



General Assembly

February Session, 2020

Raised Bill No. 5175

LCO No. 1547



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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 Section 38a-492d of the general statutes is repealed and the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

3 (a) For the purposes of this section:

4 (1) "Diabetes equipment and supplies" means equipment and
5 supplies that are used to treat diabetes, including, but not limited to,
6 blood glucose test strips, glucometers, lancets, lancing devices and
7 insulin syringes;

8 (2) "High deductible health plan" has the same meaning as that term
9 is used in subsection (f) of section 38a-493, as amended by this act;

10 (3) "Insulin drug" means a drug that contains insulin and is approved
11 by the federal Food and Drug Administration to treat diabetes,
12 including, but not limited to, insulin pens;

13 (4) "Noninsulin drug" means a drug that does not contain insulin and

14 is approved by the federal Food and Drug Administration to treat
15 diabetes, including, but not limited to, glucagen, glucose tablets and
16 glucose gels; and

17 (5) "Prescribing practitioner" has the same meaning as provided in
18 section 20-571.

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

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

29 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)
30 dispensed pursuant to subsection (b) of section 3 of this act not more
31 than three times during a policy year;

32 (3) Noninsulin drugs prescribed by a prescribing practitioner; and

33 (4) Diabetes equipment and supplies in accordance with the insured's
34 diabetes treatment plan.

35 [(b) Notwithstanding the provisions of section 38a-492a, each
36 individual health insurance policy providing coverage of the type
37 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
38 delivered, issued for delivery or renewed in this state shall provide
39 medically necessary coverage for the treatment of insulin-dependent
40 diabetes, insulin-using diabetes, gestational diabetes and non-insulin-
41 using diabetes. Such coverage shall include medically necessary
42 equipment, in accordance with the insured person's treatment plan,
43 drugs and supplies prescribed by a prescribing practitioner, as defined

44 in section 20-571.]

45 (c) (1) Notwithstanding the provisions of section 38a-492a and except
46 as provided in subdivision (2) of this subsection, no policy described in
47 subsection (b) of this section shall impose coinsurance, copayments,
48 deductibles and other out-of-pocket expenses on an insured that exceed:

49 (A) Fifty dollars for each thirty-day supply of a medically necessary
50 covered insulin drug prescribed to the insured by a prescribing
51 practitioner;

52 (B) Fifty dollars for each thirty-day supply of a medically necessary
53 covered noninsulin drug prescribed to the insured by a prescribing
54 practitioner; or

55 (C) One hundred dollars for a thirty-day supply of all medically
56 necessary covered diabetes equipment and supplies for such insured
57 that are in accordance with such insured's diabetes treatment plan.

58 (2) The combined monthly coinsurance, copayments, deductibles and
59 other out-of-pocket expenses for all medically necessary covered insulin
60 drugs prescribed to an insured by a prescribing practitioner and all
61 medically necessary covered diabetes equipment and supplies for the
62 insured shall not exceed one hundred dollars, provided such diabetes
63 equipment and supplies are in accordance with such insured's diabetes
64 treatment plan.

65 (d) The provisions of subsection (c) of this section shall apply to a
66 high deductible health plan to the maximum extent permitted by federal
67 law, except if such plan is used to establish a medical savings account
68 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code
69 of 1986, or any subsequent corresponding internal revenue code of the
70 United States, as amended from time to time, or a health savings account
71 pursuant to Section 223 of said Internal Revenue Code, as amended
72 from time to time, the provisions of said subsection (c) shall apply to
73 such plan to the maximum extent that (1) is permitted by federal law,
74 and (2) does not disqualify such account for the deduction allowed

75 under said Section 220 or 223, as applicable.

