 provider.

1185 Sec. 25. Subsection (c) of section 38a-511 of the general statutes is  
1186 repealed and the following is substituted in lieu thereof (*Effective October*  
1187 *1, 2020*):

1188 (c) The provisions of subsections (a) and (b) of this section shall not  
1189 apply to a high deductible health plan as that term is used in subsection  
1190 (f) of section 38a-493.

1191 Sec. 26. Subsection (f) of section 38a-520 of the general statutes is  
1192 repealed and the following is substituted in lieu thereof (*Effective October*  
1193 *1, 2020*):

1194 (f) Home health care benefits may be subject to an annual deductible  
1195 of not more than fifty dollars for each person covered under a policy  
1196 and may be subject to a coinsurance provision that provides for  
1197 coverage of not less than seventy-five per cent of the reasonable charges  
1198 for such services. Such policy may also contain reasonable limitations  
1199 and exclusions applicable to home health care coverage. A high  
1200 deductible health plan, as defined in Section 220(c)(2) or Section  
1201 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent  
1202 corresponding internal revenue code of the United States, as amended  
1203 from time to time, used to establish a medical savings account or an  
1204 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a  
1205 health savings account pursuant to Section 223 of said Internal Revenue  
1206 Code shall not be subject to the deductible limits set forth in this  
1207 subsection.

1208 Sec. 27. Subsection (b) of section 38a-516a of the general statutes is



1209 repealed and the following is substituted in lieu thereof (*Effective October*  
1210 *1, 2020*):

1211 (b) No such policy shall impose a coinsurance, copayment, deductible  
1212 or other out-of-pocket expense for such services, except that a high  
1213 deductible health plan, as that term is used in subsection (f) of section  
1214 38a-520, shall not be subject to the deductible limits set forth in this  
1215 section.

1216 Sec. 28. Subdivision (2) of subsection (b) of section 38a-518k of the  
1217 general statutes is repealed and the following is substituted in lieu  
1218 thereof (*Effective October 1, 2020*):

1219 (2) A coinsurance, copayment, deductible or other out-of-pocket  
1220 expense for any additional colonoscopy ordered in a policy year by a  
1221 physician for an insured. The provisions of this subdivision shall not  
1222 apply to a high deductible health plan as that term is used in subsection  
1223 (f) of section 38a-520.

1224 Sec. 29. Subsection (b) of section 38a-518o of the general statutes is  
1225 repealed and the following is substituted in lieu thereof (*Effective October*  
1226 *1, 2020*):

1227 (b) No such policy shall impose a coinsurance, copayment, deductible  
1228 or other out-of-pocket expense for such testing in excess of twenty per  
1229 cent of the cost for such testing per year. The provisions of this  
1230 subsection shall not apply to a high deductible health plan as that term  
1231 is used in subsection (f) of section 38a-520.

1232 Sec. 30. Subsection (b) of section 38a-518r of the general statutes is  
1233 repealed and the following is substituted in lieu thereof (*Effective October*  
1234 *1, 2020*):

1235 (b) No policy described in subsection (a) of this section shall impose  
1236 a coinsurance, copayment, deductible or other out-of-pocket expense for  
1237 the benefits and services required under said subsection. The provisions

1238 of this subsection shall apply to a high deductible health plan, as that  
1239 term is used in subsection (f) of section [38a-493] 38a-520, to the  
1240 maximum extent permitted by federal law, except if such plan is used  
1241 to establish a medical savings account or an Archer MSA pursuant to  
1242 Section 220 of the Internal Revenue Code of 1986 or any subsequent  
1243 corresponding internal revenue code of the United States, as amended  
1244 from time to time, or a health savings account [, as that term is used in]  
1245 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or  
1246 any subsequent corresponding internal revenue code of the United  
1247 States,] as amended from time to time, the provisions of this subsection  
1248 shall apply to such plan to the maximum extent that (1) is permitted by  
1249 federal law, and (2) does not disqualify such account for the deduction  
1250 allowed under said Section 220 or 223, as applicable. Nothing in this  
1251 section shall preclude a policy that provides the coverage required  
1252 under subsection (a) of this section and uses a provider network from  
1253 imposing cost-sharing requirements for any benefit or service required  
1254 under said subsection (a) that is delivered by an out-of-network  
1255 provider.

