



General Assembly

February Session, 2020

***Raised Bill No. 337***

LCO No. 2043



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

***AN ACT CONCERNING HIGH DEDUCTIBLE HEALTH PLANS,  
QUALIFIED HEALTH PLANS AND DISCRIMINATION AGAINST  
PERSONS ON THE BASIS OF SEXUAL ORIENTATION AND GENDER  
IDENTITY.***

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

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 Section 38a-1 of the general statutes is repealed and the  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

3 Terms used in this title and sections 2 and 3 of this act, unless it  
4 appears from the context to the contrary, shall have a scope and  
5 meaning as set forth in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly  
7 through one or more intermediaries, controls, is controlled by or is  
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or  
10 organized or constituted within or under the laws of any jurisdiction or  
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments  
13 where the making or continuance of all or some of the series of the  
14 payments, or the amount of the payment, is dependent upon the  
15 continuance of human life or is for a specified term of years. This  
16 definition does not apply to payments made under a policy of life  
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means  
20 the possession, direct or indirect, of the power to direct or cause the  
21 direction of the management and policies of a person, whether through  
22 the ownership of voting securities, by contract other than a commercial  
23 contract for goods or nonmanagement services, or otherwise, unless the  
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,  
26 incorporated, organized or constituted within or under the laws of this  
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that  
29 has been authorized by the commissioner to write surplus lines  
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district  
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or  
34 organized or constituted within or under the laws of another state or a  
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is  
37 unable to pay its obligations when they are due, or when its admitted  
38 assets do not exceed its liabilities plus the greater of: (A) Capital and  
39 surplus required by law for its organization and continued operation;  
40 or (B) the total par or stated value of its authorized and issued capital  
41 stock. For purposes of this subdivision "liabilities" shall include but not

42 be limited to reserves required by statute or by regulations adopted by  
43 the commissioner in accordance with the provisions of chapter 54 or  
44 specific requirements imposed by the commissioner upon a subject  
45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,  
47 provide services or any other thing of value on the happening of a  
48 particular event or contingency or to provide indemnity for loss in  
49 respect to a specified subject by specified perils in return for a  
50 consideration. In any contract of insurance, an insured shall have an  
51 interest which is subject to a risk of loss through destruction or  
52 impairment of that interest, which risk is assumed by the insurer and  
53 such assumption shall be part of a general scheme to distribute losses  
54 among a large group of persons bearing similar risks in return for a  
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or  
57 combination of persons doing any kind or form of insurance business  
58 other than a fraternal benefit society, and shall include a receiver of any  
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an  
61 insurer makes a promise in an insurance policy. The term includes  
62 policyholders, subscribers, members and beneficiaries. This definition  
63 applies only to the provisions of this title and does not define the  
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances  
66 pertaining to or connected with human life. The business of life  
67 insurance includes granting endowment benefits, granting additional  
68 benefits in the event of death by accident or accidental means, granting  
69 additional benefits in the event of the total and permanent disability of  
70 the insured, and providing optional methods of settlement of proceeds.  
71 Life insurance includes burial contracts to the extent provided by  
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the

74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a  
76 limited liability company, an association, a joint stock company, a  
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements  
79 and riders, purporting to be an enforceable contract, which  
80 memorializes in writing some or all of the terms of an insurance  
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled  
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an  
86 insurer that has not been granted a certificate of authority by the  
87 commissioner to transact the business of insurance in this state or an  
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories  
90 and possessions, the Commonwealth of Puerto Rico and the District of  
91 Columbia.

92 Sec. 2. (NEW) (*Effective January 1, 2021*) (a) For the purposes of this  
93 section:

94 (1) "Health carrier" has the same meaning as provided in section 38a-  
95 1080 of the general statutes, as amended by this act;

96 (2) "High deductible health plan" has the same meaning as that term  
97 is used in subsection (f) of section 38a-493 of the general statutes, as  
98 amended by this act, and subsection (f) of section 38a-520 of the general  
99 statutes, as amended by this act; and

100 (3) "Qualified high deductible health plan" means a high deductible  
101 health plan that imposes an annual deductible that is not less than the

102 minimum amount necessary for the high deductible health plan to  
103 qualify as a high deductible health plan, regardless of whether the high  
104 deductible health plan (A) is used to establish a medical savings account  
105 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code  
106 of 1986, or any subsequent corresponding internal revenue code of the  
107 United States, as amended from time to time, or a health savings account  
108 pursuant to Section 223 of said Internal Revenue Code, as amended  
109 from time to time, or (B) caps annual out-of-pocket expenses in the  
110 amount specified by the Internal Revenue Service, or any successor  
111 agency, for high deductible health plans.