76 Sec. 2. Section 38a-518d of the general statutes is repealed and the
77 following is substituted in lieu thereof (*Effective January 1, 2021*):

78 (a) For the purposes of this section:

79 (1) "Diabetes equipment and supplies" means equipment and
80 supplies that are used to treat diabetes, including, but not limited to,
81 blood glucose test strips, glucometers, lancets, lancing devices and
82 insulin syringes;

83 (2) "High deductible health plan" has the same meaning as that term
84 is used in subsection (f) of section 38a-520, as amended by this act;

85 (3) "Insulin drug" means a drug that contains insulin and is approved
86 by the federal Food and Drug Administration to treat diabetes,
87 including, but not limited to, insulin pens;

88 (4) "Noninsulin drug" means a drug that does not contain insulin and
89 is approved by the federal Food and Drug Administration to treat
90 diabetes, including, but not limited to, glucagen, glucose tablets and
91 glucose gels; and

92 (5) "Prescribing practitioner" has the same meaning as provided in
93 section 20-571.

94 [(a) Each] (b) Notwithstanding the provisions of section 38a-518a,
95 each group health insurance policy providing coverage of the type
96 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
97 delivered, issued for delivery, [or] renewed, amended or continued in
98 this state shall provide coverage for [laboratory] the treatment of all
99 types of diabetes. Such coverage shall include, but need not be limited
100 to, coverage for medically necessary:

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

104 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)
105 dispensed pursuant to subsection (b) of section 3 of this act not more
106 than three times during a policy year;

107 (3) Noninsulin drugs prescribed by a prescribing practitioner; and

108 (4) Diabetes equipment and supplies, provided such diabetes
109 equipment and supplies are in accordance with the insured's diabetes
110 treatment plan.

111 [(b) Notwithstanding the provisions of section 38a-518a, each group
112 health insurance policy providing coverage of the type specified in
113 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
114 issued for delivery or renewed in this state shall provide medically
115 necessary coverage for the treatment of insulin-dependent diabetes,
116 insulin-using diabetes, gestational diabetes and non-insulin-using
117 diabetes. Such coverage shall include medically necessary equipment,
118 in accordance with the insured person's treatment plan, drugs and
119 supplies prescribed by a prescribing practitioner, as defined in section
120 20-571.]

121 (c) (1) Notwithstanding the provisions of section 38a-518a and except
122 as provided in subdivision (2) of this subsection, no policy described in
123 subsection (b) of this section shall impose coinsurance, copayments,
124 deductibles and other out-of-pocket expenses on an insured that exceed:

125 (A) Fifty dollars for each thirty-day supply of a medically necessary
126 covered insulin drug prescribed to the insured by a prescribing
127 practitioner;

128 (B) Fifty dollars for each thirty-day supply of a medically necessary
129 covered noninsulin drug prescribed to the insured by a prescribing
130 practitioner; or

131 (C) One hundred dollars for a thirty-day supply of all medically
132 necessary covered diabetes equipment and supplies for such insured
133 that are in accordance with such insured's diabetes treatment plan.

134 (2) The combined monthly coinsurance, copayments, deductibles and
135 other out-of-pocket expenses for all medically necessary covered insulin
136 drugs prescribed to an insured by a prescribing practitioner and all
137 medically necessary covered diabetes equipment and supplies for the
138 insured shall not exceed one hundred dollars, provided such diabetes
139 equipment and supplies are in accordance with such insured's diabetes
140 treatment plan.

141 (d) The provisions of subsection (c) of this section shall apply to a
142 high deductible health plan to the maximum extent permitted by federal
143 law, except if such plan is used to establish a medical savings account
144 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code
145 of 1986, or any subsequent corresponding internal revenue code of the
146 United States, as amended from time to time, or a health savings account
147 pursuant to Section 223 of said Internal Revenue Code, as amended
148 from time to time, the provisions of said subsection (c) shall apply to
149 such plan to the maximum extent that (1) is permitted by federal law,
150 and (2) does not disqualify such account for the deduction allowed
151 under said Section 220 or 223, as applicable.