1256 Sec. 31. Subsection (b) of section 38a-518s of the general statutes is  
1257 repealed and the following is substituted in lieu thereof (*Effective October*  
1258 *1, 2020*):

1259 (b) No such policy shall impose a coinsurance, copayment, deductible  
1260 or other out-of-pocket expense for the benefits and services required  
1261 under subsection (a) of this section. The provisions of this subsection  
1262 shall apply to a high deductible health plan, as that term is used in  
1263 subsection (f) of section [38a-493] 38a-520, to the maximum extent  
1264 permitted by federal law, except if such plan is used to establish a  
1265 medical savings account or an Archer MSA pursuant to Section 220 of  
1266 the Internal Revenue Code of 1986 or any subsequent corresponding  
1267 internal revenue code of the United States, as amended from time to  
1268 time, or a health savings account [, as that term is used in] pursuant to  
1269 Section 223 of [the] said Internal Revenue Code, [of 1986 or any  
1270 subsequent corresponding internal revenue code of the United States,]

1271 as amended from time to time, the provisions of this subsection shall  
1272 apply to such plan to the maximum extent that (1) is permitted by  
1273 federal law, and (2) does not disqualify such account for the deduction  
1274 allowed under said Section 220 or 223, as applicable. Nothing in this  
1275 section shall preclude a policy that provides the coverage required  
1276 under subsection (a) of this section and uses a provider network from  
1277 imposing cost-sharing requirements for any benefit or service required  
1278 under said subsection (a) that is delivered by an out-of-network  
1279 provider.

1280 Sec. 32. Subdivision (3) of subsection (b) of section 38a-518t of the  
1281 general statutes is repealed and the following is substituted in lieu  
1282 thereof (*Effective October 1, 2020*):

1283 (3) No such policy shall impose a coinsurance, copayment, deductible  
1284 or other out-of-pocket expense for a prosthetic device that is more  
1285 restrictive than that imposed on substantially all other benefits provided  
1286 under such policy, except that a high deductible health plan, as that term  
1287 is used in subsection (f) of section 38a-520, shall not be subject to the  
1288 deductible limits set forth in this subdivision or under Medicare  
1289 pursuant to subdivision (1) of this subsection.

1290 Sec. 33. Subsection (c) of section 38a-530 of the 2020 supplement to  
1291 the general statutes is repealed and the following is substituted in lieu  
1292 thereof (*Effective October 1, 2020*):

1293 (c) Benefits under this section shall be subject to any policy provisions  
1294 that apply to other services covered by such policy, except that no such  
1295 policy shall impose a coinsurance, copayment, deductible or other out-  
1296 of-pocket expense for such benefits. The provisions of this subsection  
1297 shall apply to a high deductible health plan, as that term is used in  
1298 subsection (f) of section 38a-520, to the maximum extent permitted by  
1299 federal law, except if such plan is used to establish a medical savings  
1300 account or an Archer MSA pursuant to Section 220 of the Internal  
1301 Revenue Code of 1986 or any subsequent corresponding internal

1302 revenue code of the United States, as amended from time to time, or a  
1303 health savings account pursuant to Section 223 of said Internal Revenue  
1304 Code, as amended from time to time, the provisions of this subsection  
1305 shall apply to such plan to the maximum extent that (1) is permitted by  
1306 federal law, and (2) does not disqualify such account for the deduction  
1307 allowed under said Section 220 or 223, as applicable.

1308 Sec. 34. Subsection (b) of section 38a-530e of the general statutes is  
1309 repealed and the following is substituted in lieu thereof (*Effective October*  
1310 *1, 2020*):

1311 (b) No policy described in subsection (a) of this section shall impose  
1312 a coinsurance, copayment, deductible or other out-of-pocket expense for  
1313 the benefits and services required under said subsection (a), except that  
1314 any such policy that uses a provider network may require cost-sharing  
1315 when such benefits and services are rendered by an out-of-network  
1316 provider. The cost-sharing limits imposed under this subsection shall  
1317 apply to a high deductible health plan, as that term is used in subsection  
1318 (f) of section [38a-493] 38a-520, to the maximum extent permitted by  
1319 federal law, except if such plan is used to establish a medical savings  
1320 account or an Archer MSA pursuant to Section 220 of the Internal  
1321 Revenue Code of 1986 or any subsequent corresponding internal  
1322 revenue code of the United States, as amended from time to time, or a  
1323 health savings account [ , as that term is used in] pursuant to Section 223  
1324 of [the] said Internal Revenue Code, [of 1986 or any subsequent  
1325 corresponding internal revenue code of the United States,] as amended  
1326 from time to time, the provisions of this subsection shall apply to such  
1327 plan to the maximum extent that (1) is permitted by federal law, and (2)  
1328 does not disqualify such account for the deduction allowed under said  
1329 Section 220 or 223, as applicable.