112 (b) Notwithstanding any provision of the general statutes, each  
113 health carrier that delivers, issues for delivery, renews, amends or  
114 continues a qualified high deductible health plan in this state on or after  
115 January 1, 2021, shall apply the annual deductible for such qualified  
116 high deductible health plan on a policy year basis.

117 (c) The provisions of subsection (b) of this section shall apply to a  
118 qualified high deductible health plan to the maximum extent permitted  
119 by federal law, except if the qualified high deductible health plan is used  
120 to establish a medical savings account or an Archer MSA pursuant to  
121 Section 220 of the Internal Revenue Code of 1986, or any subsequent  
122 corresponding internal revenue code of the United States, as amended  
123 from time to time, or a health savings account pursuant to Section 223  
124 of said Internal Revenue Code, as amended from time to time, the  
125 provisions of said subsection shall apply to the maximum extent that  
126 does not disqualify such account for the deductions allowed under said  
127 sections.

128 (d) The commissioner may adopt regulations, in accordance with the  
129 provisions of chapter 54 of the general statutes, to implement the  
130 provisions of this section.

131 Sec. 3. (NEW) (*Effective January 1, 2021*) Each insurer, health care  
132 center, fraternal benefit society, hospital service corporation, medical  
133 service corporation or other entity that delivers, issues for delivery,

134 renews, amends or continues an individual or group health insurance  
135 policy in this state on or after January 1, 2021, that provides coverage of  
136 the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
137 469 of the general statutes shall require that each health care provider  
138 that provides a covered benefit to an insured and collects a coinsurance,  
139 copayment, deductible or other out-of-pocket expense from the insured  
140 under such policy for such covered benefit in an amount that exceeds  
141 the amount allowed under such policy shall, not later than three  
142 business days after such health care provider receives reimbursement  
143 for such covered benefit under such policy, issue a refund to the insured  
144 for such excess amount.

145 Sec. 4. Section 38a-1080 of the general statutes is repealed and the  
146 following is substituted in lieu thereof (*Effective July 1, 2020*):

147 For purposes of sections 38a-1080 to 38a-1093, inclusive, and section  
148 5 of this act:

149 (1) "Board" means the board of directors of the Connecticut Health  
150 Insurance Exchange;

151 (2) "Commissioner" means the Insurance Commissioner;

152 (3) "Exchange" means the Connecticut Health Insurance Exchange  
153 established pursuant to section 38a-1081;

154 (4) "Affordable Care Act" means the Patient Protection and  
155 Affordable Care Act, P.L. 111-148, as amended by the Health Care and  
156 Education Reconciliation Act, P.L. 111-152, as both may be amended  
157 from time to time, and regulations adopted thereunder;

158 (5) (A) "Health benefit plan" means an insurance policy or contract  
159 offered, delivered, issued for delivery, renewed, amended or continued  
160 in the state by a health carrier to provide, deliver, pay for or reimburse  
161 any of the costs of health care services.

162 (B) "Health benefit plan" does not include:

163 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),  
164 (14), (15) and (16) of section 38a-469 or any combination thereof;

165 (ii) Coverage issued as a supplement to liability insurance;

166 (iii) Liability insurance, including general liability insurance and  
167 automobile liability insurance;

168 (iv) Workers' compensation insurance;

169 (v) Automobile medical payment insurance;

170 (vi) Credit insurance;

171 (vii) Coverage for on-site medical clinics; or

172 (viii) Other similar insurance coverage specified in regulations issued  
173 pursuant to the Health Insurance Portability and Accountability Act of  
174 1996, P.L. 104-191, as amended from time to time, under which benefits  
175 for health care services are secondary or incidental to other insurance  
176 benefits.