152 Sec. 3. (NEW) (*Effective from passage*) (a) For the purposes of this
153 section:

154 (1) "Diabetes equipment and supplies" has the same meaning as
155 provided in sections 38a-492d and 38a-518d of the general statutes, as
156 amended by this act;

157 (2) "Insulin drug" has the same meaning as provided in sections 38a-
158 492d and 38a-518d of the general statutes, as amended by this act; and

159 (3) "Pharmacist" means a pharmacist licensed under chapter 400j of
160 the general statutes.

161 (b) Notwithstanding any provision of the general statutes, a
162 pharmacist shall immediately dispense a prescription insulin drug or
163 prescription diabetes equipment and supplies to an individual in this
164 state who does not have a valid prescription for such insulin drug or

165 diabetes equipment and supplies if the pharmacist determines, in such
166 pharmacist's professional judgment, that such individual would suffer
167 immediate physical harm if such pharmacist did not immediately
168 dispense such insulin drug or diabetes equipment and supplies to such
169 individual. Such pharmacist shall dispense to such individual the
170 minimum amount of such insulin drug or diabetes equipment and
171 supplies necessary to ensure that such individual does not suffer
172 immediate physical harm because such individual does not possess
173 such insulin drug or diabetes equipment and supplies.

174 (c) Not later than January 1, 2021, the Commissioner of Consumer
175 Protection shall send a notice, in a form and manner determined by the
176 commissioner, to each pharmacist disclosing the requirements of
177 subsection (b) of this section.

178 (d) The Commissioner of Consumer Protection may adopt
179 regulations, in accordance with the provisions of chapter 54 of the
180 general statutes, to implement the provisions of this section.

181 Sec. 4. (*Effective from passage*) (a) The Commissioner of Social Services
182 shall conduct a study regarding the feasibility of expanding the program
183 established under section 17b-363a of the general statutes to include a
184 fund for the purpose of assisting low-income diabetic individuals in this
185 state to pay for insulin and equipment and supplies used to treat
186 diabetes.

187 (b) Not later than January 1, 2021, the commissioner shall submit a
188 report, in accordance with section 11-4a of the general statutes, to the
189 joint standing committees of the General Assembly having cognizance
190 of matters relating to appropriations and insurance disclosing the
191 results of the study conducted by the commissioner pursuant to
192 subsection (a) of this section.

193 Sec. 5. Subsection (f) of section 38a-493 of the general statutes is
194 repealed and the following is substituted in lieu thereof (*Effective October*
195 *1, 2020*):

196 (f) Home health care benefits may be subject to an annual deductible
197 of not more than fifty dollars for each person covered under a policy
198 and may be subject to a coinsurance provision that provides for
199 coverage of not less than seventy-five per cent of the reasonable charges
200 for such services. Such policy may also contain reasonable limitations
201 and exclusions applicable to home health care coverage. A high
202 deductible health plan, as defined in Section 220(c)(2) or Section
203 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent
204 corresponding internal revenue code of the United States, as amended
205 from time to time, used to establish a medical savings account or an
206 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a
207 health savings account pursuant to Section 223 of said Internal Revenue
208 Code shall not be subject to the deductible limits set forth in this
209 subsection.

210 Sec. 6. Subsection (b) of section 38a-490a of the general statutes is
211 repealed and the following is substituted in lieu thereof (*Effective October*
212 *1, 2020*):

213 (b) No such policy shall impose a coinsurance, copayment, deductible
214 or other out-of-pocket expense for such services, except that a high
215 deductible health plan, as that term is used in subsection (f) of section
216 38a-493, as amended by this act, shall not be subject to the deductible
217 limits set forth in this section.

218 Sec. 7. Subdivision (2) of subsection (b) of section 38a-492k of the
219 general statutes is repealed and the following is substituted in lieu
220 thereof (*Effective October 1, 2020*):

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

226 Sec. 8. Subsection (b) of section 38a-492o of the general statutes is
227 repealed and the following is substituted in lieu thereof (*Effective October*

228 1, 2020):

229 (b) No such policy shall impose a coinsurance, copayment, deductible
230 or other out-of-pocket expense for such testing in excess of twenty per
231 cent of the cost for such testing per year. The provisions of this
232 subsection shall not apply to a high deductible health plan as that term
233 is used in subsection (f) of section 38a-493, as amended by this act.

