AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS.

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

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 Section 38a-492d of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2021):

(a) For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

[(b) Notwithstanding the provisions of section 38a-492a, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined
in section 20-571.]

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

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

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

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

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

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

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

(a) For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Fifty dollars for each thirty-day supply of a medically necessary covered noninsulin drug prescribed to the insured by a prescribing practitioner; or
(C) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes equipment and supplies for such insured that are in accordance with such insured's diabetes treatment plan.

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

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

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

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

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

(3) "Pharmacist" means a pharmacist licensed under chapter 400j of the general statutes.
(b) Notwithstanding any provision of the general statutes, a pharmacist shall immediately dispense a prescription insulin drug or prescription diabetes equipment and supplies to an individual in this state who does not have a valid prescription for such insulin drug or diabetes equipment and supplies if the pharmacist determines, in such pharmacist's professional judgment, that such individual would suffer immediate physical harm if such pharmacist did not immediately dispense such insulin drug or diabetes equipment and supplies to such individual. Such pharmacist shall dispense to such individual the minimum amount of such insulin drug or diabetes equipment and supplies necessary to ensure that such individual does not suffer immediate physical harm because such individual does not possess such insulin drug or diabetes equipment and supplies.

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

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

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

(b) Not later than January 1, 2021, the commissioner shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and insurance disclosing the results of the study conducted by the commissioner pursuant to subsection (a) of this section.
Sec. 5. Subsection (f) of section 38a-493 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2020):

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

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

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

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

(2) A coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this subdivision shall not
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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, as 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

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Sec. 10. Subsection (b) of section 38a-492s of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2020):

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

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

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

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

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

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

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

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

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

Sec. 15. Subsection (c) of section 38a-511 of the general statutes is
repealed and the following is substituted in lieu thereof (Effective October
1, 2020):

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

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

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

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

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

Sec. 18. Subdivision (2) of subsection (b) of section 38a-518k of the
general statutes is repealed and the following is substituted in lieu
thereof (Effective October 1, 2020):

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

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

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

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

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

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

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

Sec. 22. Subdivision (3) of subsection (b) of section 38a-518t of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2020):

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

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

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

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

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

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

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

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

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

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<td>Sec. 26</td>
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**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.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. DUFF, 25th Dist.  
SEN. DAUGHERTY ABRAMS, 13th Dist.; SEN. ANWAR, 3rd Dist.  
SEN. CASSANO, 4th Dist.; SEN. COHEN, 12th Dist.  
SEN. FLEXER, 29th Dist.; SEN. FONFARA, 1st Dist.
Committee Bill No. 1

SEN. HARTLEY, 15th Dist.; SEN. HASKELL, 26th Dist.
SEN. KUSHNER, 24th Dist.; SEN. LEONE, 27th Dist.
SEN. LESSER, 9th Dist.; SEN. MARONEY, 14th Dist.
SEN. MCCCRORY, 2nd Dist.; SEN. MOORE, 22nd Dist.
SEN. NEEDLEMAN, 33rd Dist.; SEN. OSTEN, 19th Dist.
SEN. SLAP, 5th Dist.; SEN. WINFIELD, 10th Dist.
REP. REYES, 75th Dist.

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