177 (C) "Health benefit plan" does not include the following benefits if  
178 they are provided under a separate insurance policy, certificate or  
179 contract or are otherwise not an integral part of the plan:

180 (i) Limited scope dental or vision benefits;

181 (ii) Benefits for long-term care, nursing home care, home health care,  
182 community-based care or any combination thereof; or

183 (iii) Other similar, limited benefits specified in regulations issued  
184 pursuant to the Health Insurance Portability and Accountability Act of  
185 1996, P.L. 104-191, as amended from time to time;

186 (iv) Other supplemental coverage, similar to coverage of the type  
187 specified in subdivisions (9) and (14) of section 38a-469, provided under  
188 a group health plan.

189 (D) "Health benefit plan" does not include coverage of the type  
190 specified in subdivisions (3) and (13) of section 38a-469 or other fixed  
191 indemnity insurance if (i) such coverage is provided under a separate  
192 insurance policy, certificate or contract, (ii) there is no coordination  
193 between the provision of the benefits and any exclusion of benefits  
194 under any group health plan maintained by the same plan sponsor, and  
195 (iii) the benefits are paid with respect to an event without regard to  
196 whether benefits were also provided under any group health plan  
197 maintained by the same plan sponsor;

198 (6) "Health care services" has the same meaning as provided in  
199 section 38a-478;

200 (7) "Health carrier" means an insurance company, fraternal benefit  
201 society, hospital service corporation, medical service corporation, health  
202 care center or other entity subject to the insurance laws and regulations  
203 of the state or the jurisdiction of the commissioner that contracts or  
204 offers to contract to provide, deliver, pay for or reimburse any of the  
205 costs of health care services;

206 (8) "Internal Revenue Code" means the Internal Revenue Code of  
207 1986, or any subsequent corresponding internal revenue code of the  
208 United States, as amended from time to time;

209 (9) "Person" has the same meaning as provided in section 38a-1, as  
210 amended by this act;

211 (10) "Qualified dental plan" means a limited scope dental plan that  
212 has been certified in accordance with subsection (e) of section 38a-1086;

213 (11) "Qualified employer" has the same meaning as provided in  
214 Section 1312 of the Affordable Care Act;

215 (12) "Qualified health plan" means a health benefit plan that has in  
216 effect a certification that the plan meets the criteria for certification  
217 described in Section 1311(c) of the Affordable Care Act and section 38a-  
218 1086;



219 (13) "Qualified individual" has the same meaning as provided in  
220 Section 1312 of the Affordable Care Act;

221 (14) "Secretary" means the Secretary of the United States Department  
222 of Health and Human Services;

223 (15) "Small employer" has the same meaning as provided in section  
224 38a-564.

225 Sec. 5. (NEW) (*Effective July 1, 2020*) (a) Notwithstanding any  
226 provision of the general statutes and to the extent permitted by federal  
227 law, each qualified health plan that is offered through the exchange at a  
228 silver level of coverage for a plan year beginning on or after January 1,  
229 2021, shall provide coverage for the following benefits:

230 (1) Angiotensin converting enzyme inhibitors for an enrollee who is  
231 diagnosed with congestive heart failure, diabetes or coronary artery  
232 disease by a licensed health care provider who is acting within such  
233 health care provider's scope of practice;

234 (2) Anti-resorptive therapy for an enrollee who is diagnosed with  
235 osteoporosis or osteopenia by a licensed health care provider who is  
236 acting within such health care provider's scope of practice;

237 (3) Beta-adrenergic blocking agents for an enrollee who is diagnosed  
238 with congestive heart failure or coronary artery disease by a licensed  
239 health care provider who is acting within such health care provider's  
240 scope of practice;

241 (4) Blood pressure monitors for an enrollee who is diagnosed with  
242 hypertension by a licensed health care provider who is acting within  
243 such health care provider's scope of practice;

244 (5) Inhaled corticosteroids and peak flow meters for an enrollee who  
245 is diagnosed with asthma by a licensed health care provider who is  
246 acting within such health care provider's scope of practice;

247 (6) Insulin and other glucose lowering agents, retinopathy screening,

248 glucometers and hemoglobin A1c testing for an enrollee who is  
249 diagnosed with diabetes by a licensed health care provider who is acting  
250 within such health care provider's scope of practice;