234 Sec. 9. Subsection (b) of section 38a-492r of the general statutes is
235 repealed and the following is substituted in lieu thereof (*Effective October*
236 *1, 2020*):

237 (b) No policy described in subsection (a) of this section shall impose
238 a coinsurance, copayment, deductible or other out-of-pocket expense for
239 the benefits and services required under said subsection. The provisions
240 of this subsection shall apply to a high deductible health plan, as that
241 term is used in subsection (f) of section 38a-493, as amended by this act,
242 to the maximum extent permitted by federal law, except if such plan is
243 used to establish a medical savings account or an Archer MSA pursuant
244 to Section 220 of the Internal Revenue Code of 1986, or any subsequent
245 corresponding internal revenue code of the United States, as amended
246 from time to time, or a health savings account [, as that term is used in]
247 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or
248 any subsequent corresponding internal revenue code of the United
249 States,] as amended from time to time, the provisions of this subsection
250 shall apply to such plan to the maximum extent that (1) is permitted by
251 federal law, and (2) does not disqualify such account for the deduction
252 allowed under said Section 220 or 223, as applicable. Nothing in this
253 section shall preclude a policy that provides the coverage required
254 under subsection (a) of this section and uses a provider network from
255 imposing cost-sharing requirements for any benefit or service required
256 under said subsection (a) that is delivered by an out-of-network
257 provider.

258 Sec. 10. Subsection (b) of section 38a-492s of the general statutes is
259 repealed and the following is substituted in lieu thereof (*Effective October*

260 1, 2020):

261 (b) No such policy shall impose a coinsurance, copayment, deductible
262 or other out-of-pocket expense for the benefits and services required
263 under subsection (a) of this section. The provisions of this subsection
264 shall apply to a high deductible health plan, as that term is used in
265 subsection (f) of section 38a-493, as amended by this act, to the
266 maximum extent permitted by federal law, except if such plan is used
267 to establish a medical savings account or an Archer MSA pursuant to
268 Section 220 of the Internal Revenue Code of 1986, or any subsequent
269 corresponding internal revenue code of the United States, as amended
270 from time to time, or a health savings account [, as that term is used in]
271 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or
272 any subsequent corresponding internal revenue code of the United
273 States,] as amended from time to time, the provisions of this subsection
274 shall apply to such plan to the maximum extent that (1) is permitted by
275 federal law, and (2) does not disqualify such account for the deduction
276 allowed under said Section 220 or 223, as applicable. Nothing in this
277 section shall preclude a policy that provides the coverage required
278 under subsection (a) of this section and uses a provider network from
279 imposing cost-sharing requirements for any benefit or service required
280 under said subsection (a) that is delivered by an out-of-network
281 provider.

282 Sec. 11. Subdivision (3) of subsection (b) of section 38a-492t of the
283 general statutes is repealed and the following is substituted in lieu
284 thereof (*Effective October 1, 2020*):

285 (3) No such policy shall impose a coinsurance, copayment, deductible
286 or other out-of-pocket expense for a prosthetic device that is more
287 restrictive than that imposed on substantially all other benefits provided
288 under such policy, except that a high deductible health plan, as that term
289 is used in subsection (f) of section 38a-493, as amended by this act, shall
290 not be subject to the deductible limits set forth in this subdivision or
291 under Medicare pursuant to subdivision (1) of this subsection.

