



Health Insurance Coverage for Insulin and Diabetes Under PA 20-4 (JSS)

An Act Concerning Diabetes and High Deductible Health Plans

Beginning January 1, 2022, [PA 20-4](#), July Special Session (JSS), expands fully-insured commercial health insurance coverage for insulin and diabetes equipment and supplies, including by (1) limiting the amount an individual will pay out-of-pocket and (2) covering emergency medicine and supplies. Generally, the new law applies to fully insured health insurance policies in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan (hereafter “applicable health insurance policies”). However, the out-of-pocket cost limits may not fully apply to individuals with high deductible health plans (HDHPs) (see below).

Expanded Coverage Under PA 20-4

Currently, the applicable health insurance policies must cover (1) laboratory and diagnostic tests for all types of diabetes and (2) medically necessary treatment (including equipment, drugs, and supplies) for insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes.

Under PA 20-4, JSS, the applicable policies must cover treatment for all types of diabetes, including:

1. laboratory and diagnostic tests and screening, including hemoglobin A1c testing and retinopathy screening;
2. prescribed insulin and non-insulin drugs;
3. diabetes devices in accordance with the insured’s treatment plan; and
4. diabetic ketoacidosis devices in accordance with the insured’s treatment plan.

Fully-Insured vs. Self-Insured

Generally, a fully-insured health plan assumes the risk and pays claims in return for premiums. PA 20-4 applies to most fully insured health plans, which [cover approximately half](#) of privately insured state residents. Under a self-insured plan, the insured assumes the plan’s risk. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates (including coverage under this act) do not apply to self-insured benefit plans.

Out-of-Pocket Limits

Under the act, covered individuals generally do not pay more out-of-pocket than:

1. \$25 for each 30-day supply of a covered, prescribed, medically necessary insulin or non-insulin glucagon drug, and
2. \$100 for each 30-day supply of a covered, medically necessary diabetes device or diabetic ketoacidosis device.

HDHPs

These out-of-pocket limits only apply to HDHPs to the extent that they do not disqualify insureds with these plans from certain federal tax benefits. Under federal law, individuals with eligible HDHPs may make pre-tax contributions to health savings accounts or Archer Medical Savings Accounts. To maintain these accounts' tax advantaged status, the IRS prohibits the associated HDHPs from limiting deductibles (i.e., out-of-pocket costs) except for certain preventive care items, which may include certain insulin and diabetes supplies.

Insurance for Diabetic Emergencies

In certain emergency situations, PA 20-4, JSS, requires pharmacists to prescribe and dispense up to a 30-day emergency supply of diabetes-related drugs and devices to a patient. Generally, under the act, an emergency is when a patient (1) has less than a week's supply of insulin or glucagon drugs, or diabetes or diabetic ketoacidosis devices, and (2) in the pharmacist's professional opinion, will likely suffer significant physical harm within a week without the drugs or devices.

Under the act, the applicable health insurance policies must cover emergency:

1. insulin and glucagon drugs, up to once per policy year;
2. diabetes devices, up to once per policy year; and
3. diabetic ketoacidosis devices, up to once per policy year.

The out-of-pocket maximums described above also apply to these emergency drugs and devices. Generally, this means that a covered individual will not pay more than (1) \$25 for an emergency supply of insulin or a glucagon drug or (2) \$100 for an emergency supply of diabetes or diabetic ketoacidosis devices.

The act limits how much a pharmacist may charge insured patients to the coinsurance, copayment, deductible, or out-of-pocket costs required by the insurance plan (i.e., for fully insured patients covered by the act, \$25 or \$100 for drugs or devices, respectively). For uninsured patients, pharmacists may charge up to the usual customary charge to the public for these items.

Definitions

Insulin Drugs – Drugs containing insulin, including insulin pens

Non-Insulin Drugs – Drugs that do not contain insulin, such as glucagon drugs and glucose tablets and gels

Diabetes Devices – Devices used to diagnose or treat diabetes or low blood sugar, including blood glucose test strips, glucometers, continuous glucometers, lancets, lancing devices, and insulin syringes

Diabetic Ketoacidosis Devices - Devices used to screen for or prevent diabetic ketoacidosis

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