251 (7) International normalized ratio testing for an enrollee who is  
252 diagnosed with liver disease or a bleeding disorder by a licensed health  
253 care provider who is acting within such health care provider's scope of  
254 practice;

255 (8) Low density lipoprotein testing for an enrollee who is diagnosed  
256 with heart disease by a licensed health care provider who is acting  
257 within such health care provider's scope of practice;

258 (9) Selective serotonin reuptake inhibitors for an enrollee who is  
259 diagnosed with depression by a licensed health care provider who is  
260 acting within such health care provider's scope of practice; and

261 (10) Statins for an enrollee who is diagnosed with heart disease or  
262 diabetes by a licensed health care provider who is acting within such  
263 health care provider's scope of practice.

264 (b) Notwithstanding any provision of the general statutes and to the  
265 extent permitted by federal law, each qualified health plan described in  
266 subsection (a) of this section shall:

267 (1) Have a minimum actuarial value of at least seventy per cent; and

268 (2) Provide enrollees with access to the broadest provider network  
269 available under qualified health plans offered by the health carrier  
270 through the exchange.

271 Sec. 6. Section 38a-447 of the general statutes is repealed and the  
272 following is substituted in lieu thereof (*Effective October 1, 2020*):

273 No life insurance company doing business in this state may: (1) Make  
274 any distinction or discrimination between persons on the basis of race,  
275 sexual orientation or gender identity as to the premiums or rates  
276 charged for policies upon the lives of such persons; (2) demand or

277 require greater premiums from persons of one race, sexual orientation  
278 or gender identity than such as are at that time required by that  
279 company from persons of another race, sexual orientation or gender  
280 identity of the same age, sex, general condition of health and hope of  
281 longevity; or (3) make or require any rebate, diminution or discount on  
282 the basis of race, sexual orientation or gender identity upon the sum to  
283 be paid on any policy in case of the death of any person insured, nor  
284 insert in the policy any condition, nor make any stipulation whereby  
285 such person insured shall bind [himself, his heirs,] such person, such  
286 person's heirs, executors, administrators or assigns to accept any sum  
287 less than the full value or amount of such policy, in case of a claim  
288 accruing thereon by reason of the death of such person insured, other  
289 than such as are imposed upon all persons in similar cases; and each  
290 such stipulation or condition so made or inserted shall be void.

291 Sec. 7. Subsection (f) of section 38a-493 of the general statutes is  
292 repealed and the following is substituted in lieu thereof (*Effective October*  
293 *1, 2020*):

294 (f) Home health care benefits may be subject to an annual deductible  
295 of not more than fifty dollars for each person covered under a policy  
296 and may be subject to a coinsurance provision that provides for  
297 coverage of not less than seventy-five per cent of the reasonable charges  
298 for such services. Such policy may also contain reasonable limitations  
299 and exclusions applicable to home health care coverage. A high  
300 deductible health plan, as defined in Section 220(c)(2) or Section  
301 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent  
302 corresponding internal revenue code of the United States, as amended  
303 from time to time, used to establish a medical savings account or an  
304 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a  
305 health savings account pursuant to Section 223 of said Internal Revenue  
306 Code shall not be subject to the deductible limits set forth in this  
307 subsection.

308 Sec. 8. Subsection (b) of section 38a-490a of the general statutes is  
309 repealed and the following is substituted in lieu thereof (*Effective October*

310 1, 2020):

311 (b) No such policy shall impose a coinsurance, copayment, deductible  
312 or other out-of-pocket expense for such services, except that a high  
313 deductible health plan, as that term is used in subsection (f) of section  
314 38a-493, as amended by this act, shall not be subject to the deductible  
315 limits set forth in this section.