292 Sec. 12. Subsection (c) of section 38a-503 of the 2020 supplement to
293 the general statutes is repealed and the following is substituted in lieu
294 thereof (*Effective October 1, 2020*):

295 (c) Benefits under this section shall be subject to any policy provisions
296 that apply to other services covered by such policy, except that no such
297 policy shall impose a coinsurance, copayment, deductible or other out-
298 of-pocket expense for such benefits. The provisions of this subsection
299 shall apply to a high deductible health plan, as that term is used in
300 subsection (f) of section 38a-493, as amended by this act, to the
301 maximum extent permitted by federal law, except if such plan is used
302 to establish a medical savings account or an Archer MSA pursuant to
303 Section 220 of the Internal Revenue Code of 1986 or any subsequent
304 corresponding internal revenue code of the United States, as amended
305 from time to time, or a health savings account pursuant to Section 223
306 of said Internal Revenue Code, as amended from time to time, the
307 provisions of this subsection shall apply to such plan to the maximum
308 extent that (1) is permitted by federal law, and (2) does not disqualify
309 such account for the deduction allowed under said Section 220 or 223,
310 as applicable.

311 Sec. 13. Subsection (b) of section 38a-503e of the general statutes is
312 repealed and the following is substituted in lieu thereof (*Effective October*
313 *1, 2020*):

314 (b) No policy described in subsection (a) of this section shall impose
315 a coinsurance, copayment, deductible or other out-of-pocket expense for
316 the benefits and services required under said subsection (a), except that
317 any such policy that uses a provider network may require cost-sharing
318 when such benefits and services are rendered by an out-of-network
319 provider. The cost-sharing limits imposed under this subsection shall
320 apply to a high deductible health plan, as that term is used in subsection
321 (f) of section 38a-493, as amended by this act, to the maximum extent
322 permitted by federal law, except if such plan is used to establish a
323 medical savings account or an Archer MSA pursuant to Section 220 of
324 the Internal Revenue Code of 1986 or any subsequent corresponding

325 internal revenue code of the United States, as amended from time to
326 time, or a health savings account [, as that term is used in] pursuant to
327 Section 223 of [the] said Internal Revenue Code, [of 1986 or any
328 subsequent corresponding internal revenue code of the United States,]
329 as amended from time to time, the provisions of this subsection shall
330 apply to such plan to the maximum extent that (1) is permitted by
331 federal law, and (2) does not disqualify such account for the deduction
332 allowed under said Section 220 or 223, as applicable.

333 Sec. 14. Subsection (b) of section 38a-503f of the general statutes is
334 repealed and the following is substituted in lieu thereof (*Effective October*
335 *1, 2020*):

336 (b) No policy described in subsection (a) of this section shall impose
337 a coinsurance, copayment, deductible or other out-of-pocket expense for
338 the benefits and services required under said subsection. The provisions
339 of this subsection shall apply to a high deductible health plan, as that
340 term is used in subsection (f) of section 38a-493, as amended by this act,
341 to the maximum extent permitted by federal law, except if such plan is
342 used to establish a medical savings account or an Archer MSA pursuant
343 to Section 220 of the Internal Revenue Code of 1986 or any subsequent
344 corresponding internal revenue code of the United States, as amended
345 from time to time, or a health savings account [, as that term is used in]
346 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or
347 any subsequent corresponding internal revenue code of the United
348 States,] as amended from time to time, the provisions of this subsection
349 shall apply to such plan to the maximum extent that (1) is permitted by
350 federal law, and (2) does not disqualify such account for the deduction
351 allowed under said Section 220 or 223, as applicable. Nothing in this
352 section shall preclude a policy that provides the coverage required
353 under subsection (a) of this section and uses a provider network from
354 imposing cost-sharing requirements for any benefit or service required
355 under said subsection (a) that is delivered by an out-of-network
356 provider.

357 Sec. 15. Subsection (c) of section 38a-511 of the general statutes is

358 repealed and the following is substituted in lieu thereof (*Effective October*
359 *1, 2020*):

360 (c) The provisions of subsections (a) and (b) of this section shall not
361 apply to a high deductible health plan as that term is used in subsection
362 (f) of section 38a-493, as amended by this act.