1330 Sec. 35. Subsection (b) of section 38a-530f of the general statutes is  
1331 repealed and the following is substituted in lieu thereof (*Effective October*  
1332 *1, 2020*):

1333 (b) No policy described in subsection (a) of this section shall impose  
 1334 a coinsurance, copayment, deductible or other out-of-pocket expense for  
 1335 the benefits and services required under said subsection. The provisions  
 1336 of this subsection shall apply to a high deductible health plan, as that  
 1337 term is used in subsection (f) of section [38a-493] 38a-520, to the  
 1338 maximum extent permitted by federal law, except if such plan is used  
 1339 to establish a medical savings account or an Archer MSA pursuant to  
 1340 Section 220 of the Internal Revenue Code of 1986 or any subsequent  
 1341 corresponding internal revenue code of the United States, as amended  
 1342 from time to time, or a health savings account, as that term is used in  
 1343 Section 223 of [the] said Internal Revenue Code, [of 1986 or any  
 1344 subsequent corresponding internal revenue code of the United States,]  
 1345 as amended from time to time, the provisions of this subsection shall  
 1346 apply to such plan to the maximum extent that (1) is permitted by  
 1347 federal law, and (2) does not disqualify such account for the deduction  
 1348 allowed under said Section 220 or 223, as applicable. Nothing in this  
 1349 section shall preclude a policy that provides the coverage required  
 1350 under subsection (a) of this section and uses a provider network from  
 1351 imposing cost-sharing requirements for any benefit or service required  
 1352 under said subsection (a) that is delivered by an out-of-network  
 1353 provider.

1354 Sec. 36. Subsection (c) of section 38a-550 of the general statutes is  
 1355 repealed and the following is substituted in lieu thereof (*Effective October*  
 1356 *1, 2020*):

1357 (c) The provisions of subsections (a) and (b) of this section shall not  
 1358 apply to a high deductible health plan as that term is used in subsection  
 1359 (f) of section 38a-520.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>January 1, 2021</i>	20-571
Sec. 3	<i>January 1, 2021</i>	20-616

Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>January 1, 2021</i>	21a-254(j)
Sec. 6	<i>January 1, 2021</i>	21a-65(b)
Sec. 7	<i>January 1, 2021</i>	21a-70(a)
Sec. 8	<i>January 1, 2021</i>	21a-249(j)
Sec. 9	<i>January 1, 2021</i>	38a-492a
Sec. 10	<i>January 1, 2021</i>	38a-518a
Sec. 11	<i>January 1, 2021</i>	53a-13(b)(1)
Sec. 12	<i>January 1, 2021</i>	20-619(l)
Sec. 13	<i>January 1, 2022</i>	38a-492d
Sec. 14	<i>January 1, 2022</i>	38a-518d
Sec. 15	<i>October 1, 2020</i>	38a-493(f)
Sec. 16	<i>October 1, 2020</i>	38a-490a(b)
Sec. 17	<i>October 1, 2020</i>	38a-492k(b)(2)
Sec. 18	<i>October 1, 2020</i>	38a-492o(b)
Sec. 19	<i>October 1, 2020</i>	38a-492r(b)
Sec. 20	<i>October 1, 2020</i>	38a-492s(b)
Sec. 21	<i>October 1, 2020</i>	38a-492t(b)(3)
Sec. 22	<i>October 1, 2020</i>	38a-503(c)
Sec. 23	<i>October 1, 2020</i>	38a-503e(b)
Sec. 24	<i>October 1, 2020</i>	38a-503f(b)
Sec. 25	<i>October 1, 2020</i>	38a-511(c)
Sec. 26	<i>October 1, 2020</i>	38a-520(f)
Sec. 27	<i>October 1, 2020</i>	38a-516a(b)
Sec. 28	<i>October 1, 2020</i>	38a-518k(b)(2)
Sec. 29	<i>October 1, 2020</i>	38a-518o(b)
Sec. 30	<i>October 1, 2020</i>	38a-518r(b)
Sec. 31	<i>October 1, 2020</i>	38a-518s(b)
Sec. 32	<i>October 1, 2020</i>	38a-518t(b)(3)
Sec. 33	<i>October 1, 2020</i>	38a-530(c)
Sec. 34	<i>October 1, 2020</i>	38a-530e(b)
Sec. 35	<i>October 1, 2020</i>	38a-530f(b)
Sec. 36	<i>October 1, 2020</i>	38a-550(c)