316 Sec. 9. Subdivision (2) of subsection (b) of section 38a-492k of the  
317 general statutes is repealed and the following is substituted in lieu  
318 thereof (*Effective October 1, 2020*):

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

324 Sec. 10. Subsection (b) of section 38a-492o of the general statutes is  
325 repealed and the following is substituted in lieu thereof (*Effective October*  
326 *1, 2020*):

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

332 Sec. 11. Subsection (b) of section 38a-492r of the general statutes is  
333 repealed and the following is substituted in lieu thereof (*Effective October*  
334 *1, 2020*):

335 (b) No policy described in subsection (a) of this section shall impose  
336 a coinsurance, copayment, deductible or other out-of-pocket expense for  
337 the benefits and services required under said subsection. The provisions  
338 of this subsection shall apply to a high deductible health plan, as that  
339 term is used in subsection (f) of section 38a-493, as amended by this act,

340 to the maximum extent permitted by federal law, except if such plan is  
341 used to establish a medical savings account or an Archer MSA pursuant  
342 to Section 220 of the Internal Revenue Code of 1986, or any subsequent  
343 corresponding internal revenue code of the United States, as amended  
344 from time to time, or a health savings account [, as that term is used in]  
345 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or  
346 any subsequent corresponding internal revenue code of the United  
347 States,] as amended from time to time, the provisions of this subsection  
348 shall apply to such plan to the maximum extent that (1) is permitted by  
349 federal law, and (2) does not disqualify such account for the deduction  
350 allowed under said Section 220 or 223, as applicable. Nothing in this  
351 section shall preclude a policy that provides the coverage required  
352 under subsection (a) of this section and uses a provider network from  
353 imposing cost-sharing requirements for any benefit or service required  
354 under said subsection (a) that is delivered by an out-of-network  
355 provider.

356 Sec. 12. Subsection (b) of section 38a-492s of the general statutes is  
357 repealed and the following is substituted in lieu thereof (*Effective October*  
358 *1, 2020*):

359 (b) No such policy shall impose a coinsurance, copayment, deductible  
360 or other out-of-pocket expense for the benefits and services required  
361 under subsection (a) of this section. The provisions of this subsection  
362 shall apply to a high deductible health plan, as that term is used in  
363 subsection (f) of section 38a-493, as amended by this act, to the  
364 maximum extent permitted by federal law, except if such plan is used  
365 to establish a medical savings account or an Archer MSA pursuant to  
366 Section 220 of the Internal Revenue Code of 1986, or any subsequent  
367 corresponding internal revenue code of the United States, as amended  
368 from time to time, or a health savings account [, as that term is used in]  
369 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or  
370 any subsequent corresponding internal revenue code of the United  
371 States,] as amended from time to time, the provisions of this subsection  
372 shall apply to such plan to the maximum extent that (1) is permitted by  
373 federal law, and (2) does not disqualify such account for the deduction

374 allowed under said Section 220 or 223, as applicable. Nothing in this  
375 section shall preclude a policy that provides the coverage required  
376 under subsection (a) of this section and uses a provider network from  
377 imposing cost-sharing requirements for any benefit or service required  
378 under said subsection (a) that is delivered by an out-of-network  
379 provider.

380 Sec. 13. Subdivision (3) of subsection (b) of section 38a-492t of the  
381 general statutes is repealed and the following is substituted in lieu  
382 thereof (*Effective October 1, 2020*):

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

390 Sec. 14. Subsection (c) of section 38a-503 of the 2020 supplement to  
391 the general statutes is repealed and the following is substituted in lieu  
392 thereof (*Effective October 1, 2020*):

393 (c) Benefits under this section shall be subject to any policy provisions  
394 that apply to other services covered by such policy, except that no such  
395 policy shall impose a coinsurance, copayment, deductible or other out-  
396 of-pocket expense for such benefits. The provisions of this subsection  
397 shall apply to a high deductible health plan, as that term is used in  
398 subsection (f) of section 38a-493, as amended by this act, to the  
399 maximum extent permitted by federal law, except if such plan is used  
400 to establish a medical savings account or an Archer MSA pursuant to  
401 Section 220 of the Internal Revenue Code of 1986 or any subsequent  
402 corresponding internal revenue code of the United States, as amended  
403 from time to time, or a health savings account pursuant to Section 223  
404 of said Internal Revenue Code, as amended from time to time, the  
405 provisions of this subsection shall apply to such plan to the maximum

406 extent that (1) is permitted by federal law, and (2) does not disqualify  
407 such account for the deduction allowed under said Section 220 or 223,  
408 as applicable.