363 Sec. 16. Subsection (f) of section 38a-520 of the general statutes is
364 repealed and the following is substituted in lieu thereof (*Effective October*
365 *1, 2020*):

366 (f) Home health care benefits may be subject to an annual deductible
367 of not more than fifty dollars for each person covered under a policy
368 and may be subject to a coinsurance provision that provides for
369 coverage of not less than seventy-five per cent of the reasonable charges
370 for such services. Such policy may also contain reasonable limitations
371 and exclusions applicable to home health care coverage. A high
372 deductible health plan, as defined in Section 220(c)(2) or Section
373 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent
374 corresponding internal revenue code of the United States, as amended
375 from time to time, used to establish a medical savings account or an
376 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a
377 health savings account pursuant to Section 223 of said Internal Revenue
378 Code shall not be subject to the deductible limits set forth in this
379 subsection.

380 Sec. 17. Subsection (b) of section 38a-516a of the general statutes is
381 repealed and the following is substituted in lieu thereof (*Effective October*
382 *1, 2020*):

383 (b) No such policy shall impose a coinsurance, copayment, deductible
384 or other out-of-pocket expense for such services, except that a high
385 deductible health plan, as that term is used in subsection (f) of section
386 38a-520, as amended by this act, shall not be subject to the deductible
387 limits set forth in this section.

388 Sec. 18. Subdivision (2) of subsection (b) of section 38a-518k of the

389 general statutes is repealed and the following is substituted in lieu
390 thereof (*Effective October 1, 2020*):

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

396 Sec. 19. Subsection (b) of section 38a-518o of the general statutes is
397 repealed and the following is substituted in lieu thereof (*Effective October*
398 *1, 2020*):

399 (b) No such policy shall impose a coinsurance, copayment, deductible
400 or other out-of-pocket expense for such testing in excess of twenty per
401 cent of the cost for such testing per year. The provisions of this
402 subsection shall not apply to a high deductible health plan as that term
403 is used in subsection (f) of section 38a-520, as amended by this act.

404 Sec. 20. Subsection (b) of section 38a-518r of the general statutes is
405 repealed and the following is substituted in lieu thereof (*Effective October*
406 *1, 2020*):

407 (b) No policy described in subsection (a) of this section shall impose
408 a coinsurance, copayment, deductible or other out-of-pocket expense for
409 the benefits and services required under said subsection. The provisions
410 of this subsection shall apply to a high deductible health plan, as that
411 term is used in subsection (f) of section [38a-493] 38a-520, as amended
412 by this act, to the maximum extent permitted by federal law, except if
413 such plan is used to establish a medical savings account or an Archer
414 MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or
415 any subsequent corresponding internal revenue code of the United
416 States, as amended from time to time, or a health savings account [, as
417 that term is used in] pursuant to Section 223 of [the] said Internal
418 Revenue Code, [of 1986 or any subsequent corresponding internal
419 revenue code of the United States,] as amended from time to time, the
420 provisions of this subsection shall apply to such plan to the maximum

421 extent that (1) is permitted by federal law, and (2) does not disqualify
422 such account for the deduction allowed under said Section 220 or 223,
423 as applicable. Nothing in this section shall preclude a policy that
424 provides the coverage required under subsection (a) of this section and
425 uses a provider network from imposing cost-sharing requirements for
426 any benefit or service required under said subsection (a) that is
427 delivered by an out-of-network provider.