409 Sec. 15. Subsection (b) of section 38a-503e of the general statutes is  
410 repealed and the following is substituted in lieu thereof (*Effective October*  
411 *1, 2020*):

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

431 Sec. 16. Subsection (b) of section 38a-503f of the general statutes is  
432 repealed and the following is substituted in lieu thereof (*Effective October*  
433 *1, 2020*):

434 (b) No policy described in subsection (a) of this section shall impose  
435 a coinsurance, copayment, deductible or other out-of-pocket expense for  
436 the benefits and services required under said subsection. The provisions  
437 of this subsection shall apply to a high deductible health plan, as that

438 term is used in subsection (f) of section 38a-493, as amended by this act,  
439 to the maximum extent permitted by federal law, except if such plan is  
440 used to establish a medical savings account or an Archer MSA pursuant  
441 to Section 220 of the Internal Revenue Code of 1986 or any subsequent  
442 corresponding internal revenue code of the United States, as amended  
443 from time to time, or a health savings account [, as that term is used in]  
444 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or  
445 any subsequent corresponding internal revenue code of the United  
446 States,] as amended from time to time, the provisions of this subsection  
447 shall apply to such plan to the maximum extent that (1) is permitted by  
448 federal law, and (2) does not disqualify such account for the deduction  
449 allowed under said Section 220 or 223, as applicable. Nothing in this  
450 section shall preclude a policy that provides the coverage required  
451 under subsection (a) of this section and uses a provider network from  
452 imposing cost-sharing requirements for any benefit or service required  
453 under said subsection (a) that is delivered by an out-of-network  
454 provider.

455 Sec. 17. Subsection (c) of section 38a-511 of the general statutes is  
456 repealed and the following is substituted in lieu thereof (*Effective October*  
457 *1, 2020*):

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

461 Sec. 18. Subsection (f) of section 38a-520 of the general statutes is  
462 repealed and the following is substituted in lieu thereof (*Effective October*  
463 *1, 2020*):

464 (f) Home health care benefits may be subject to an annual deductible  
465 of not more than fifty dollars for each person covered under a policy  
466 and may be subject to a coinsurance provision that provides for  
467 coverage of not less than seventy-five per cent of the reasonable charges  
468 for such services. Such policy may also contain reasonable limitations  
469 and exclusions applicable to home health care coverage. A high



470 deductible health plan, as defined in Section 220(c)(2) or Section  
471 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent  
472 corresponding internal revenue code of the United States, as amended  
473 from time to time, used to establish a medical savings account or an  
474 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a  
475 health savings account pursuant to Section 223 of said Internal Revenue  
476 Code shall not be subject to the deductible limits set forth in this  
477 subsection.

478       Sec. 19. Subsection (b) of section 38a-516a of the general statutes is  
479 repealed and the following is substituted in lieu thereof (*Effective October*  
480 *1, 2020*):

481       (b) No such policy shall impose a coinsurance, copayment, deductible  
482 or other out-of-pocket expense for such services, except that a high  
483 deductible health plan, as that term is used in subsection (f) of section  
484 38a-520, as amended by this act, shall not be subject to the deductible  
485 limits set forth in this section.

486       Sec. 20. Subdivision (2) of subsection (b) of section 38a-518k of the  
487 general statutes is repealed and the following is substituted in lieu  
488 thereof (*Effective October 1, 2020*):

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

494       Sec. 21. Subsection (b) of section 38a-518o of the general statutes is  
495 repealed and the following is substituted in lieu thereof (*Effective October*  
496 *1, 2020*):

497       (b) No such policy shall impose a coinsurance, copayment, deductible  
498 or other out-of-pocket expense for such testing in excess of twenty per  
499 cent of the cost for such testing per year. The provisions of this  
500 subsection shall not apply to a high deductible health plan as that term

501 is used in subsection (f) of section 38a-520, as amended by this act.