428 Sec. 21. Subsection (b) of section 38a-518s of the general statutes is
429 repealed and the following is substituted in lieu thereof (*Effective October*
430 *1, 2020*):

431 (b) No such policy shall impose a coinsurance, copayment, deductible
432 or other out-of-pocket expense for the benefits and services required
433 under subsection (a) of this section. The provisions of this subsection
434 shall apply to a high deductible health plan, as that term is used in
435 subsection (f) of section [38a-493] 38a-520, as amended by this act, to the
436 maximum extent permitted by federal law, except if such plan is used
437 to establish a medical savings account or an Archer MSA pursuant to
438 Section 220 of the Internal Revenue Code of 1986 or any subsequent
439 corresponding internal revenue code of the United States, as amended
440 from time to time, or a health savings account [, as that term is used in]
441 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or
442 any subsequent corresponding internal revenue code of the United
443 States,] as amended from time to time, the provisions of this subsection
444 shall apply to such plan to the maximum extent that (1) is permitted by
445 federal law, and (2) does not disqualify such account for the deduction
446 allowed under said Section 220 or 223, as applicable. Nothing in this
447 section shall preclude a policy that provides the coverage required
448 under subsection (a) of this section and uses a provider network from
449 imposing cost-sharing requirements for any benefit or service required
450 under said subsection (a) that is delivered by an out-of-network
451 provider.

452 Sec. 22. Subdivision (3) of subsection (b) of section 38a-518t of the
453 general statutes is repealed and the following is substituted in lieu

454 thereof (*Effective October 1, 2020*):

455 (3) No such policy shall impose a coinsurance, copayment, deductible
456 or other out-of-pocket expense for a prosthetic device that is more
457 restrictive than that imposed on substantially all other benefits provided
458 under such policy, except that a high deductible health plan, as that term
459 is used in subsection (f) of section 38a-520, as amended by this act, shall
460 not be subject to the deductible limits set forth in this subdivision or
461 under Medicare pursuant to subdivision (1) of this subsection.

462 Sec. 23. Subsection (c) of section 38a-530 of the 2020 supplement to
463 the general statutes is repealed and the following is substituted in lieu
464 thereof (*Effective October 1, 2020*):

465 (c) Benefits under this section shall be subject to any policy provisions
466 that apply to other services covered by such policy, except that no such
467 policy shall impose a coinsurance, copayment, deductible or other out-
468 of-pocket expense for such benefits. The provisions of this subsection
469 shall apply to a high deductible health plan, as that term is used in
470 subsection (f) of section 38a-520, as amended by this act, to the
471 maximum extent permitted by federal law, except if such plan is used
472 to establish a medical savings account or an Archer MSA pursuant to
473 Section 220 of the Internal Revenue Code of 1986 or any subsequent
474 corresponding internal revenue code of the United States, as amended
475 from time to time, or a health savings account pursuant to Section 223
476 of said Internal Revenue Code, as amended from time to time, the
477 provisions of this subsection shall apply to such plan to the maximum
478 extent that (1) is permitted by federal law, and (2) does not disqualify
479 such account for the deduction allowed under said Section 220 or 223,
480 as applicable.

481 Sec. 24. Subsection (b) of section 38a-530e of the general statutes is
482 repealed and the following is substituted in lieu thereof (*Effective October*
483 *1, 2020*):

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

486 the benefits and services required under said subsection (a), except that
487 any such policy that uses a provider network may require cost-sharing
488 when such benefits and services are rendered by an out-of-network
489 provider. The cost-sharing limits imposed under this subsection shall
490 apply to a high deductible health plan, as that term is used in subsection
491 (f) of section [38a-493] 38a-520, as amended by this act, to the maximum
492 extent permitted by federal law, except if such plan is used to establish
493 a medical savings account or an Archer MSA pursuant to Section 220 of
494 the Internal Revenue Code of 1986 or any subsequent corresponding
495 internal revenue code of the United States, as amended from time to
496 time, or a health savings account [, as that term is used in] pursuant to
497 Section 223 of [the] said Internal Revenue Code, [of 1986 or any
498 subsequent corresponding internal revenue code of the United States,]
499 as amended from time to time, the provisions of this subsection shall
500 apply to such plan to the maximum extent that (1) is permitted by
501 federal law, and (2) does not disqualify such account for the deduction
502 allowed under said Section 220 or 223, as applicable.

503 Sec. 25. Subsection (b) of section 38a-530f of the general statutes is
504 repealed and the following is substituted in lieu thereof (*Effective October*
505 *1, 2020*):

506 (b) No policy described in subsection (a) of this section shall impose
507 a coinsurance, copayment, deductible or other out-of-pocket expense for
508 the benefits and services required under said subsection. The provisions
509 of this subsection shall apply to a high deductible health plan, as that
510 term is used in subsection (f) of section [38a-493] 38a-520, as amended
511 by this act, to the maximum extent permitted by federal law, except if
512 such plan is used to establish a medical savings account or an Archer
513 MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or
514 any subsequent corresponding internal revenue code of the United
515 States, as amended from time to time, or a health savings account, as
516 that term is used in Section 223 of [the] said Internal Revenue Code, [of
517 1986 or any subsequent corresponding internal revenue code of the
518 United States,] as amended from time to time, the provisions of this
519 subsection shall apply to such plan to the maximum extent that (1) is

520 permitted by federal law, and (2) does not disqualify such account for
 521 the deduction allowed under said Section 220 or 223, as applicable.
 522 Nothing in this section shall preclude a policy that provides the
 523 coverage required under subsection (a) of this section and uses a
 524 provider network from imposing cost-sharing requirements for any
 525 benefit or service required under said subsection (a) that is delivered by
 526 an out-of-network provider.

527 Sec. 26. Subsection (c) of section 38a-550 of the general statutes is
 528 repealed and the following is substituted in lieu thereof (*Effective October*
 529 *1, 2020*):

530 (c) The provisions of subsections (a) and (b) of this section shall not
 531 apply to a high deductible health plan as that term is used in subsection
 532 (f) of section 38a-520, as amended by this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2021</i>	38a-492d
Sec. 2	<i>January 1, 2021</i>	38a-518d
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>October 1, 2020</i>	38a-493(f)
Sec. 6	<i>October 1, 2020</i>	38a-490a(b)
Sec. 7	<i>October 1, 2020</i>	38a-492k(b)(2)
Sec. 8	<i>October 1, 2020</i>	38a-492o(b)
Sec. 9	<i>October 1, 2020</i>	38a-492r(b)
Sec. 10	<i>October 1, 2020</i>	38a-492s(b)
Sec. 11	<i>October 1, 2020</i>	38a-492t(b)(3)
Sec. 12	<i>October 1, 2020</i>	38a-503(c)
Sec. 13	<i>October 1, 2020</i>	38a-503e(b)
Sec. 14	<i>October 1, 2020</i>	38a-503f(b)
Sec. 15	<i>October 1, 2020</i>	38a-511(c)
Sec. 16	<i>October 1, 2020</i>	38a-520(f)
Sec. 17	<i>October 1, 2020</i>	38a-516a(b)
Sec. 18	<i>October 1, 2020</i>	38a-518k(b)(2)
Sec. 19	<i>October 1, 2020</i>	38a-518o(b)
Sec. 20	<i>October 1, 2020</i>	38a-518r(b)

Sec. 21	<i>October 1, 2020</i>	38a-518s(b)
Sec. 22	<i>October 1, 2020</i>	38a-518t(b)(3)
Sec. 23	<i>October 1, 2020</i>	38a-530(c)
Sec. 24	<i>October 1, 2020</i>	38a-530e(b)
Sec. 25	<i>October 1, 2020</i>	38a-530f(b)
Sec. 26	<i>October 1, 2020</i>	38a-550(c)

Statement of Purpose:

To: (1) Expand required health insurance coverage for prescription drugs, equipment and supplies used to treat diabetes; (2) restrict cost-sharing for such drugs, equipment and supplies; (3) require licensed pharmacists to dispense such drugs, equipment and supplies without a prescription in certain circumstances; (4) require the Commissioner of Social Services to study and report regarding the feasibility of implementing a low-income diabetes assistance fund; and (5) make changes to various provisions of the general statutes concerning high deductible health plans to more closely conform to provisions of the Internal Revenue Code concerning health savings accounts and medical savings accounts.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]