502       Sec. 22. Subsection (b) of section 38a-518r of the general statutes is  
503 repealed and the following is substituted in lieu thereof (*Effective October*  
504 *1, 2020*):

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

526       Sec. 23. Subsection (b) of section 38a-518s of the general statutes is  
527 repealed and the following is substituted in lieu thereof (*Effective October*  
528 *1, 2020*):

529       (b) No such policy shall impose a coinsurance, copayment, deductible  
530 or other out-of-pocket expense for the benefits and services required  
531 under subsection (a) of this section. The provisions of this subsection  
532 shall apply to a high deductible health plan, as that term is used in

533 subsection (f) of section [38a-493] 38a-520, as amended by this act, to the  
534 maximum extent permitted by federal law, except if such plan is used  
535 to establish a medical savings account or an Archer MSA pursuant to  
536 Section 220 of the Internal Revenue Code of 1986 or any subsequent  
537 corresponding internal revenue code of the United States, as amended  
538 from time to time, or a health savings account [, as that term is used in]  
539 pursuant to Section 223 of [the] said Internal Revenue Code<sub>2</sub> [of 1986 or  
540 any subsequent corresponding internal revenue code of the United  
541 States,] as amended from time to time, the provisions of this subsection  
542 shall apply to such plan to the maximum extent that (1) is permitted by  
543 federal law, and (2) does not disqualify such account for the deduction  
544 allowed under said Section 220 or 223, as applicable. Nothing in this  
545 section shall preclude a policy that provides the coverage required  
546 under subsection (a) of this section and uses a provider network from  
547 imposing cost-sharing requirements for any benefit or service required  
548 under said subsection (a) that is delivered by an out-of-network  
549 provider.

550 Sec. 24. Subdivision (3) of subsection (b) of section 38a-518t of the  
551 general statutes is repealed and the following is substituted in lieu  
552 thereof (*Effective October 1, 2020*):

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

560 Sec. 25. Subsection (c) of section 38a-530 of the 2020 supplement to  
561 the general statutes is repealed and the following is substituted in lieu  
562 thereof (*Effective October 1, 2020*):

563 (c) Benefits under this section shall be subject to any policy provisions  
564 that apply to other services covered by such policy, except that no such

565 policy shall impose a coinsurance, copayment, deductible or other out-  
 566 of-pocket expense for such benefits. The provisions of this subsection  
 567 shall apply to a high deductible health plan, as that term is used in  
 568 subsection (f) of section 38a-520, as amended by this act, to the  
 569 maximum extent permitted by federal law, except if such plan is used  
 570 to establish a medical savings account or an Archer MSA pursuant to  
 571 Section 220 of the Internal Revenue Code of 1986 or any subsequent  
 572 corresponding internal revenue code of the United States, as amended  
 573 from time to time, or a health savings account pursuant to Section 223  
 574 of said Internal Revenue Code, as amended from time to time, the  
 575 provisions of this subsection shall apply to such plan to the maximum  
 576 extent that (1) is permitted by federal law, and (2) does not disqualify  
 577 such account for the deduction allowed under said Section 220 or 223,  
 578 as applicable.

579       Sec. 26. Subsection (b) of section 38a-530e of the general statutes is  
 580 repealed and the following is substituted in lieu thereof (*Effective October*  
 581 *1, 2020*):

582       (b) No policy described in subsection (a) of this section shall impose  
 583 a coinsurance, copayment, deductible or other out-of-pocket expense for  
 584 the benefits and services required under said subsection (a), except that  
 585 any such policy that uses a provider network may require cost-sharing  
 586 when such benefits and services are rendered by an out-of-network  
 587 provider. The cost-sharing limits imposed under this subsection shall  
 588 apply to a high deductible health plan, as that term is used in subsection  
 589 (f) of section [38a-493] 38a-520, as amended by this act, to the maximum  
 590 extent permitted by federal law, except if such plan is used to establish  
 591 a medical savings account or an Archer MSA pursuant to Section 220 of  
 592 the Internal Revenue Code of 1986 or any subsequent corresponding  
 593 internal revenue code of the United States, as amended from time to  
 594 time, or a health savings account [ , as that term is used in] pursuant to  
 595 Section 223 of [the] said Internal Revenue Code, [of 1986 or any  
 596 subsequent corresponding internal revenue code of the United States,]  
 597 as amended from time to time, the provisions of this subsection shall  
 598 apply to such plan to the maximum extent that (1) is permitted by

599 federal law, and (2) does not disqualify such account for the deduction  
600 allowed under said Section 220 or 223, as applicable.

601 Sec. 27. Subsection (b) of section 38a-530f of the general statutes is  
602 repealed and the following is substituted in lieu thereof (*Effective October*  
603 *1, 2020*):

604 (b) No policy described in subsection (a) of this section shall impose  
605 a coinsurance, copayment, deductible or other out-of-pocket expense for  
606 the benefits and services required under said subsection. The provisions  
607 of this subsection shall apply to a high deductible health plan, as that  
608 term is used in subsection (f) of section [38a-493] 38a-520, as amended  
609 by this act, to the maximum extent permitted by federal law, except if  
610 such plan is used to establish a medical savings account or an Archer  
611 MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or  
612 any subsequent corresponding internal revenue code of the United  
613 States, as amended from time to time, or a health savings account, as  
614 that term is used in Section 223 of [the] said Internal Revenue Code, [of  
615 1986 or any subsequent corresponding internal revenue code of the  
616 United States,] as amended from time to time, the provisions of this  
617 subsection shall apply to such plan to the maximum extent that (1) is  
618 permitted by federal law, and (2) does not disqualify such account for  
619 the deduction allowed under said Section 220 or 223, as applicable.  
620 Nothing in this section shall preclude a policy that provides the  
621 coverage required under subsection (a) of this section and uses a  
622 provider network from imposing cost-sharing requirements for any  
623 benefit or service required under said subsection (a) that is delivered by  
624 an out-of-network provider.

625 Sec. 28. Subsection (c) of section 38a-550 of the general statutes is  
626 repealed and the following is substituted in lieu thereof (*Effective October*  
627 *1, 2020*):

628 (c) The provisions of subsections (a) and (b) of this section shall not  
629 apply to a high deductible health plan as that term is used in subsection  
630 (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-1
Sec. 2	<i>January 1, 2021</i>	New section
Sec. 3	<i>January 1, 2021</i>	New section
Sec. 4	<i>July 1, 2020</i>	38a-1080
Sec. 5	<i>July 1, 2020</i>	New section
Sec. 6	<i>October 1, 2020</i>	38a-447
Sec. 7	<i>October 1, 2020</i>	38a-493(f)
Sec. 8	<i>October 1, 2020</i>	38a-490a(b)
Sec. 9	<i>October 1, 2020</i>	38a-492k(b)(2)
Sec. 10	<i>October 1, 2020</i>	38a-492o(b)
Sec. 11	<i>October 1, 2020</i>	38a-492r(b)
Sec. 12	<i>October 1, 2020</i>	38a-492s(b)
Sec. 13	<i>October 1, 2020</i>	38a-492t(b)(3)
Sec. 14	<i>October 1, 2020</i>	38a-503(c)
Sec. 15	<i>October 1, 2020</i>	38a-503e(b)
Sec. 16	<i>October 1, 2020</i>	38a-503f(b)
Sec. 17	<i>October 1, 2020</i>	38a-511(c)
Sec. 18	<i>October 1, 2020</i>	38a-520(f)
Sec. 19	<i>October 1, 2020</i>	38a-516a(b)
Sec. 20	<i>October 1, 2020</i>	38a-518k(b)(2)
Sec. 21	<i>October 1, 2020</i>	38a-518o(b)
Sec. 22	<i>October 1, 2020</i>	38a-518r(b)
Sec. 23	<i>October 1, 2020</i>	38a-518s(b)
Sec. 24	<i>October 1, 2020</i>	38a-518t(b)(3)
Sec. 25	<i>October 1, 2020</i>	38a-530(c)
Sec. 26	<i>October 1, 2020</i>	38a-530e(b)
Sec. 27	<i>October 1, 2020</i>	38a-530f(b)
Sec. 28	<i>October 1, 2020</i>	38a-550(c)

**Statement of Purpose:**

To: (1) Require certain high deductible health plans to apply annual deductibles on a calendar year basis; (2) require certain health care providers to promptly refund excess cost-sharing payments for covered benefits; (3) require certain qualified health plans offered through the Connecticut Health Insurance Exchange to cover certain benefits, have a minimum actuarial value of at least seventy per cent and offer a broad provider network; (4) prohibit life insurers from discriminating against

persons on the basis of sexual orientation or gender identity; 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.]*